



Welcome to the November 2018 Mental Capacity Report, including from the newest recruit to the editorial team, Katherine Barnes. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: an update on the Mental Capacity (Amendment) Bill; sex, risk and public anxiety; and a slew of significant decisions relating to medical treatment;

(2) In the Practice and Procedure Report: Sir James Munby addresses the LAG Community Care Conference and updates from the Court Users Group;

(4) In the Wider Context Report: relevant developments from around the world, including an important decision from Australia reflecting back on practice under the MCA;

(5) In the Scotland Report: a report from the World Guardianship Congress, and the impact in Scotland of an important case concerning disability discrimination and autism.

There is no Property and Affairs Report this month as our editor is having a well-earned break; but he would relay to you if here the frustrating news of the delay to the Law Commission's project on wills.

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

Mental Capacity (Amendment) Bill Report stage

Ahead of the Report stage of the Bill on 21 November, the Government has proposed a series of amendments. They are available [here](#), although are somewhat impenetrable in their published form. Helpfully, Tim Spencer-Lane has summarised the effect of the key ones as follows:

1. Extending the Liberty Protection Safeguards to 16 and 17 year olds;
2. Replacing the term “unsound mind” with “mental disorder;”
3. Explicitly stating that the cared-for person must be consulted with;
4. Explicitly stating that the cared-for person’s wishes and feelings must be considered as part of the necessary & proportionate assessment;
5. Requiring responsible bodies to decide if care home managers should arrange the assessments and statement or if the responsible body takes on these functions;
6. Requiring that assessments cannot be carried out by someone with a financial conflict of interest;
7. Confirmation that the responsible body arranges the pre-authorisation review;

8. A duty to appoint an IMCA if a person doesn’t have an ‘appropriate person’ representing them, unless it is in the person’s best interests not to have an IMCA;
9. Removing the requirement that a care home manager must notify the responsible body whether or not an IMCA should be appointed;
10. Requiring that medical and capacity assessments must be completed by those with appropriate experience and knowledge.

One obvious omission from the list is the statutory definition of deprivation of liberty that Lord O’Shaughnessy indicated on the second day of Committee stage the Government would attempt.

Further briefing documents have been published by, amongst others, the [Law Society](#); updates on the Bill’s progress can also be found on Alex’s [website](#).

Sex, risk, and public anxiety

Manchester City Council v LC [2018] EWCOP 30 (Hayden J)

Best interests – contact – mental capacity – sexual relations

Summary¹

This case, concerning the sexual relationships of LC, a young woman with autism and a learning disability, received considerable public attention shortly before this judgment was handed down, a Times journalist having been given permission to access documents from the proceedings and

¹ Nicola Kohn being involved in this case, she did not contribute to this report.

to write about them (though without any reasoned judgment being available). The short judgment from Hayden J, who was hearing the case for the first time, summarises the proceedings with the aim of putting properly in the public domain *"the issues that this case raises so that there can be, as there ought to be, appropriate and informed public debate."*

LC had been found by the court in 2016 to have capacity to: engage in sexual relations; marry; make decisions in relation to contraception. But she was found to lack capacity to; conduct the proceedings; make decisions on her contact with men; make decisions about care and residence; make decisions as to whether to enter or terminate a tenancy; decide whether or not she should access mobile phones or social networking sites.

Hayden J referred to the obvious tension to which these differing determinations of capacity gave rise, saying *"[t]hus, though it may not be intuitive, it is perfectly logical, looking at capacity in an issue-specific context (as the MCA requires), to possess the decision-making facility to embark on sexual relations whilst, at the same time, not being able to judge with whom it is safe to have those relations."*

At the time of the hearing, LC was living in a residential placement with other young women, having visits from her husband five times a week including two overnight visits.

The court referred to discussion that had taken place at the hearing as to whether these limitations on LC's freedom of action in respect of her marriage could be authorised under the MCA:

There has been a legal argument as to whether the MCA, by collateral declarations, is apt to limit the autonomy of individuals in spheres where they are capacitous. In simple terms, whether the measures put in place to protect LC in those areas where she lacks capacity may legitimately impinge on her autonomy in those areas where her capacity is established. It has been canvassed that if the court is to restrict LC either in part or, potentially, fully in such a sphere (i.e. where she has capacity), the court ought only to consider such measures under the parens patriae jurisdiction of the High Court. Happily, it is unnecessary for me to resolve that issue today, indeed, it may not arise. It does require to be said that whenever a court has to curtail the liberty of an individual whether capacitous or not, the burden is acute and the responsibility grave. In future, it seems to me, where issues arise that may necessitate restrictions in areas where adults have capacity, these should be heard by a High Court Judge in the Court of Protection.

Comment

The full details of the decisions made in LC's case may yet be put in the public domain, as the court directed further expert evidence and a further hearing. From the details in this judgment, it is difficult to have an informed view on the press coverage of the proceedings previously and in particular the decision to allow LC to have male visitors to her property, in accordance with her wishes.

The proposal that cases where capacity and incapacity are found in related areas of decision-making should be heard in the High Court is

understandable, but may result in a larger number of cases coming before the High Court than Hayden J anticipated. While he was correct to say that the reported cases in this arena were all heard by High Court judges, that is, in the authors' experience, more a function of the fact that High Court judges are much more likely to give written published judgments than other judges than a reflection of where these issues are decided.

It is to be hoped that the question of capacity might receive some further clarification in a public judgment in this case. Hayden J refers to the woman having significant learning disabilities, yet she is considered to have capacity to consent to marry and to have sexual relations and to make decisions about contraception, and was able to address the judge on a number of issues.

Novel treatments and best interests

UCLH NHS Trust v KG [2018] EWCOP 29 (Cohen J)

Best interests – medical treatment

Summary and comment²

In this case, Cohen J had to decide whether to give authority to administer an entirely novel treatment to a middle-aged man suffering from sporadic CJD. All agreed, including the Official Solicitor's behalf, that the treatment was in his best interests. It was vitally important that treatment begin immediately, as the man's condition was progressing rapidly.

In approving the treatment, Cohen J identified

that the best interests test, here, could be broken down into the following factors (at paragraph 17):

[first] the nature of the treatment that is proposed, what is involved and what its prospects of success are. Secondly, what are the views of the patient, what does he want and what do his nearest and dearest want? Thirdly, how do I feed into the thought process the fact that this is a novel and experimental treatment.

As to nature, the actual treatment was not hugely invasive, it might require direct placement into the brain, together with continual – and potentially uncomfortable – monitoring. Cohen J identified a series of safeguards that were in place regarding the novelty of the treatment, including (at paragraph 22) that:

Next, the Trust in the middle of this year, anticipating that this sort of case would arise within the reasonably foreseeable future, has been in communication with the Official Solicitor and has had at least one meeting with the Official Solicitor involving the appropriate medical staff. That is a step which I applaud. It means the Official Solicitor has had time to consider all the relevant facts and, even though he was doing so in a vacuum without a patient on hand, it permitted the thought processes about the relevant matters to develop without the pressure of a case that was coming imminently before the courts.

When it came to wishes, it was clear that KG himself wanted it. Perhaps slightly more surprisingly, Cohen J also took into account the

² Tor being involved in the case, she has not contributed to this report.

wishes of and, impact upon, his family, following *Simms v NHS Trust* [2002] EWHC 2734 (Fam), concerning an (unrelated) 16 year and an 18 year old, in which Dame Elizabeth Butler-Sloss had noted that:

The impact of refusal by this court of granting the declarations on each set of parents and, in one case, 5 siblings, and in the other case, one sibling, would in my view be enormous and palpable. In a finely balanced case I should give the views of the parents and the effect upon them of refusal great weight in the wider considerations of the best interests test which the court has to apply to each patient.

Cohen J had no hesitation in approving the treatment as being in his best interests.

Two further points of importance arose:

1. In making the application, the Trust made clear that, following the judgment in *Y* it propose to bring further applications before the court in the event that it proposes to treat future patients with PRN100 and the patient and his/her family are in agreement. Cohen J demurred, noting that:

30. Obviously I am not dealing with other cases, but I would respectfully suggest that it might be premature to arrive at such a conclusion until the results of this treatment are known. It may be that the benefit or risk analysis changes.

31. I do, of course, accept that these cases are extremely urgent and they must be brought on to a hearing with great speed. That this can be done is evidenced by this case, an application

issued I think on Thursday last week, possibly Wednesday, and is now before me for a final hearing on the Monday of the following week.

2. The Official Solicitor invited the court to persuade the court that the *Bolam* test was one that should be adopted, drawing attention to the passage in *Simms* at paragraph 42, where the President had said:

First [the doctor] must act at all times in accordance with a responsible and competent body of relevant professional opinion, generally described as the 'Bolam test'... [Secondly] ... a duty to act in the best interests of a mentally incapacitated patient.

However, Cohen J declined to do so, noting (at paragraph 33) that

Simms was a case that pre-dated the Mental Capacity Act, and I do not think it is helpful to layer an additional level of test on top of those which are set out in the Mental Capacity Act.

The test is therefore simply that contained in the MCA, although we would suggest that a doctor who was acting entirely outside the scope of a body of relevant professional opinion would in the ordinary run of events have a difficult time explaining how they could be said reasonably to be acting in the best interests of the patient to whom they were administering the treatment.

Will vs preferences in action?

Re SJ [2018] EWCOP 28 (Moor J)

Best interests – medical treatment

Summary

This case concerned SJ, a 43 year old diabetic suffering from chronic, unhealed bed sores in the context of significant obesity and incontinence. He had previously been detained under the Mental Health Act 1983 during which time he suffered from psychosis and some form of cognitive decline. SJ's treating clinicians were united in the view that SJ lacked capacity to consent to medical treatment and that the insertion of a colostomy was vital to his recovery and survival. His consultant surgeon Mr V gave evidence – via telephone from a taxi, the pavement outside his home, and his home itself – that without colostomy surgery, SJ was likely to die within 6 months.

SJ's sister MJ opposed the use of a colostomy on the basis that SJ had lost substantial amounts of weight and said he did not want the operation. She disputed the capacity evidence and argued the Court should allow SJ's wishes not to have the surgery to be determinative.

Moor J noted SJ's own opposition to the surgery and, at paragraph 35, the conclusions of Munby J in *Re M; ITW v Z* [2009] EWHC 2525 that "... the weight to be attached to [P's] wishes and feelings must depend upon the particular context..."; that the nearer to the borderline of capacity P is, the more weight must be attached to his wishes and feelings; the significance of the strength and consistency of the views P expresses; the possible impact upon him of his wishes and feelings not being given effect; the extent to which P's wishes and feelings are or not rational; and the extent to which P's wishes and feelings could be given effect to within the court's assessment of his best interests. Moor J further noted the conclusion of the Supreme Court in

Aintree University Hospitals NHS Foundation Trust v James [2003] UKSC 67 as to the starting point being, not the reasonable patient, but the person themselves.

He concluded (at paragraph 42):

I am clear that this is an operation that should now take place as being overwhelmingly in SJ's interests. I take the view that, if he had capacity, he would, in fact, see that and would wish to save his life in that way. There is absolutely no indication that he really wants his life to end. I am quite clear that, if he could understand the evidence that I have heard today from the three doctors, he would say "Judge, I do not know why we are in court; of course I must have this operation. Please do it quickly". Because of his incapacity, he is unable to weigh the matters up in this regard. But for that very reason I take the view that I should overrule his wishes, notwithstanding having very carefully considered all the law on this point and the wishes as he has set them out both to the doctors and to the Official Solicitor

Comment

In many cases, including others discussed in this report, sufficient clarity as to the answer as to what the person would have done would give the answer to what lies in their best interests. In other cases, of which this may be an example, what the person really wants and what they say they want (in CRPD language, what their will is and what their preferences appear to be) are in tension: the best interests test in its post-*Aintree* formulation allows this to be accommodated.

As an interesting aside, the case also provides an example of the robust yet flexible case managing

powers available to judges which, it could be argued, more judges in the Court of Protection should exercise. Taking the unorthodox step required in light of the urgency of the case, Moor J heard evidence from one clinician via phone from a taxi. SJ's sister MJ applied to vacate just 2 days before the hearing. Moor J refused to adjourn but made clear to MJ that he would hear any application to adjourn at court. In the event, MJ failed to appear at court without giving any clear reason why. Moor J concluded that it would help neither SJ nor his sister to adjourn matters, furthermore that the case was too urgent to delay. He therefore granted the order sought by the applicant trust in MJ's absence and held that the matter should also be brought finally to an end.

Sex, contraception and the courts

Re P (Sexual Relations and Contraception) [2018] EWCOP 10 (Baker J)

Best interests – contract – contraception – mental capacity – sexual relations

Summary

This case concerned a young woman with learning disabilities, in respect of whom Court of Protection proceedings had been ongoing for a considerable period of time. In 2012, the court determined that P lacked capacity to make decisions about contraception and consented on her behalf to the insertion of an IUD under general anaesthetic. P was never told about the IUD.

In 2016, the local authority applied to restore the proceedings to revisit the question of P's capacity to engage in sexual relations and to make decisions about contraception, and to

consider her best interests and to authorise her deprivation of liberty at her supported living placement.

The court was asked to decide (1) does P has capacity to consent to sexual relations? (2) If she does, what steps should be authorised to facilitate the relationship between P and her boyfriend, or between P and any other person with whom she wished to have a sexual relationship? (3) is the proposed relaxation in supervision in her best interests? In addition, the court reviewed wider issues concerning her treatment, including the question whether it should continue to be covert or whether P should be informed about it.

The court accepted psychiatric evidence that P lacked capacity to make decisions about contraception, residence, care and contact. She was vulnerable to harm from others and could not identify how she would judge whether someone she met posed a risk to her, including with regard to a sexual relationship.

On the topic of capacity to consent to sexual relations, Baker J applied the current caselaw and found that P had capacity, but noted that

many people would agree with the strong views expressed by [P's mother] in a statement filed for the hearing before me in which [she] said inter alia:

"if P lacks capacity to make decisions regarding contact (in particular of people who may cause a risk to her) how on earth can she have capacity in respect of sexual relations? A decision just to have sex with a person surely needs to include a decision based on STDs and other risks involved.

Such a decision in my view is narrow-minded and does not include any thought of consequences for care, accommodation, family etc."

Baker J described the situation as a 'paradigm case' in which P's "relationships need to be supported, managed and, if necessary, controlled by the court" in view of her lack of capacity to make decisions about contact but her capacity to consent to sexual relations.

Baker J noted that the IUD had been fitted without any opportunity for P to express her views and that P's care manager said that if P was asked now, it was her view that P would say she did not want the IUD. Nevertheless, the court concluded that it was in P's best interests for the IUD to remain in place for the rest of its natural lifespan, relying on matters including the following:

1. P would suffer emotional and psychological harm if she became pregnant again, particularly if her child was (as had happened previously on two occasions) removed from her care at birth;
2. P had said consistently she did not want to have a baby at this stage;
3. P's mother considered the IUD should remain in place, in light of her concerns about P's vulnerability to abuse;
4. Even though P was subject to 24 hour supervision, there was a very small risk that she would put herself at risk of exploitation;
5. An IUD remained the most reliable form of contraception for P and there was no medical reason for it to be removed.

Baker J further held that it was not in P's best interests to tell her of the existence of the IUD, accepting that the impact on P's relationships with her family and care team would be put at risk if she lost her trust in them. The judge stated however that this position could not remain forever: "*although I approve the plan to retain the IUD, and not to tell P about it at this stage, I regard it as imperative that professionals working with P keep this issue under review at all times and start planning now for ways in which further decisions about contraception can be taken in a way that includes P and respects her personal autonomy and human rights.*"

Finally, Baker J authorised a trial period of reduction in the supervision afforded to P, in light of her wish to have more freedom. The judge recognised that further problems were likely to arise, as P's mother did not support the relaxation in supervision and remained concerned about sexual exploitation, whereas the local authority were taking steps to see whether P's relationship with her boyfriend could be supported. Having approved the reduction in supervision, however, Baker J said that "*I do not consider it appropriate to include in the order a provision that it is lawful for the local authority to facilitate a sexual relationship between P and a potential partner in accordance with the draft care plan.*" This was not because (for instance) of the possible risk of complicity in offences under the Sexual Offences Act 2003 on the part of the local authority, but simply because he wanted to take a staged approach in light of the history of sexual exploitation.

Comment

This case is, as the judge observed, a paradigm example of the difficulties that arise when a

person is judged to have capacity to consent to sexual relations but not to other, closely related, matters, such as contraception and contact. The net result in this case was that P was permitted to have some time free from 1:1 supervision, but despite her capacity to consent to sexual relations, the local authority could not 'facilitate' a sexual relationship with her partner. The Court of Protection would remain involved, to monitor and make decisions about P's relationship - despite the low threshold test for capacity to consent to sexual relations having been set at that level at least in part to avoid state interference in people's private lives.

Although Baker J did not say so expressly, the judgment suggests that the approval of covert insertion of an IUD might not have been the appropriate way forward back in 2012. Further, and whilst the judgment in the *Y* case was still anticipated, Baker J noted that, whatever the Supreme Court might say about bringing applications concerning serious medical treatment to court, *"given the serious infringement of rights involved in the covert insertion of a contraceptive device, it is in my judgement highly probable that, in most, if not all, cases, professionals faced with a decision whether to take that step will conclude that it is appropriate to apply to the court to facilitate a comprehensive analysis of best interests, with P having the benefit of legal representation and independent expert advice."*

The importance of a natural death

Leeds Teaching Hospital v JF [2018] EWCOP 32 (Cohen J)

Best interests – medical treatment

Summary

A 46 year old lady, N, had breast cancer, and had only a number of months to live. Whilst in the taxi on the way to the hospital to seek assistance after complications with oral medication for her cancer, she suffered a cardiac arrest. For 20 minutes or so ceased breathing and suffered a severe hypoxic injury. In consequence she suffered a very significant and severe brain injury. She remained essentially unconscious. There was no anticipation of any significant improvement in her neurological condition, certainly within the life expectancy of her cancer which was some six to eight months.

Three issues were before Cohen J. The first was whether a tracheostomy tube should be removed; it had been inserted (following approval at an earlier interim hearing) to replace an oral tube which had been causing increasing discomfort and was causing irritation. The Trust sought removal of the tube because they considered that nothing more should be done to extend or prolong N's life. Removal of the tube would have the effect (but not the purpose) of hastening her death, either because N would *"die either by infection of the secretions [that would build up] or would drown."* The family, and the Official Solicitor, wanted to keep it in place; the judge accepted their contention that N would want a natural death, such that it *"would need a very good reason to hasten it in this way."* Cohen J came to the clear view that the tube should remain in place.

The second issue was as to whether or not N should receive an escalation of invasive care or treatment, in particular vasoactive drugs, renal replacement therapy, ventilation treatment that requires central venous action or CPR. There

was agreement in relation to all of these in relation to antibiotics, which the family wanted on the basis that this was *"treatment for a super-imposed condition which would not cause her natural death if treated."* Cohen J held that antibiotics do not need to be provided in the event of there being an infection and that it would not be in N's best interests to provide treatment to seek to avert what would be a natural death.

The last issue was in relation to the administration of morphine. Although N did not discuss her health in a significant way with her family, she and other members of her family did have a fixed objection to morphine. That came from the fact that two members of the family had died at a time that they were taking morphine which had been prescribed for them as a result of very serious health difficulties which they themselves had. The family had formed the view that morphine had played some part in the demise of those two relatives. Although N was not yet far up the analgesic ladder potentially to require morphine, the evidence from her treating team was that there was no better substitute to morphine. However, her treating doctor accepted that *"if a conscious patient had been able to make a balanced decision that he or she did not want morphine he would not seek to impose it upon the patient."* Cohen J noted that he, *"of course, ha[d] to take the decision for others, but I bear in mind the strong family opposition shared by N to the use of morphine."* He therefore authorised medications, but not morphine. However, he gave the Trust permission to apply in relation to morphine if in due course it transpired that there is no alternative that might be able to do the job. As he noted:

Whether the court will order it will depend on the circumstances at that time, but if all other avenues have been exhausted it seems to me that it would be quite wrong for me to bar the treating team from a position of being able to apply for permission to use morphine in circumstances where their conscience makes this, not only highly desirable, but something that should be imminently implemented.

Comment

Although this case was decided shortly before Y (but not reported until more recently) this is the quintessential example of a case which would still be required to come to court even following the clarification of the scope of s.5 MCA 2005 in that case. What does not appear from the judgment in this case is whether mediation was attempted, but, again, this is a paradigm case in which such might have bridged the gap between the family and the treating team as to what was in N's best interests.

Dementia, nutrition and equality of arms

RAO v ROO [2018] EWCOP 33 (Williams J)

Best interests – medical treatment

Summary

In this unusual case, a husband sought orders in relation to medical treatment in relation to his wife, ROO, who was on palliative care in hospital. She had suffered a stroke in 2008, which had serious consequences (inter alia) that she required nursing care in a home thereafter. In 2012, her condition deteriorated, in circumstances that the husband believed had never been adequately investigated, but

considered might arise from the consequences of a malfunctioning shunt. Following a move to a new nursing home in early 2018, her health declined, and she became increasingly resistant to care and regularly refused fluids, food and medication. She was admitted to hospital after her weight had fallen significantly, a diagnosis being made of post-stroke admission. After a period in hospital she was discharged back to the nursing home, but was readmitted shortly thereafter with pneumonia. Attempts to insert a nasogastric tube to assist with nutrition were unsuccessful, although she continued to accept food and drink on occasions orally.

Her husband – acting in person – brought an emergency application in the Court of Protection on the basis that artificial nutrition had been withdrawn and his wife put on palliative care without consultation or agreement, a best interests meeting or an application to the Court of Protection. He sought declarations that: (1) that it was not in best interests to be discharged from hospital in her present condition; (2) that it was in her best interests for her to be taken off palliative care until there had been a full investigation and definitive diagnosis of the cause of her deterioration since 2012; and (3) she be given artificial feeding until she could eat enough to keep her alive.

At an expedited hearing, the Trust invited the court to go beyond the scope of the orders sought by the husband and to make declarations as regards future treatment, in identifying a ceiling of treatment or non-escalation and providing only for palliative care. However, Williams J declined to go down that route having regard to the "seriousness of the issues that were engaged in pursuing such a course and the lack of

notice to [the husband] and the limited time available to the court."

The Trust's position was that ROO was suffering from irreversible and progressive vascular dementia, and that she was now in the final stages of her illness which could be a matter of weeks or months but more likely weeks. They do not consider that any further investigations are required to understand her current condition from a neurological perspective. The Trust considered the provision of intravenous nutrition will do nothing to address the underlying condition. If it were provided and weight were gained and it were then withdrawn ROO would simply lose weight again, and that (in fact) weight gain could not assist her to regain the muscle mass she needed to regain organ function. The Trust also identified risks to artificial nutrition, not least that it was likely that ROO would object to the treatment and the resultant higher level of medicalisation that would be involved. The Trust also noted that, as ROO was being provided with antibiotics if necessary, the palliative care described should not be equated to end of life care. The Trust resisted her transfer to another hospital, as she did not need to be an acute medical ward, and would be comfortable and more receptive to her family in the environment of a nursing home.

Williams J summarised his conclusion as to the approach dictated by the MCA in the post-*Aintree* world thus (at paragraph 35, emphasis in original):

*Therefore, a host of matters must all go into the balance when the judge seeks to arrive at his objective assessment of whether **this** treatment is in **this** patient's best interests. In particular I must*

consider the values and beliefs of ROO as well as any views she expressed when she had capacity that shed light on the likely choice she would make if she were able to and what she would have considered relevant or important. Where those views can be ascertained with sufficient certainty they should carry great weight and usually should be followed; as they would be for a person with capacity who did express such views.

Williams J made clear that each of the three questions before the court on the husband's application depended to a significant extent upon whether there was a definitive diagnosis in relation to the cause of ROO's deterioration since 2012. On a detailed analysis, Williams J was clear the medical evidence that her neurological condition was attributable to those causes which took place in 2008/2012 and subsequent further progressive changes compounded by acute events. They did not result from the consequences of a malfunctioning shunt. He was of the clear view that her condition was irreversible and had been in my view fully explored.

In light of this conclusion, the answers to the questions before him became relatively straightforward. Williams J, however, sought to identify ROO's wishes and feelings to assist, although:

70. The evidence in relation to ROO's wishes and feelings in relation to the application is very limited. She of course does not currently have capacity. She has not given any advance directive in relation to her treatment and there is nothing in writing elsewhere from her which would indicate what her views

would be in respect of the treatment proposed. In respect of what she said to the hospital staff and the indication she gave to Dr Brooke [the hospital had recorded two instances when ROO has said the words 'I want to die'. She also nodded her head when Dr Brooke asked her whether it was true that she wanted to die.] I do not think it's safe to place any reliance on that as her real indication of what she wishes to happen to her. The evidence suggests that at times when she is in a better condition she engages with her children and ROA and takes pleasure from that interaction. She may also still gain pleasure from eating or contemplation. At other times she may have an awareness of her condition and may wonder whether it is worth continuing. In particular if she is feeling unwell she might understandably express a wish to die but I do not think that much, if any, weight can be placed on this in the context of what else is known about ROO. She is described as a fighter, independent, a believer in the circle of life. There are also though indications that while she does not have capacity she is unhappy at intrusive medical treatment or other intrusions into her personal space. She removed the nasogastric tube. She declined medication, food, she does not want a nasogastric tube reinserted. That suggests that she does not welcome further medical intervention, and the more intrusive it is the less she would welcome it. I therefore do not think she would want to be subjected to intrusive treatment which would accompany intravenous feeding. It is clear that an intravenous line would have to be inserted and that it would require intensive medical intervention in terms of monitoring thereafter. I do not consider from what I'm able to glean of her wishes and feelings that she would

want this to be undertaken particularly if she knew that the medical evidence was that it would not actually bring any benefit to her. Nor do I consider she would be likely to want to undergo further investigations such as a further lumbar puncture still less an operation when the medical evidence was that it was neither necessary or appropriate. The evidence is that she needed to be sedated for the 2014 lumbar puncture which indicates that she was not comfortable with that.

Williams J concluded (at paragraph 74) that, as when ROO's best interests were viewed on the broadest perspective, that:

a. Due to the nature of her neurological condition ROO will not recover in a way which will lead to her eating enough to keep her alive. The nature of the progressive vascular dementia that she is suffering from is such that she will sustain loss of appetite and will wish to eat less and less as time passes. That is an inevitable consequence of her condition. There is therefore no prospect of her reaching a position where she can eat enough to keep herself alive in the sense that it appears in the application; namely that she will recover to a position where she will want to and will be able to eat anything approaching a normal diet which would be accompanied by exercise in a way which would sustain her life. Thus having regard in particular to the evidence of Dr Johnston and the guidance on artificial nutrition in patients with dementia there is no benefit to ROO of giving artificial nutrition and nor do I believe she would want to be given it having regard to the intrusive nature of it being administered and the risks of complications which accompany it. I therefore do not consider it to be in ROO's

best interests in the circumstances she currently is in to be given artificial feeding by way of intravenous nutrition.

b. The medical evidence clearly establishes the nature of ROO's neurological condition. There has been a full investigation and insofar as medical science allows there is a definitive diagnosis. There is no need or purpose in further investigation or attempts to reach an alternative diagnosis. The only alternative identified by ROA namely the malfunctioning shunt has been comprehensively addressed and discounted by a number of doctors including Professor Whitfield. I therefore do not find that it is in ROO's best interests to have further investigations in order to reach an alternative diagnosis. Dr Brooke told me, as I have referred to earlier, that ROO is still being given treatment for her condition. She is not being treated as an end-of-life patient at the current time. She has been given antibiotics and other medication for instance. In that sense she is not on what ROA describes as a palliative care regime. The evidence is that ROO is in a stable condition and fit to be discharged to a nursing home where she would continue to be nursed in a manner appropriate to her deteriorating condition. I therefore conclude that it is not in ROO's best interests for her to be taken off palliative care until there has been a full investigation and definitive diagnosis of the cause of her deterioration since 2012.

c. The premise underlying the first order that ROA seeks is that ROO should remain in hospital so that artificial nutrition can be administered and so that further investigations can be undertaken. ROA says that she should remain in

hospital albeit being transferred to the North Devon hospital nearer to ROA and her sons. The NHS Trust and Dr Johnston have concluded that there is no purpose to be served in her remaining on an acute medical ward and given my conclusions in respect of artificial nutrition and further neurological investigational treatment, I am in agreement with them. Dr Johnston in particular, having regard to the various guidelines, identified that to maximise the quality of life that ROO has and in particular to maximise the environment in which she takes oral nutrition and is able to interact with people a transfer to a nursing home close to her sons and ROA would appear to be in her best interests. The more relaxed and natural environment of a nursing home would be more conducive to her engagement with her family and other aspects of her life including feeding than the environment of an acute medical ward. I do not therefore agree that it is not in her best interests to be discharged from hospital in her present condition. As matters stand it would appear that her best interests would be met by transfer to a local nursing home.

Comment

The outcome of this sad case is perhaps not entirely surprising, although (read also with *RW*) is a useful contribution to the caselaw on best interests in the context of advanced dementia. However, Williams J was clearly, and rightly, troubled about the fact that the husband in this case was acting as a litigant in person. Whilst he was clearly able to advance his case clearly and cogently, the inequality of arms here was striking – and arguably troubling. One could imagine a compelling argument that where a litigant in person in such a case obtain permission from

the court to bring an application (hence filtering out entirely hopeless applications), then they should be eligible for assistance in formulating their case. One can also imagine (sadly) how that argument would fly with the Ministry of Justice...

Risk tolerance in practice

LB Islington v AA [2018] EWCOP 24 (Senior Judge Hilder)

Best interests – P's wishes – residence

Summary

This judgment of Senior Judge Hilder does not lay down any new principles of law but is an interesting example of the decision on the facts balancing toleration of risks against P's wishes and feelings.

P (AA) was 46 years old and came to England from Bangladesh at the age of 8. She was of Muslim faith and her first language was Sylheti. Her brothers were BA, BB and BC. AA was married at the age of 23 and had two children. The marriage came into an end and AA returned to live with her mother and brothers, without her husband and children.

AA was diagnosed as suffering from schizophrenia and was detained under the Mental Health Act. She was later admitted to hospital and discharged to a nursing home with the agreement of her family. She made trips back to the family home for contact and, on one occasion, the family failed to return AA to the nursing home for several days until social services intervened.

AA is then said to have disclosed to a psychiatrist and a social worker that her brothers

abused her. Her brothers denied that any abuse occurred. A few days later, BA took AA out of the nursing home for a walk and did not return her. When the social worker and police visited the family home, AA said that she wanted to remain there and not to return to the nursing home. Proceedings were then issued by the local authority.

The local authority sought a number of findings of fact which were collected under three separate headings – financial, neglect and physical/verbal abuse. The court found some, but not all, of the allegations to be proven. In particular, the court was considered that AA was at times in a state of health crisis and there were some deficiencies in the care of AA but a basically adequate level of care was provided by her family. There was no evidence at all to substantiate the allegation of continuous severe neglect. In relation to the financial allegations, the court was satisfied that there was some degree of AA's benefits being used as reasonable contribution to combined household costs but the court was also satisfied that there had been significant inappropriate use of AA's funds for matters (including mobile phones and online gambling services) which were not for AA's benefit. AA's standard of living could have been improved by more appropriate use of her funds during the time that the family were the care providers.

In light of the court's findings of fact, the court concluded that it was entirely appropriate that responsibility for AA's finances should no longer lie with family members and the local authority now acted as appointee. In relation to her residence and care, the local authority argued that it was in AA's best interests to move back to

HV, a rehabilitation unit, a support AA to gain the skills and confidence in activities of daily living that would facilitate her being able to live as independently as possible in the community. The family's position was that AA should remain living in the family home. BA said that the family could now manage better than they had in the past.

AA's representative considered that AA should remain at home with a further review by the court in 2 months' time. In particular, giving the continuing clarity of AA's wish to live at home, and the level of distress which had recently been manifested when that wish was not given effect, AA's representative contended on the part of AA that "even if it is not perfect, and is not providing all that a rehabilitation placement can" at this point, it was in AA's best interests to remain living at home.

HHJ Hilder reached the conclusion that it was in AA's best interests to remain at home, at least in the short term, and placed significant weight on AA's own wishes and feelings at paragraphs 90 and 92:

I am concerned that the approach of the Local Authority appears to take too little account of AA's wishes and feelings, particularly in the presently uncertain circumstances of her physical health needs. The aim of rehabilitation is laudable but there is insufficient information available to satisfy me that AA's engagement in rehabilitation is realistically achievable at the moment. I can find nothing to suggest that compelling AA's return to HV now, as the LA seeks, would be any less traumatic to her than Dr Hanlon assessed it to be barely a month ago. If she is traumatised in her return to HV, there must be serious

doubt that she would be able to benefit from HV's rehabilitative approach in the short term at least...

I am not satisfied that it would be in the best interests of AA to compel her return to HV against her wishes, even for the laudable aims of rehabilitation support, whilst there is the very real prospect that she will imminently be admitted to hospital, for significant treatment. I am satisfied that it is in the best interests of AA to require further information to be provided about her physical healthcare needs before a final decision is made as to where she should live and receive care. Until that further information is available, in my judgment it is in AA's best interests that she remains living at home with the current care package. I consider that a care package of 4 hours a day, 7 days a week, by independent carers, provides sufficient support for the family so as to mitigate the risks suggested by past crises, and sufficient oversight of the situation for the Local Authority to be able to respond very quickly to any deterioration in AA's wellbeing if necessary. I consider that the family ought to be taken at their word, and given the opportunity to show that they can cooperate with the care package and "do better this time".

Comment

This case is another example of the increasing importance and weight being afforded to P's own wishes and feelings even where it leads to an outcome which might be inherently more risky than alternative.

DoLS statistics

The most recent DoLS statistics for the period 1

April 2017 to 31 March 2018 have now been published.

There were 227,400 applications for DoLS received during 2017-18, with almost three quarters relating to people aged 75 and over. This represents an increase of 4.7% on 2016-17 although the rate of increase is slowing compared to previous years.

	Applications received	Year-on-year change
2013-14	13,715	-
2014-15	137,540	123,825
2015-16	195,840	58,300
2016-17	217,235	21,395
2017-18	227,400	10,165

Source: NHS Digital

There were more DoLS applications received than were completed (181,785) in 2017-18. The number of DoLS applications that were completed increased by 19.6% from 151,970 in 2016-17. The proportion of these that were granted was 61.1% in 2017-18.

The reported number of cases that were not completed as at year end was 125,630. Of these just under 40% (48,555) were received prior to 1 April 2017 – in other words, had still not been completed at least a year after they had been received.

The average length of time to complete a DoLS application increased from 120 days in 2016-17 to 138 days in 2017-18, although in addition the number of applications completed within 90 days increased by a fifth. Nationally the proportion of standard applications that were completed within 21 days (as required in the regulations and the Code of Practice) fell from 23.3% in 2016-17 to 21.7% in 2017-18. The range of months it would take for local authorities to clear their applications not

completed as at 31 March 2018 if they did not receive any new applications, based on their rates of completion during 2017-18 ranges from 0 months to 61.6 months, the average being 7.6 months.

As in previous years, there was a wide range of variation across the country in the volumes of DoLS applications, their outcomes and how they were administered. As in previous years also, however, the bare statistics are difficult to compare because of the very different practices that different local authorities have adopted in order to try and keep abreast.

The statistics can be fleshed out by reference to the picture of DoLS provided in the CQC's annual State of Care report for 2017/2018. Although good practice was highlighted in a number of places, as in previous years, the CQC:

continued to observe variation in how care home and hospital providers use DoLS and the MCA. This variation can lead to poor practice and have a negative effect on people using services, for example unnecessary restrictive practices that can result in a loss of freedom. In some cases, these practices can breach people's human rights. Our inspections found that although most care home providers comply with DoLS legislation, there remains variation in the quality of how the safeguards are applied in services.

Depressingly:

Varied practice appears in different ways depending on the sector, but is commonly linked with a basic lack of understanding of DoLS and the wider MCA. This can then be reinforced by

limited staffing levels and a lack of time to complete applications, as well as inadequate staff training. The general complexity of the DoLS legislation and a lack of local authority resources to deal with the number of DoLS applications also influence varied practice.

PRACTICE AND PROCEDURE

Sir James Munby's address to LAG

Sir James Munby's address to the LAG Community Care Law Conference is now available [online](#).³ The address is separated into two main parts. First, Sir James considers "the continuing fall-out" from the Supreme Court's decision in *Cheshire West*, particularly in respect of children. Secondly, he identifies various challenges which arise from the approach outlined in *N v A Clinical Commissioning Group and others* [2017] UKSC 22.

Fall-out from Cheshire West for children

Sir James' first main observation was the difficulty (yet importance) of applying Lady Hale's "acid test" from *Cheshire West* to children. In other words, in what circumstances is a child subject to a deprivation of liberty within the meaning of Article 5?

With reference to his decision in *Re D* [2017] EWCA Civ 1695, and stressing that the Supreme Court's judgment in the case was pending, Sir James reiterated his view that whether there has been a deprivation of liberty in a child case will turn on the age of the child in question.

As for the age at which the "acid test" bites, Sir James relied on his observations in *Re A-F* [2018] EWHC 138 (Fam), at paragraph 43:

One has to proceed on a case-by-case basis having regard to the actual circumstances of the child and comparing them with the notional

circumstances of the typical child of the same "age", "station", "familial background" and "relative maturity" who is "free from disability". Little more than "rule of thumb" suggests:

(a) A child aged 10, even if under pretty constant supervision, is unlikely to be "confined".

(b) A child aged 11, if under constant supervision, may, in contrast be so "confined", though the court should be astute to avoid coming too readily to such a conclusion.

(c) Once a child who is under constant supervision has reached the age of 12, the court will more readily come to that conclusion."

In light of this, Sir James went on to stress that the resource implications of having to deal with such cases on a "case-by-case" are very considerable, and this is in the context of a system which is already under great pressure.

Sir James then addressed another "fall-out" of *Cheshire West*, and the question at the heart of *Re D*: whether parental power extended to giving consent to the "confinement" of a child who is 16 or 17 years old. He explained that – in his view – the answer lies in the House of Lords decision of *Gillick*.⁴ Therefore, in a case where the child has not yet acquired "Gillick capacity," the parents are able to provide consent for a deprivation of liberty beyond the child's sixteenth birthday. He speculated that the confusion in this area, and failure to appreciate the relevance of *Gillick*, had

³ Sir James was unable to deliver the address on the day due to illness. This summary was prepared without input from Alex, Tor or Annabel, given their involvement in *Re D*.

⁴ *Gillick v West Norfolk and Wisbech Area Health Authority and Department of Health and Social Security* [1986] AC 112.

arisen because these sorts of cases lie at the intersection of three different fields of domestic law, each served by a different set of legal specialists: *[t]he existence of these institutional and professional silos has bedevilled this area of the law."*

Challenges arising from N v A Clinical Commissioning Group

As for *N v A Clinical Commissioning Group*, Sir James reminded us the Court of Protection cannot direct that resources be made available or that services be provided; it can merely seek to persuade. As to the correct approach to be taken by the court in this regard, Sir James referred to the principles set out when the case was before the Court of Appeal ([\[2015\] EWCA Civ 411](#)):

34. ...the court, if it seeks to alter the local authority's care plan, must achieve its objective by persuasion rather than by compulsion.

35. The said, the court is not obliged to retreat at the first rebuff. It can invite the local authority to reconsider its care plan and, if need be, more than once... How far the court can properly go down this road is matter of some delicacy and difficulty. There are no fixed and immutable rules. It is impossible to define in the abstract or even to identify with any precision in the particular case the point to which the court can properly press matters but beyond which it cannot properly go. The issue is always one for fine judgment, reflecting sensitivity, realism and an appropriate degree of judicial understanding of what can and cannot

sensibly be expected of the local authority."

That is all very well in principle, but as Sir James pointed out with reference to some of his recent cases, the application can be highly problematic. In particular, Sir James was concerned that cases involving vulnerable children being inadequately supported by the State were being transferred "up" to senior judges in the hope that such judges are more "persuasive." In so doing, however, he suggested, the line between persuasion and compulsion became increasingly blurred. Further, there were no means of ensuring that the most needy cases were prioritised.

Sir James concluded, however, that this is the lesser of two evils:

*...what is one supposed to do? What is the alternative? Wash one's hands and wait for an inquest, followed by much hand wringing, "we have all learnt lessons, it will not happen again"? I think not. There are occasions, and surely *Re X*⁵ was one, where, *pace Lord Sumption*, a judge in a family court or in the Court of Protection is duty-bound to act even if the prime responsibility lies elsewhere. I am unrepentant.*

Comment

The Supreme Court's decision in *Re D* is much anticipated, with many hoping that it will provide valuable clarity in respect of the way in which the law on deprivations of liberty applies to those under 18. As Sir James suggests, however, clarity of principle is one thing, but, in an area of law where the "correct" approach is often

⁵ *Re X (A Child) (No 4)* [2017] EWHC 2084 (Fam).

inextricably tied to an assessment of the individual facts, challenges for judges, decision-makers and practitioners are set to remain. Of course, the challenge is further heightened by inadequate resourcing of a system which is under ever increasing pressure.

Court User's Group October meeting

The Court of protection users group met on 17 October 2018. The minutes can be found [here](#). Of note:

- There has been an 8% increase in applications and a 10% decrease in disposals compared to the last 12 months.
- For urgent applications, a COP 9 can be submitted which will be dealt with by the Urgent Business Judge (UBJ) who will deal with it if it is truly urgent.
- Bundles must be removed from the Court after hearings, otherwise they are treated as abandoned and reported to the Information Commissioner.
- In order to comply with GDPR a new system for the appointment of ALRs has been in place since 28 August, whereby HMCTS go to the Law Society to approach an individual ALR for consent to disclose their details. [We note that there seem to be, at a minimum, teething problems with ALRs: we would be particularly interested in any positive practice experiences that can be shared by those solicitors who have been appointed ALRs so that, if possible, these teething problems can be sorted out].
- If an ALR is requested or appropriate, the case is referred to the Urgent Business

Judge (UBJ) and if it is agreed, an ALR is identified and approached. The ALR then has 24 hours to respond. Concern was raised that since the end of August only 7 ALRs have been appointed.

- Section 16 and 21A applications should be issued in regional hubs. All property and affairs cases should be issued in First Avenue House.

The new President of the Court of Protection is likely to make a decision about whether counsel should be robed in public hearings before tier 3 judges (i.e. High Court judges) in the New Year. He has indicated that he is likely to take the view that counsel should be robed. We thought it would be interesting to obtain the views of practitioners on this topic and so Katie Scott is collating responses on this topic, so please send any comments or views to ks@39essex.com.

THE WIDER CONTEXT

ENGLAND AND WALES

Litigation capacity – some definite don'ts

Mr & Mrs Z v Kent County Council [2018] EWFC B65 (Family Court (HHJ Lazarus))

Mental capacity – litigation – other proceedings – family (public law)

Summary

This case concerned a wide range of issues in the context of family proceedings which had gone badly wrong, of which for present purposes the most relevant is the issue of litigation capacity. HHJ Lazarus took the opportunity to conduct a detailed review of how this issue should be considered and approach. She noted that the presumption of capacity was not included in the MCA to obviate examination of whether a party to proceedings lacked capacity, and that it could not have been Parliament's intention to place a vulnerable person in danger of their lack of capacity being overlooked at the expense of their rights by a slack reliance on the presumption. The judge considered the relevant guidance and caselaw and noted that while it was usually the case that medical evidence as to incapacity would be required, if it was not possible to obtain an assessment (for example because the party refused to participate), then the court would have to do the best it could on the evidence available to it:

t) Such a determination could be based on a careful review of the other relevant material that may be available, such as a report from a clinician who knows the party's condition well enough to report without interviewing the party (if available and appropriate), other medical records,

accounts of family members, accounts of the social worker or other agency workers who may be supporting the parent, and occasionally direct evidence from a parent.

u) Any such finding made without expert assessment evidence that leads to a declaration of protected party status due to lack of litigation capacity could always be reviewed upon expert evidence being obtained to suggest that the finding was incorrect, and by ensuring that the question of assessment is regularly revisited with the protected party by their litigation friend, their solicitor and the court.

In the particular case, there had been a failure to assess or determine the issue of the mother's capacity to conduct the proceedings despite her known personality disorder and alcohol misuse, which had led ultimately to the wrong decisions being made for the child.

Having rehearsed the case-law, which she correctly identified as containing some internal tensions, HHJ Lazarus set out what she considered to be obviously impermissible steps that could be found from those cases, namely:

- failure to grasp the nettle fully and early,*
- ignoring information or evidence that a party may lack capacity,*
- purporting to 'adopt' the Presumption of Capacity in circumstances where capacity has been questioned,*
- making directions addressing the capacity issue, but discharging them or failing to comply with them and thereby leaving the issue inadequately addressed,*
- failing to obtain evidence (expert or otherwise) relevant to capacity,*
- use of 'unless' orders,*
- similarly, using personal service or 'warning notices' on that party,*

- *relying on non-engagement by that party either with assessments or the proceedings,*
- *proceeding with any substantive directions, let alone making final orders, in the absence of adequate enquiry and proper determination of the capacity issue,*
- *treating a party as having provided consent to any step, let alone a grave and possibly irrevocable final step, where capacity has been questioned but the issue not determined.*

Comment

Although made in the context of family proceedings, the observations of HHJ Lazarus are of wider application, in any proceedings where it becomes clear that there may be an issue as to one party's capacity to conduct them. At that point, the court is into difficult territory, trying to navigate a path which secures competing rights. Those rights are, importantly, competing from the perspective of the person concerned, including balancing the right not to be deprived of legal capacity without a proper process against the right not to have substantive decisions taken in proceedings they cannot, in truth, conduct. The observations made by HHJ Lazarus are useful in identifying what steps cannot be taken at that stage, even if they leave open the question of what can be done.

Children and deprivation of liberty

Another in the growing list of cases considering the application of *Cheshire West* to younger children (in this case 13) can be found in the decision in *Re HC (A Minor: Deprivation of Liberty)* [2018] EWHC 2961 (Fam). Standard orders following those proposed by the former President in *Re A-F (Children)(No 2)* [2018] EWHC 2129 (Fam) have also been approved, although

at present appear only to be available behind paywalls. We recall also that these orders do not make reference to the basis upon which the child is deprived of their liberty – is it on the basis of Article 5(1)(d) (educational supervision) or Article 5(1)(e) (unsoundness of mind)? We would respectfully suggest that they need to make this clear, not least to direct the nature of the evidence required.

Short note: the inequities of healthcare for those with learning disabilities

The Institute of Health Equality has published a summary report on [A Fair, Supportive Society](#), commissioned by NHS England, which shockingly highlights that those with learning disabilities will die 15-20 years sooner on average than the general population. Many of the early deaths of people with learning disabilities could be reduced through improved healthcare and preventative actions. Children with learning disabilities are also at increased risk of mental health conditions, including depression; and half of the increased risk of mental health difficulties is attributable to poverty, poor housing, discrimination and bullying.

In response to this appalling state of affairs, the report makes 11 important recommendations:

1. NHSE, with PHE, DHSE, DWP, the Association of Directors of Children's Services (ADCS), HMT, the Home Office and Other Government Departments (OGDs) and stakeholders, should develop an evidence-based integrated strategy that supports households holistically, from identification of a learning disability through to related early years support, and also onwards throughout life.

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2. Joined-up working is key. Teams from the above-mentioned departments and others in the community, should integrate to improve outcomes through action on specific social determinants of health for people with learning disabilities. For example, to reduce poverty and simultaneously improve the physical and social environment for people living in deprived areas.
 3. To ensure no one is left out, early identification rates should be improved and information-sharing rationalised across all agencies and across registers, such as sharing all age General Practice (GP) Learning Disability registers with local authorities and to inform the education, health and care (EHC) plan process.
 4. DfE and Health and Social Care Commissioners should lead the change in the 'choice architecture' by removing unhealthy options at influential institutional settings, such as in hospitals and care settings, to support healthier behaviours for people with learning disabilities, and to support the parents of children with learning disabilities to do the same.
 5. DfE and NHSE should adopt the 'equal right to sight' approach and work together with charities to appropriately design eyesight and hearing tests, administered to all children in special and mainstream schools within their first year of joining.
 6. The DfE and NHSE should formally require that specific actions are included in the education, health and care plan process from the beginning, to ensure improved take-up of: appropriate-to-age screening tests, improvements in health behaviours, and improved action on the social determinants of health.
 7. DWP and DHSC, with the Joint Health and Work Unit (JHWU), should learn from trials and existing programmes, and work with local authorities and employers to ensure that employment offers for people with learning disabilities are available nationally, and provide stakeholders with a timetable that delivers this as rapidly as possible.
 8. The Government, specifically DWP and DHSC, should undertake a systematic review of how it supports people with learning disabilities, ensuring that access to work, homes, benefits, health and care services and education are adequate. A review of the sufficiency of the personal budget for EHC plans is advised, to identify whether or not this is being adequately rolled out to those in most need.
 9. PHE, local authorities and NHSE should support coordinated campaigns for greater integration of people with learning disabilities into mainstream society, to reduce discrimination and stigma and support representation. This should include a push towards more inclusion of children with learning disabilities within mainstream schooling. To build on progress made by NHSE, public sector employers should be mandated to provide opportunities for those with learning disabilities, and private sector employers should be incentivised to do the same by supporting apprenticeships for people with learning disabilities.
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10. A hearts and minds campaign is recommended, led by a collaboration of learning disability campaign groups close to the cause, to improve attitudes towards people with learning disabilities. This should build on successful campaigns for other minority groups. Alongside this, a review of general attitudes and perceived safeguarding requirements and procedures within professional, community and educational settings may be useful to understand detrimental attitudes towards people with learning disabilities. This work should be evaluated given that there is little evidence regarding effective practice in this area. Further, tougher and more visible punishment of crimes against those with learning disabilities should be considered by the Home Office.

11. Friendship support groups should be made available to all people with learning disabilities. As a part of EHC plans, children and young people with learning disabilities should be linked with friendship groups, and to networks that will support their participation in society. A wellbeing plan for adults with learning disabilities should consider not just the medical needs arising from their disability, but also their social interaction needs. Professionals should be required to link people with a learning disability with appropriate friendship support groups.

We very much hope that these recommendations will be taken seriously by the government and implemented quickly. We will keep readers updated on any significant developments.

Older people in care homes: Sex, Sexuality and Intimate Relationships

The Royal College of Nursing has updated its guidance on sexual intimacy and care homes. The new guidance includes frameworks for decision-making and case scenarios, as well as a summary of the applicable legal principles. It is likely to be of particular interest to nurses, care assistants, social workers and care home managers, and can be downloaded [here](#).

Participants wanted!

Amber Pugh, a PhD student at the University of Liverpool, is conducting very timely research on how decisions about sex and contraception involving adults with learning disabilities are made. For more details, and to become involved, see [here](#).

We are always willing to advertise research projects like this – contact one of the editors. We do not charge (or ask for a donation to charity) where the research is being conducted by a university or a charity.

GMC consent consultation

The General Medical Council is consulting on their revised consent guidance. The updated guidance focuses on the importance of communication, personalised conversations, and doctors and patients making decisions about treatment and care together.

The consultation is open until Wednesday 23 January 2019 and there are several ways you can take part.

[Full questionnaire for medical and lay professionals](#): aimed at those with a detailed working knowledge of the policy, practice and law around consent. You'll need to read the guidance to answer the questions.

[A survey for doctors and other healthcare professionals](#): aimed at those with a detailed working knowledge of the issues, but who may not have time to respond to the full questionnaire.

[A survey for patients, carers and members of the public](#): aimed at those who may not be familiar with the GMC guidance, but will have views on good consent practice.

Talking about death

The Royal College of Physicians has published a report entitled: *Talking about dying: How to begin honest conversations about what lies ahead*. As the RCP identify, timely, honest conversations about their future that patients want are not happening. The report begins to highlight and challenge professional reluctance to engage in conversations with patients about uncertainty, treatment ceilings, resuscitation status and death. It includes offer some 'mythbusters' to get physicians thinking and offers signposts to tools and educational resources to support physicians and other healthcare professionals.

Mental Health (Use of Force) Act

The Mental Health Units (Use of Force) Act 2018 which started life as a private members bill by Labour MP Steve Reed has been granted Royal Assent.

Widely referred to as "Seni's Law" in reference to Olaseni "Seni" Lewis who died in 2010 having

been restrained by 11 police officer at Bethlem Royal Hospital, the Act makes provision for the oversight and management of appropriate force in relation to people in mental health units and other similar units. It requires mental health units to appoint a responsible person who must publish a policy regarding the use of force by staff who work there (s.3(1)), which must include steps taken to reduce the use of force by staff in the unit (s.3(7)). The Act also provides that each responsible person must publish information for patients at a mental health unit about their rights in relation to the use of force by staff (s.4(1)). As a means of effecting greater scrutiny, the Act also provides that the responsible person must maintain a record of the use of force (s.6(1)) which must include, inter alia, records of the patient's disabilities and mental disorder and whether they suffer from learning disabilities or autism; further, in circumstances where a police officer is going to a mental health unit on duty that involve assisting staff who work there, the police officer must take a body camera if reasonably practicable (s.12).

We congratulate all those involved in taking this Bill through to enactment as a law – and trust that implementation will lead to real changes, as opposed to the mere completion of more paperwork.

Negligence, human rights, murder and the failure to detain

Griffiths v Chief Constable of Suffolk [2018] EWHC 2538 (QB) (High Court (Ouseley J))

Other proceedings – civil

Summary

Ouseley J has examined whether a claim in negligence following a murder committed by an individual whom a mental health trust failed to detain under the MHA could succeed. He concluded ultimately that it could not on the basis that the relevant NHS Trust had not acted negligently in performing its s.2 assessment and that it had had no duty to warn the relevant victim or the police.

The case concerned a claim for damages brought by the three children of Mary Griffiths. Ms Griffiths was murdered by a man John McFarlane after she had made clear to him that she did not wish to have a romantic relationship with him. In the days prior to the murder, Mr McFarlane had attempted suicide. Having been saved by the intervention of friends, he was taken to North Suffolk NHS Foundation Trust where a panel was convened to determine whether he was eligible for admission pursuant to s.2 Mental Health Act 1983. It concluded that he did not meet the criteria for admission on the basis that he was not suffering from mental disorder of a nature or degree which warranted detention and released him. Two days later, Ms Griffiths called Suffolk police complaining that Mr McFarlane was harassing her and she was frightened. The Police offered to send someone round the next morning. A few hours later at 2.40am, Mr McFarlane broke into Ms Griffiths house and murdered her in the street in front of her children.

Ms Griffiths' young daughters pursued a claim under the Fatal Accidents Act 1976 on the basis that her death was caused by the wrongful act, neglect or default of either Suffolk Police or the North Suffolk NHS trust. The daughters also claimed damages under s.8 of the Human Rights

Act 1998 alleging breaches of Articles 2,3 and 8 ECHR.

The claim was argued on the basis that the NHS Trust ought to have admitted Mr McFarlane under section and/or to have warned Ms Griffiths and/or Suffolk police that he posed a danger to her; further that having received a worried call from Ms Griffiths, the police should have graded the risk to her as more severe and taken swifter action.

Ouseley J noted that counsel for the claimants *"denied that the allegation was that detention ought to have taken place unlawfully; yet his questions at times came perilously close to such a suggestion, and at least suggested that the issues which the criteria require to be resolved could and should be fudged, where other difficulties were present, such as accommodation or risk."* (paragraph 265)

Having concluded that the s.2 MHA assessment was properly carried out, Ouseley J concluded that there was no expert support for the claim that the NHS Trust breached its duty of care towards Mr McFarlane.

With regard to the duty of the various statutory bodies towards Ms Griffiths, Ouseley J engaged in an analysis of the notoriously difficult area of proximity in tort law – though interestingly it appears that this case was not pleaded and therefore did not address the possibility of Ms Griffiths children as being secondary victims to her murder (ie as suffering from what was formerly referred to as "nervous shock").

Ouseley J identified the key issues as control over the malefactor with proximity to the victim, and the existence of a positive duty to safeguard someone and noted at paragraph 446 that "a duty to warn does not exist without some

relationship between both the person being warned, and the person about whom the warning is given. The special relationship between defendant and wrongdoer [is] not the only relationship which mattered because there also had to [be] a relationship of proximity between the defendant and the person injured."

On whether there was sufficient proximity between Ms Griffiths and the NHS Trust for a duty of care to arise, Ouseley J held that there was not. He noted that once Mr McFarlane was discharged from hospital, having been deemed not to meet the statutory criteria for admission – an assessment which Ouseley J had already concluded was not negligent – the issue of whether or not Mr McFarlane was in the "control" of the NHS Trust became more complicated.

Ouseley J held that:

if the panel foresaw or should reasonably have foreseen the risk of Mr McFarlane murdering her or assaulting her in a way which breached Article 3, serious physical assault, the law would in my judgment impose an obligation to safeguard her by taking steps such as warning her or alerting the police. I consider that that duty would have arisen whether or not he had been sectioned or admitted voluntarily. The gravity of the risk would be sufficient to impose such a duty; a good measure of that point is that it would be at the point at which the duty of confidentiality to the patient was overridden by the public interest in the avoidance of risk to others (para 459)

However, Ouseley J concluded on the facts of the case that there was no basis upon which the panel could have foreseen that Mr McFarlane

might murder Ms Griffiths, holding at paragraph 462 that:

The facts are not such as to impose responsibility for protecting Ms Griffiths on the NHS Trust. When it comes to the legal imposition of responsibility, the fact that the potential victim is aware of all the relevant behaviour tells against it with some force, especially, as here, if the NHS Trust has nothing of significance to add to what she knows. Nor did Ms Griffiths, in my judgment, come into the category of a victim vulnerable through disability or mental capacity or state, in respect of whom a warning should be given to the police, rather than to the potential victim."

With regard to the Human Rights Act claims Ouseley J noted (at 472) the *Osman v UK* (1998) 29 EHRR 245 basis for the state's protective duty towards a potential victim and its conclusion that "*the positive obligation [arising under Article 2 ECHR] should not be applied in such a way as to impose impossible or disproportionate burdens on the authorities. Not every claimed risk to life could entail an obligation to take operational measures to prevent it. To prove a violation of that positive obligation to prevent and suppress offences against the person, in the context of Article 2, [116] : "... it must be established...that the authorities knew or ought to have known at the time of the existence of a real and immediate threat to the life of an identified individual or individuals from the criminal acts of a third party and that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk..."*

Ouseley J at paragraph 504 further concluded that no Article 8 claim could arise given the failure of any claim pursuant to Articles 2 and 3.

even if the operational duty in these circumstances could impose an obligation to take reasonable steps to protect Ms Griffiths against stalking, harassment or sexual assault, and could lead to a breach of the duties under Articles 2 and 3, because such steps might have in fact prevented the murder, albeit unintentionally and unforeseeably, there was no breach. That risk was not foreseen nor ought it to have been. There were no steps which the assessors ought to have taken which they failed to take. It is at the very least debatable what nature and degree of the risk would permit patient confidentiality to be breached, and how the knowledge of the potential victim of the relevant facts would affect that duty. In my judgment, nothing short of knowledge of the position as at the time the police were phoned on 5 May, and of how Ms Griffiths then saw matters, could have produced any obligation, and the likeliest would have been to alert the police. But that situation did not arise.

Ouseley J noted the severity of the level of failure in operation or in a system necessary to constitute a breach of the protective duties in either Articles 2 or 3 (paragraph 619), none of which arose in the case. Even though there was clearly a risk of harassment and stalking to Ms Griffiths of which Suffolk Police were aware,

there was nothing to suggest that it was an imminent risk, against which measures were required that night. So if there were a protective duty in relation to such a risk, which could arise under Article 8, the Suffolk Police did not breach it in their response, by grading the call as 3, and ringing back at 21.43 and acting in reliance upon what Ms Griffiths said. I do not accept that a breach of Article 8 can

be raised where Articles 2 and 3 were not breached, nor that Strasbourg jurisprudence permits a breach of Articles 2 or 3 to be based on a failure to take steps which an Article 8 duty would have required, where no breach of Articles 2 or 3 was or should have been foreseen (parah 620).

Comment

This is a tragic case and it is in the context of its extreme facts that Ouseley J dedicates over 600 paragraphs to analysis of the rights and duties at play. Given the conclusions as to the appropriateness of the s.2 Mental Health Act assessment however, the ultimate conclusion that there was no breach of duty is, in the context of existing tort law and Strasbourg jurisprudence, unsurprising. It is an important case, however, in terms of confirming that it is always necessary to consider what the relevant individuals knew or ought to have known at the time, and not to superimpose hindsight through the operation of the ‘retrospectoscope’ that can all too often be deployed.

OVERSEAS DEVELOPMENTS OF RELEVANCE

Capacity, ECT and comparative law

PBU and NJE v Mental Health Tribunal [2018] VSC 564 (Supreme Court of Victoria (Bell JJ))

Mental capacity – assessing capacity – medical treatment – other proceedings – other

Summary

This significant judgment of the Supreme Court of Victoria, Australia, concerned two patients for whom electro-convulsive therapy (‘ECT’) was proposed. PBU did not agree that he had

schizophrenia but accepted that he had mental health problems, namely depression, anxiety and post-traumatic stress disorder. He was willing to receive psychiatric and psychological treatment for those conditions but not ECT or anti-psychotic medication or treatment. He wished to be discharged from hospital to a prevention and recovery facility and then return home. The detaining hospital considered him to be too unwell for discharge and instead sought the authority of the tribunal to provide ECT on the basis that he lacked capacity to make the relevant decision. NJE suffered from treatment resistant schizophrenia. She wanted to remain in hospital and continue to receive depot and other prescribed medication but the tribunal found that ECT provided the best chance of addressing her symptoms.

At first instance, the tribunal decided that each patient could understand and remember relevant information and communicate a decision in relation to ECT but could not use or weigh that information. It found that each patient lack capacity to give informed consent and that, in the absence of any less restrictive alternative, ordered a course of ECT to be given. On appeal, Justice Bell found that the tribunal had erred in law. It was wrong to conclude that a supposed lack of insight was determinative of PBU's lack of capacity. And requiring NJE to give "careful consideration" to the advantages and disadvantages of ECT set too high a threshold of capacity which was discriminatory. Accordingly, the tribunal decisions were quashed.

The judgment is of particular relevance to the law in England and Wales as the Australian statutory provisions being considered are similar to those in the Mental Health Act 1983 and the

Mental Capacity Act 2005. That is, a detained patient with the relevant capacity cannot be compelled to have ECT. Before analysing particular areas of legal interest, it may be helpful to tailor to our domestic law some of Justice Bell's summary of relevant principles (para 206):

1. Providing treatment for mental illness is to be done in a manner that affords equal respect for patients' human rights and particularly their right to self-determination, to be free of non-consensual medical treatment and to personal inviolability.
2. There is a (rebuttable) presumption that people with mental illness (as for people without that illness) have the capacity to give informed consent which is issue-specific, can fluctuate, and may be enhanced with support, all of which may have significant implications for the capacity-assessing process and the ultimate determination.
3. The test of capacity is a functional one in which the question is whether the person has the ability to understand, retain, use and weigh relevant information and communicate a decision; not whether the person has actually done so. The purpose of the functional test (as distinct from a status or outcome-based test) is to ensure that, in relation to capacity to give informed consent, people with mental illness are afforded the same respect for their inherent dignity and autonomy-space as people not having that illness.
4. The capacity test must be applied in a non-discriminatory manner so as to ensure that people with mental illness are not deprived

of their equal right to exercise legal capacity upon the basis of contestable value-judgments relating to their illness, decisions or behaviour, rather than upon the basis of the neutral application of the statutory criteria. In short, the test is not to be applied so as to produce social conformity at the expense of personal autonomy.

5. The right to make unwise decisions recognises that self-determination is important for both dignity and health and that people with mental illness should have the same dignity of risk in relation to personal healthcare decision-making as other people. This reflects the two-way relationship between self-determination, freedom from non-consensual medical treatment and personal inviolability on the one hand and personal health and wellbeing on the other.
6. Those assessing capacity must vigilantly ensure that the assessment is evidence-based, patient-centred, criteria-focussed and non-judgmental, and not made to depend, implicitly or explicitly, upon identification of a so-called objectively reasonable outcome.
7. The threshold of capacity is relatively low and the person need only possess the functional abilities in respect of the salient features of the decision.
8. Acceptance of, belief in and insight into the diagnosis of illness and need for treatment varies significantly depending upon the person and the situation. It is not a normative criterion. Depending upon the facts of the case, a person with mental

illness may lack that insight or otherwise not accept or believe that the person has a mental illness or needs treatment yet may have the capacity to give informed consent when assessed under the statutory test. The opposite may be so.

With that overview, we focus on two specific issues that arose in the case before him, but are of equal difficulty and importance in consideration and application of functional tests of capacity like the MCA 2005.

Capacity and insight

Analysing the Mental Capacity Act 2005, Justice Bell noted the absence of a belief requirement which had appeared previously at common law in *Re C* [1994] 1 WLR 290, 292 (the gangrenous leg case). He went on to consider the relevance of belief and emphasised that in *Re C*, Thorpe J had referred to how the patient "*in his own way* [C] *believes it*":

190. ... Thus Thorpe J appears to have approached the matter by considering the extent to which the person could weigh or use the information. In other words, his Honour has taken belief and insight in respect of the diagnosis and treatment into account not as a criterion (a normative consideration) but as a factual consideration.

It followed that a lack of insight was not necessarily indicative of a lack of capacity: "A person who lacks insight may, not must, be lacking in capacity" (para 193) and Justice Bell went on to observe:

194. Insight into one's diagnosis and need for treatment varies significantly between different persons and between

the same persons in different situations. Insight is potentially affected in nature and degree by various non-capacity influences, including educational background, language proficiency, familiarity with medical issues and family and social relationships (negative and positive) and (often critically) the availability of appropriate support. For these reasons, it is but one of the factual considerations that may be relevant when assessing capacity to give informed consent. As disability law scholars have written:

A lack of insight may impact a person's ability to understand [or use or weigh] relevant information, but the presence or absence of insight is not a proxy for the presence or absence of decision-making capacity. Insight is an extremely complicated phenomenon that is rarely either simply present or absent. Various aspects of insight – such as insight into diagnosis, insight into the presence or veracity of phenomenology and insight into the need for treatment – may all vary independently.⁶ This, in combination with the requirement that a person only needs to understand information that is

relevant to the decision being made, means that while a lack of insight may suggest a lack of decision-making capacity, this deficit alone will rarely be determinative.⁷

195. The way in which lack of belief or insight in respect of the illness and the need for treatment is considered when assessing capacity is a matter of importance to people with mental disability. This is because it is not uncommon, for various personal, social and medical reasons, for a person with mental disability to deny or diminish the illness and the need for treatment, or to choose non-advised treatment.⁸ Nor is it uncommon, for various personal, social and medical reasons, for persons not having mental disability to deny or diminish illness or the need for treatment, or to choose non-advised treatment. In neither case does this mean of itself that the person lacks capacity. ...

198. In conclusion, it may be accepted that the presence of delusional thinking and irrational fears is 'capable of depriving a person of capacity. The question is whether it does'.⁹ So may it be accepted that lack of belief or insight in respect of a mental illness or need for treatment may be capable of supporting

⁶ Kate Diesfeld, 'Insight: Unpacking the Concept in Mental Health law' (2003) 10 *Psychiatry, Psychology and Law* 63; Yuval Melamed et al, 'Insight and Competence to Consent to Psychiatric Hospitalization' (1997) 16 *Medicine and Law* 721; TE Smith et al, 'Insight and recovery from psychosis in chronic schizophrenia and schizoaffective disorder patients' (2004) 38 *Journal of Psychiatric Research* 169.

⁷ Christopher Ryan, Sascha Callaghan and Carmelle Peisah, 'The capacity to refuse psychiatric treatment: A guide to the law for clinicians and tribunal members' (2015) 49 *Australian and New Zealand Journal of Psychiatry* 324, 328.

⁸ See, eg, *Re SB v (A patient: Capacity to consent to termination)* [2013] EWHC 1417 (COP) (21 May 2013) [15] (Holman J); *Heart of England NHS Foundation Trust* [2014] EWHC 342 (COP) (17 February 2014) [9] (Peter Jackson J).

⁹ *Cooper* [2009] 1 WLR 786, 1794 [28] (Baroness Hale, Lord Hope, Lord Rodger, Lord Brown and Lord Mance agreeing); this conclusion was reached after an analysis that included consideration of *Re C* [1994] 1 WLR 290, *Re MB* (1997) 2 FLR 426 and *NHS Trust* [2005] 1 All ER 387: at 1793 [24].

a finding of incapacity. The question is whether it does. This means giving due consideration to a relevant fact, not (in effect) applying a determinative normative criterion...

227... [T]o rebut the presumption of capacity, it is not sufficient to find that a person does not accept or believe the diagnosis that the person has a mental illness or that the person has no insight into the need for treatment. According to the statutory criteria, a person may not have that acceptance, belief or insight yet may have capacity to give an informed consent, although these matters may be factually relevant in the overall consideration. This is important if the capacity criteria and are to be applied in a manner that is non-discriminatory towards and respects the autonomy space of people with mental illness...

231. It is of the first importance that the test of capacity ... is applied in a way that does not discriminate against people with mental disability upon that ground, implicitly or explicitly. For anybody, mentally disabled or not, non-belief or non-acceptance of a diagnosis and lack of insight into the need for treatment would not be a sufficient basis for rebutting the presumption of capacity at common law (see above), and it is not under these provisions. As discussed, for a variety of reasons, people have deficiencies of belief, acceptance or insight in relation to the need for medical treatment that to others defy reality. Out of respect for the diversity of humanity and the dignity of risk, the capacity of

people not having mental disability is not denied for that reason alone, and it would be discriminatory to deny people with mental disability the same respect. Giving that respect is consistent with ensuring the equal right of people with people with mental disability to self-determination, to freedom from non-consensual medical treatment and to personal inviolability.

Objectivity when assessing capacity

Developing the need to avoid the protection imperative so as to maintain objectivity when determining someone's ability to decide, Justice Bell noted:

167. It has been said that capacity assessments are inherently risky, uncertain and 'epistemologically fallible',¹⁰ driving many capacity assessors to the apparent safe ground of the 'reasonable' outcome as an implicit default criterion. One can understand the natural human tendency of health professionals and judicial officers, among others, to make decisions in the best interests of vulnerable persons, especially where treatment for grievous ill-health, or even the person's life, is at stake.¹¹ It has been described as the 'protection imperative'.¹²...

169. Moreover, in relation to something as personal as whether a person should consent to or refuse medical treatment, it is problematic to suggest that one person can necessarily determine that another person's decision is objectively unreasonable: a decision to consent to or

¹⁰ Mary Donnelly, *Healthcare Decision-Making and the Law* (Cambridge University Press, 2010) 116.

¹¹ *PH v A Local Authority* [2011] EWCOP 1704 (30 June 2011) [16(iii)] (Baker J) ('PH').

¹² *A University Hospital NHS Trust v CA* [2016] EWCOP 51 (8 December 2016) [19(8)] (Baker J); see also *PH* [2011] EWCOP 1704 (30 June 2011) [16(iii)] (Baker J).

refuse such treatment may be so subjectively anchored in the individual values, relationships and life's experience of the person as to make it difficult for another even to comprehend the decision; or even if properly comprehended, it may be so subjectively anchored in those respects as simply to defy objective characterisation at all. This is so whether the person has capacity to consent or refuse or not.¹³...

172.... The judgment of MacDonald J, and those of Peter Jackson J in Heart of England NHS Foundation Trust¹⁴ and Wye Valley NHS Trust v B¹⁵ and the plurality in Starson v Swayze,¹⁶ all concerned with highly eccentric individuals, are notable for applying the capacity test in a way that is criteria-focused, evidence-based, patient-centred and non-judgmental.

In NJE's case, the tribunal was concerned that she was spending several nights per week without sleep because she was working with psychic healing powers. But it did not relate this to the statutory criteria regarding capacity. Justice Bell held:

242. A person may be frequently active and awake at night due to a desire to work with psychic healing powers. This may or may not help to support a finding that the person does not have the ability to use or weigh relevant information. It is important to determine capacity by reference to the statutory criteria, which are based on domains of cognitive functioning, not by reference to decisions

or behaviours, which give rise to contestable value judgments. Variation in human behaviour is normal and not necessarily a sign of lacking the capacity to give informed consent. Normal people often believe what to others is extraordinary. Being frequently active and awake during the night is not unheard of in the general population. Many people believe in the power of prayer to heal either individuals or humanity, and actively stay awake at night (sometimes all night) praying with that belief. Some people believe they can heal others by touching or be healed themselves by bathing in or drinking sacred water, and touch others or bath in or drink those waters with that belief. Psychiatric evidence may establish that the belief or behaviour is delusional. Even then, the person may be able to use or weigh relevant information in relation to ECT (and the subjective value of the belief or behaviour to the patient must count in determining whether there is no less restrictive way to treat the patient, having regard to the patient's views and preferences, where this is reasonable...). The capacity assessment needs to go into the relationship (if any) between the delusion and the ability to use or weigh the relevant information, for that is what the statutory criteria and respect for human rights requires.

Comment

This judgment is catnip for capacity geeks like the editors (and we also note with pleasure that it specifically cites from research conducted by our Scottish contributor, Jill Stavert). It provides

¹³ See further Emily Jackson, 'From "Doctor Knows Best" to Dignity: Placing Adults Who Lack Capacity at the Centre of Decisions about Their Medical Treatment' (2018) 81(2) *Modern Law Review* 247, 263–4.

¹⁴ [2014] EWHC 342 (COP) (17 February 2014).

¹⁵ [2015] EWCOP 60 (28 September 2015).

¹⁶ [2003] 1 SCR 722 (Iacobucci, Major, Bastarache, Binnie, Arbour and Deschamps JJ) ('Starson').

a fascinating, detailed summary of relevant academic opinion and case-law from around the globe, including extensive consideration of Court of Protection judgments. Extracts will – spoiler alert – undoubtedly be festooning forthcoming editions of the Court of Protection Practice and the Court of Protection Handbook (and have already made their way into a skeleton argument at appellate level here). In addition to the extracts that we have concentrated on here, the judgment also contains an important summary of the state of the current art as regards the place of mental capacity in the context of the CRPD, which will be equally useful in informing these debates as they continue to roll around the globe.

Mental health and human rights – international developments

An extremely helpful [systematic review](#) has been published by the University of Melbourne of global practices that aim to reduce, prevent and end coercive practices in mental health settings. It was commissioned by the United Nations to inform a report of the United Nations Special Rapporteur on the Rights of Persons with Disabilities. In similar vein, a report by the United Nations High Commissioner for Human Rights on mental health on human rights has recently also been [published](#) (on 24 July 2018, but only made available more recently), reporting on a consultation on human rights and mental health held in Geneva on 14 and 15 May 2018. It contains a summary of the discussions, as well as conclusions and recommendations from the consultation.

International Journal of Mental Health and Capacity Law

The most recent edition of this has now been [published](#), and (abusing editor's privilege, Alex being one of the editorial team), we reproduce the editorial:

There is an Antipodean theme to this, the fifth issue of the Journal in its new guise. As editors, we were delighted that a paper published in the fourth issue provoked a reaction from the President of the Tribunal whose work was under scrutiny. Christopher Maylea and Christopher James Ryan's article 'Decision-Making Capacity and the Victorian Mental Health Tribunal' ([2017] International Journal of Mental Health and Capacity Law 87) had proposed an interpretation of how the Mental Health Act 2014 in Victoria, Australia, should work, before turning to two empirical studies which analysed the decisions of the Statements of Reasons of the Victoria Mental Health Tribunal to gain some appreciation of how the Act was working. Maylea and Ryan argued that the Tribunal had an obligation to consider the assessment of a compulsory patient's decision-making capacity when determining whether or not to make a compulsory Treatment Order, and that the Tribunal was falling into error by not meeting this positive obligation to take this matter into consideration.

The President of the Tribunal, Matthew Carroll, in a rejoinder published in this issue, suggests that this criticism was based on: a fundamental misinterpretation of relevant law, a misunderstanding of the processes of the Tribunal, and a lack of sufficient recognition of the distinctive features of the legislation that establishes the Tribunal and its processes. Carroll further suggests that Maylea and Ryan

generated a misconception that by not focusing on their decision-making capacity, the perspectives of mental health consumers are not being considered as part of Tribunal hearings in Victoria.

So as not to leave readers in suspense, this issue also contains a response by Maylea and Ryan, to the effect, broadly, that the President's understanding of the way that the Tribunal should operate is understandable, but does not, in their view, reflect the best reading of the legislation. Many may wish to follow their suggestion of returning to the analysis presented in their original paper and review it in light of Carroll's criticism. Should the President wish to continue the debate, the pages of the Journal are firmly open, and the editors would be delighted to facilitate further debate on what is undeniably a very important, yet perhaps, penumbrous topic within the Tribunal jurisdiction.

Next is a stimulating article by Bennetts, Maylea, McKenna and Makregiorgos on the 'tricky dance' of advocacy, a study of non-legal mental health advocacy in Victoria, Australia. The article serves the useful purpose both of reviewing some of the underpinning drivers and models of advocacy in the context of the Convention on the Rights of Persons with Disabilities ('CRPD'), and describing the application of the model of non-legal representational advocacy within the Victorian context, drawing on indepth qualitative interviews with advocates and other key stakeholders. The authors state that this is not an evaluation of this model or its impact, but rather a descriptive illustration of its intent and approach. This is exactly the sort of illustration which is required to flesh out what can

otherwise become sterile exchanges of slogans.

We then have a review paper by Piers Gooding on recent United Nations activity concerning Article 19 CRPD. As Gooding highlights, Article 19 produces an unusual consensus: "commentators across the spectrum – from those who see a role for coercion and substituted decision - making, to those who think they should be eliminated – appear to agree on the need for more resources for people with intellectual, cognitive and psychosocial disabilities to exercise their right to live independently and participate in the community ." In the personal experience of one of the editors (Ruck Keene) on the independent review of the Mental Health Act 1983 in England and Wales under way at the time of writing, this consensus is not merely shared by commentators, but also by those seeking to take forward law reforms in this area. Gooding's article, therefore, serves the invaluable purpose of placing the recent 'General Comment' No. 5 (August 2017) on Article 19 in its context, summarising its content, and critically analysing its key provisions. Remaining focused on the CRPD, the final paper relates to an entirely different part of the world and is a valuable spotlight on a jurisdiction based on a mixture of civil law and Shari'a law. Patricia Cuenca Gómez, María del Carmen Barranco Avilés and Pablo Rodríguez del Pozo review the provisions of Qatari law relating to deprivation of liberty in the context of psychosocial disability in the light of the CRPD. They find the provisions substantially lacking, and propose reforms to ensure that persons with psychosocial disabilities enjoy the right to liberty on equal terms with others.

Submissions to the journal are always welcome: details can be found [here](#).

A Standing Inquiry Into Abuse and Neglect of Vulnerable Adults: Learning from New South Wales

“Atrocious” neglect and abuse

In Australia an important report from a recent standing inquiry (‘the inquiry’) went to the New South Wales (‘NSW’) Parliament calling for more action to protect adults with disability from abuse and neglect in community settings, including within family homes. *Abuse and neglect of vulnerable adults in NSW – the need for action*, published on 2 November 2018, was presented by the NSW Ombudsman including a finding that

...the inquiry has identified highly vulnerable adults who are living in atrocious circumstances, and experiencing serious and ongoing abuse and neglect.

These are just three examples of what was reported to the NSW Ombudsman during their recent inquiry:

A young woman with intellectual and physical disability who is unable to verbally communicate and relies on a feeding tube for nutrition lives at home with her mother and her mother’s partner. The mother uses cable ties, a dog leash and sheets to tie the young woman to her wheelchair and bed. The mother terminated the services of a previous disability in-home support provider who made a report to police about her restraining the young woman and leaving her alone in the house for the evening while she went out.

A young man with intellectual disability lives at home with his parent. He shows signs of neglect, including poor hygiene, weight loss, and limited access to food. He has unexplained bruising, does not have access to medical treatment for his health issues, his parent has stopped him from seeing his psychiatrist, and he turns up to his day program in a sedated state. The young man does not have any access to his own money, and it is suspected he is exposed to domestic violence and drug use in the home.

[A] young man lived in a converted garage at the back of his family’s house, and the neighbour reported that the young man was left at home unsupervised and extremely distressed for most of the day. The young man was observed to wander the backyard for hours, slapping his face, biting himself, crying out, and banging on the door to the main house. The man’s family was seen by the neighbour to hit him with a broom to move him away if he approached visitors to the home.

Background and mandatory reporting

In 2014 legislation in NSW introduced the *Disability Reportable Incidents* scheme requiring the Department of Family and Community Services (FACS) and funded disability providers to notify the *NSW Ombudsman* “of serious incidents of abuse, neglect and ill-treatment of people with disability living in supported group accommodation”. NSW has led the way in the mandatory reporting and independent oversight of the abuse and neglect of people with disability in disability accommodation settings.

From 2015, as the numbers of contacts with the NSW Ombudsman about these matters increased, “coinciding with the progressive

withdrawal of FACS from the provision of specialist disability services" the decision was taken to commence a standing inquiry; it reflected "the seriousness of the matters that were being reported" to the NSW Ombudsman, and the fact that no other agency has *"the powers to adequately investigate these types of allegations."*

Reports to the inquiry

Between August 2015 and October 2018, the NSW Ombudsman received 358 contacts relating to the alleged abuse and neglect of adults with disability living in community settings. 206 reports did not relate to the conduct of service providers but were about *"the conduct of the person's family and other informal supports, and members of the community."* Of the 206, just under a third were referred to the inquiry via the National Disability Abuse and Neglect Hotline and the rest via reported external agencies or individuals. Most of the allegations were of abuse and/or neglect by family members including partner/ spouse, parent or sibling.

Two of the limits of the inquiry

The scope of the NSW Ombudsman's inquiry was limited to *"adults with disability who receive, or are eligible to receive, community services"* and therefore could not include all vulnerable adults; for example many incidents of elder abuse did not fall within these limits. The report notes that there is a NSW Elder Abuse Helpline and Resource Unit funded by FACS but its function is to support rather than investigate or coordinate cases management. Another key limit of the inquiry was that the NSW Ombudsman had no power to enter private residences to gain direct access to the alleged victim and the information

they obtain is not necessarily admissible in legal proceedings.

A new body and new legislation?

The inquiry found that there was *"horrendous abuse occurring in family homes and other community settings."* The report provides powerful evidence in support of the recommendation of the NSW Law Reform Commission for a Public Advocate to *"(among other things) investigate – of its own motion or in response to a complaint – cases of potential abuse and neglect of people who need decision-making assistance."* It also calls for new law to enable inter-agency information sharing and supported decision making and further review to find ways to strengthen the NSW system for protecting vulnerable adults.

The inquiry concluded that there needs to be *"swift action to establish a comprehensive adult safeguarding approach that will both fill the looming gap in relation to adults with disability, and address the longstanding gap in relation to vulnerable older persons."*

New guidance for people who interview vulnerable adults

In 2016 I spent two months in New South Wales to help set up a witness intermediary scheme based on the English model. NSW went one step further than any other jurisdiction has so far and introduced witness intermediaries at the same time as pre-recording of cross-examination (Cooper, 2016) and the scheme has been very positively, independently evaluated (Cashmore et al., 2017). NSW legislation does not, as yet, extend intermediaries to vulnerable adults, however the importance of research-informed questioning techniques (see for example my

latest research publication and The Advocate's Gateway) is already being realised in NSW.

I have been working for some time with the NSW Ombudsman to create an evidence-based guide to interviewing people with cognitive disability and communication support needs. It forms part of the NSW Ombudsman's Rights Project for people with disability which was funded by FACS.

It is critical that concerted and ongoing efforts are made to maximise the ability of more vulnerable members of the community, including people with cognitive impairment, to be able to speak up about abuse and other unacceptable situations.. it does a disservice to vulnerable adults to provide information about how to exercise their rights without ensuring that appropriate supports are in place to help them to do so, and that services are adequately prepared and equipped to respond.

The Guide is intended to give disability workers and investigators tasked with responding to allegations and complaints, advice about how to obtain the best evidence from people with cognitive impairment, particularly those who are the subject of, or witnesses to, alleged abuse. The Guide covers:

- how to remove barriers to effective participation in an interview by making reasonable adjustments
- conducting a pre-interview assessment – gathering key information about the interviewee and assessing issues such as 'capacity' and 'competence'

- the impact of trauma on communication and how to manage this
- critical steps in interview planning and preparation
- assistance with communication and support for the interviewee – the role of support people; communication assistants, such as intermediaries; interpreters and using communication aids
- strategies for rapport building
- factors to consider in choosing the right time and location for the interview, and the right interviewer, and
- obtaining an account – questioning techniques and things to avoid

I hope that that this guide will be put to practical use in the United Kingdom. We share New South Wales' desire to improve the ways in which we enable vulnerable adults to be heard and to exercise their rights. The Guide is due for release within months and an update for readers will follow.

Penny Cooper, PhD
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[Penny's academic research projects at Birkbeck, University of London, include studies funded by the Nuffield Foundation and the AHRC about the participation of witnesses and parties, including P in the Court of Protection. Penny's forthcoming book, Access to Justice for Vulnerable People, edited with Linda Hunting will be available in December from Wildy & Sons Ltd.]

SCOTLAND

World Congress 2022 in Scotland

The 5th World Congress on Adult Guardianship was held in Seoul, Korea, on 23rd – 26th October 2018. At a meeting of the International Advisory Board on 23rd October, the 7th World Congress on Adult Guardianship, in 2022, was awarded to Scotland. With the next Congress, in 2020, due to take place in Buenos Aires, Argentina, by the time that Scotland hosts the Congress it will have been held in every inhabited continent except Africa. The 2022 Congress will only be the second one in Europe, a significant accolade for Scotland, recognising that at its time Scotland's legislation of 2000 was world-leading, and also that there are reasonable prospects that by 2022 the current Scottish Government processes of review will have been completed, amending legislation enacted and brought into force, and experience of our updated regime already gained in practice.

Previous World Congresses were in Japan (2010), Australia (2012), United States of America (2014) and Germany (2016). The event has been described as "the Olympics of the subject". The 5th World Congress in Seoul was typical: approximately 500 from some 30 countries in attendance, 140 presentations in parallel sessions, and important plenary sessions. Scotland's involvement was significant, with Jan Killeen moderating and addressing a session on good practice for supported decision-making, her own contribution being on "Creating a national supported decision-making strategic framework", and Jill Carson speaking on "Making powers of attorney accessible to all: the Scotland story". My addresses to plenary

sessions are available [here](#) (on the CRPD) and [here](#) (enabling citizens to plan for incapacity). I moderated two other sessions, and Scotland was the only country with two participants in the panel discussion at the end of the final general session (Jan and me). I was also involved all day in a workshop session for China, Japan, Korea and other Asian countries after conclusion of the full international part of the Congress.

Alan Eccles, Public Guardian for England & Wales, was the most prominent other UK contributor, addressing a plenary session on the changing mental capacity environment in England & Wales, and how his office has evolved since implementation of the Mental Capacity Act 2005; and also participating in the workshop day for Asian countries.

Overall, the Congress reflected major and diverse efforts across the world to develop better provision and support for people with cognitive impairments, and deliver the promise of the UN Convention on the Rights of Persons with Disabilities in the everyday lives of people with mental and intellectual disabilities, and their families, supporters and others involved in their lives. Particularly on the final day, there appeared to be a growing recognition of the need to draw together contradictory and disputed viewpoints towards serving a common purpose.

"Guardianship" in the title of these events, though not outdated, masks a much broader range of coverage, leading to the adoption of the sub-title "Supporting the exercise of legal capacity" for the 6th and 7th Congresses.

While not featuring in the official programme, Korea's own Ms Mi Yeon Kim, elected to serve on the UN Committee on the Rights of Persons with

Disabilities from 1st January 2019, attended several sessions and engaged extensively with some of us between and after sessions of the Congress – when, of course, so much of value in such events takes place.

The 7th World Congress will be held in the Edinburgh International Conference Centre on 7th – 9th June 2022.

Adrian D Ward

Disability discrimination and autism

The August 2018 Upper Tribunal Administrative Appeals Chamber appeal decision in *C & C v Ors* [2018] UKUT 269 concerns disability discrimination in the provision of education. Whilst the case relates to a situation arising in England, the fact that the decision revolves around European Convention on Human Rights (ECHR) and Equality Act 2010 rights makes it equally applicable to Scotland. Whilst a full reading of the Upper Tribunal's decision, particularly its consideration of what is reasonable and objective justification for differential treatment is strongly advised, this article provides a summary of the main elements of the decision and its implications.

The facts

The case concerns L who has autism, anxiety and Pathological Demand Avoidance. The appellants, L's parents, brought a claim under the Equality Act 2010 complaining of disability discrimination. This particular appeal was against an earlier decision by the First-Tier Tribunal and relates to an incident where L was excluded from school for a fixed period of 1½ days when L was 11 years old. The reason given

for the exclusion was L's aggressive behaviour. This behaviour was attributable to his autism.

The law

For a person to be protected from disability discrimination by the Equality Act 2010 they must fall within the definition in section 6(1) of the Act which defines a person (P) as having a 'disability' if:

- (a) P has a physical or mental impairment, and*
- (b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities.*

Details on what amounts to discrimination generally (which includes failure to provide reasonable adjustments) under the Act can be found in sections 15 and 20. However, section 85(1) deals specifically with discrimination in admissions to schools and section 85(2) provides that:

- The responsible body of [a school to which this section applies] must not discriminate against a pupil-*
- (a) in the way it provides education for the pupil;*
 - (b) in the way it affords the pupil access to a benefit, facility or service;*
 - (c) by not providing education for the pupil;*
 - (d) by not affording the pupil access to a benefit, facility or service;*
 - (e) by excluding the pupil from school;*
 - (f) by subjecting the pupil to any other detriment.'*

Section 85(6) also imposes a duty on schools to make reasonable adjustments. Paragraph 2 of

Schedule 13 of the Act makes it clear that this duty applies to deciding who is offered admission as a pupil and the provision of education or access to a benefit, facility or service.

However, regulation 4(1)(c) of the Equality Act 2010 (Disability) Regulations 2010¹⁷ states that certain conditions will not amount to impairments within the meaning of the Equality Act. These are:

- (a) a tendency to set fires,
- (b) a tendency to steal,
- (c) a tendency to physical or sexual abuse of other persons,
- (d) exhibitionism, and
- (e) voyeurism.

In terms of relevant ECHR rights, the effect of Article 14 ECHR (prohibition of discrimination)¹⁸ in conjunction with Article 2 of ECHR Protocol 1 (the right to education)¹⁹ is that a disabled child should not be denied education where such denial is a disproportionate measure in the particular circumstances.

¹⁷ S.I. 2010/2028.

¹⁸ Article 14 ECHR states: 'The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.' It is clear that 'other status' is deemed to include disability (see *Glor v Switzerland*, ECtHR, April 2009, Application No. 13444/04).

¹⁹ Article 2 ECHR Protocol 1 provides: 'No person shall be denied the right to education. In the exercise of any functions which it assumes in relation to education and to teaching, the State shall respect the right of parents to ensure such education and teaching in conformity with their own religious and philosophical convictions.'

Decision

The First-Tier Tribunal had considered that L met the definition of a disabled person for the purposes of section 6 of the Equality Act. However, it considered that the Act's protection did not apply because L had been excluded as a result of his 'tendency to physical abuse' thus falling within regulation 4(1)(c) of the 2010 Regulations. The applicants had submitted that regulation 4(1)(c) should be read down or disapplied in order to avoid a breach of Article 14 ECHR (prohibition of discrimination)²⁰ in conjunction with Article 2 of ECHR Protocol 1 (the right to education)²¹ but the First-Tier tribunal had not accepted this.

In the appeal to the Upper Tribunal the First-Tier Tribunal's finding that L had a 'tendency to physical abuse.' was not challenged. The issue before the Upper Tribunal was whether the First-Tier Tribunal had made an error of law when it found that L was not 'disabled' insofar as his 'tendency to physical abuse' was concerned. In particular, the Upper Tribunal had to determine whether regulation 4(1)(c) of the 2010

²⁰ Article 14 ECHR states: 'The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.' It is clear that 'other status' is deemed to include disability (see *Glor v Switzerland*, ECtHR, April 2009, Application No. 13444/04).

²¹ Article 2 ECHR Protocol 1 provides: 'No person shall be denied the right to education. In the exercise of any functions which it assumes in relation to education and to teaching, the State shall respect the right of parents to ensure such education and teaching in conformity with their own religious and philosophical convictions.'

Regulations was compatible with Article 14 read in conjunction with Article 2 ECHR Protocol 1. It concluded that it was not compatible.²²

The Upper Tribunal referred to section 3(1) of the Human Rights Act 1998 which requires that, provided it does not disturb a fundamental feature of regulation 4(1)(c), allowed the tribunal to read and give effect to this regulation in a way which is compatible with ECHR rights.²³ It found that, when construed in accordance with section 3 of the Human Rights Act 1998, regulation 4(1)(c) does not apply to schoolchildren who have a recognised condition that is more likely to result in a tendency to physical abuse.²⁴ L thus met the definition of a disabled person for the purposes of section 6 of the Equality Act, the First-Tier Tribunal had therefore made a material error on the point of law and L had indeed been unlawfully discriminated against when he had been excluded from school on that occasion.²⁵

In reaching its decision the Upper Tribunal considered the public policy consideration underpinning regulation 4(1)(c) which was not to protect people where their condition results anti-social or criminal activity.

Moreover, in considering Article 14 ECHR in conjunction with Article 2 ECHR Protocol 1, the Upper Tribunal felt that in permitting the exclusion from the definition of 'disability' as a result of their aggressive behaviour regulation

4(1)(c) allowed disabled children such as L to be treated differently to other disabled children. However, it asked, could this difference be justified? In other words, had the ECHR requirement for proportionality in the limitation of its rights been met? It concluded that it had not in this case.

The Upper Tribunal considered that there was a lack of evidence that the regulation struck the right balance. The effect of regulation was extremely severe (and one which apparently affects a significant number of schoolchildren) because it permitted schools to exclude disabled children such L on the basis of a 'tendency to abuse' without having to provide justification even where this behaviour might actually be the result of the school's own failure to make reasonable adjustments. Moreover, it noted that aggressive behaviour was not necessarily a choice for autistic children, who might not understand their behaviour thus making it inappropriate to label it as criminal or anti-social. Indeed, if the regulation did not apply, schools would not be compelled to accept violent behaviour, they would simply have to demonstrate that they had made reasonable adjustments or justify the proportionality of any decision to exclude the child.²⁶

Implications for Scotland

related to a person's disability or related impairment is discriminatory and thus unacceptable. See, for example, Committee on the Rights of Persons with Disabilities, *General comment No. 6 (2018) on equality and non-discrimination*, CRPD/C/GC/6, 26 April 2018. Available at:

https://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD/C/GC/6&Lang=en

²² At para 93.

²³ At paras 94-95.

²⁴ At para 95.

²⁵ At paras 101-102.

²⁶ The Upper Tribunal made no reference to this, and it is beyond the scope of this article, but it should be noted that the UN Convention on the Rights of Persons with Disabilities in fact considers that reasonable and objective justification for the denial of rights which is

As with the rest of the UK, what this ultimately means for disabled children where they have a condition that gives rise to a 'tendency to physical abuse' is that they will be protected against exclusion without proper justification. Schools will be required to genuinely make reasonable adjustments for such children before any justification for exclusion is considered reasonable and objective, in other words proportionate.

Jill Stavert

Safeguarding vulnerable adults in Scotland: Good practice across the counselling professions

This resource, Safeguarding vulnerable adults in Scotland, authored by the Report's two Scottish Contributors, Adrian Ward and Jill Stavert, offers information to assist practitioners in Scotland in determining the legal obligations to vulnerable adults. It focuses in particular on laws which may affect adults who come into contact with counselling and psychotherapy services and provides assistance to practitioners in Scotland in determining their legal obligations to vulnerable adults. The resource explains in clear terms the legislative framework, key organisations, duties of confidentiality, social care support, disclosure obligations, and handling vulnerable witnesses in court. It also highlights the importance of international human rights legislation in the development of laws.

Although the guidance is intended for practitioners in Scotland, much of the advice regarding the Human Rights Framework is equally applicable across the UK. The resource also serves as a useful and comprehensive

reference guide to the legal framework in Scotland for cross-border practitioners outside of Scotland who may not be familiar with the relevant provisions.

Annabel Lee

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Conferences

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 December. 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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