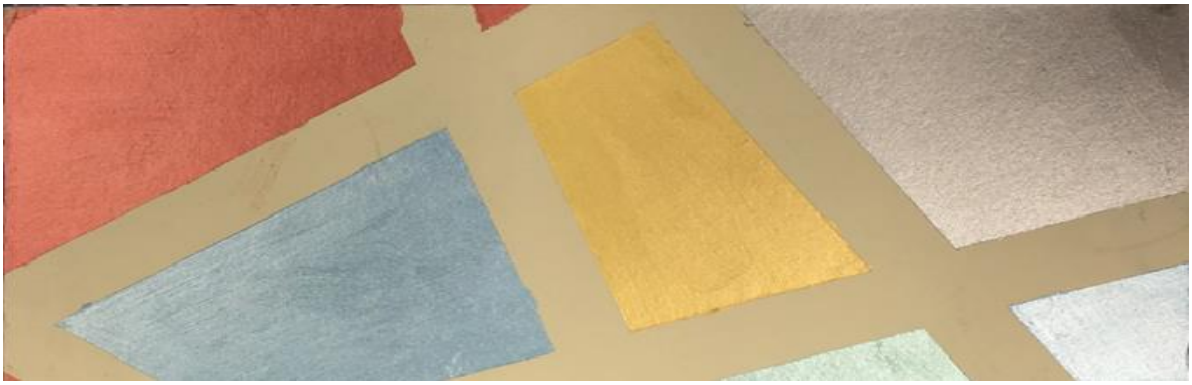

Welcome to the February 2019 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: a personal view on the Mental Capacity (Amendment) Bill from Tor, damages where the MCA has gone awry and the Supreme Court on the MHA in the community;

(2) In the Property and Affairs Report: neglect and attorneys, a speedy (and sensitive) statutory will and attorneys as personal representatives;

(3) In the Practice and Procedure Report: a challenging decision on the inherent jurisdiction, CoP statistics and guidance on anonymisation;

(4) In the Wider Context Report: the Code of Practice is being revised, guidance on CANH and the Mental Capacity Action Day looms;

(5) In the Scotland Report: a welcome change to guidance in relation to voter registration, and the death of the former Director of the Mental Welfare Commission.

Last, but very much not least, her fellow editors invite you to join in congratulating Tor on her appointment as Queen's Counsel.

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.

Contents

HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

Mental Capacity (Amendment) Bill – a personal view

The government continues to plough ahead with the MCA Amendment Bill (Report Stage and Third Reading being on 12 February) despite near-universal alarm about the weakening of crucial safeguards and non-compliance with the requirements of Article 5. The hashtag #DolsRights on Twitter is being used to collect stories about the benefits of DOLS and successful outcomes, both at court and during the DOLS assessment process, to contradict the claims made, without evidence, that DOLS benefits barely any of the people to whom it applies, and to show how significant the benefits actually are to the individuals concerned. Readers are encouraged to join in with examples from their own experience.

The latest version of the Bill is available here, and the revised Impact Assessment here. Proposed Government amendments for Third Reading which go some way to addressing a few of the concerns raised are summarised by Tim Spencer-Lane thus:

1. An independent hospital cannot be a responsible body – in cases involving deprivation of liberty in an independent hospital, the responsible body in England is the local authority meeting the person's needs or in whose area the hospital is situated, or in Wales the Local Health Board;
2. A duty on responsible bodies to publish information about authorisations and to take steps at the outset of the authorisation process to ensure that the person and appropriate persons understand the process.
3. A regulation-making power to allow Government to set out requirements which must be met for a person to make a determination or carry out an assessment, such as the required knowledge and experience.
4. To require that where a variation is to be made to the authorisation, a review must be carried out first, or if that is not practicable or appropriate, it must be carried out as soon as possible after variation.
5. A new duty to carry out a review if a relevant person makes a request – and a power in such cases to refer the authorisation to the AMCP.

The remaining problems include the following – and there is now not much time to get them fixed) before the Bill is finally approved.

- The statutory definition, which is inevitably going to lead, very swiftly, to further litigation as the courts are asked to interpret it in a way that is compliant with Article 5;
- The absence of any mechanism to challenge emergency detention, which at present could continue without time limit and without access to non-means-tested legal aid;
- The new scheme removes the entitlement to advocacy services specifically aimed at assisting a person who is deprived of their liberty to challenge that in court;

- Too much scope for those with power to decide that scrutiny or advocacy are not required – an AMCP gets to decide whether to accept a referral in some cases; advocates are only appointed for 'unbefriended' people if that is thought to be in their best interests, despite access to the court under Article 5(4) not being a best interests issue. Puzzlingly, in an open letter to Inclusion London, the government suggested that the latter provision is in place because it would be wrong to appoint an IMCA where someone was expressly objecting to having one. Given that (a) the person concerned is, by definition, unlikely to have a complete grasp of the role of an IMCA and the circumstances surrounding their care, and (b) any IMCA appointed could take an independent decision about what level of support to offer the cared-for person, the Government's objection is difficult to understand, not least when one thinks about the much more serious consequence to a person who needs an IMCA but is not given one as a result of this provision.
- Continued over-reliance on the cared-for person expressing an objection to trigger safeguards, when many of those concerned will not be able to express any informed view and where their behaviour may be conveniently viewed as 'part of their condition' rather than something that means further scrutiny of their care arrangements is required.
- The position of 16/17 year olds and the interaction with other statutory frameworks.

Tor Butler-Cole

Giving the MCA teeth

Esegbona v King's College NHS Trust [2019] EWHC 77 (QB) High Court (Queen's Bench Division) (HHJ Coe QC)

Other proceedings – civil

Summary[1]

This case concerned a disastrous failure to follow the principles of the MCA in relation to the discharge from hospital of a seriously ill 68 year old woman. Mrs Esegbona was admitted to hospital from A&E and required repeated admissions to intensive care due to a range of health problems. By the time she was able to be discharged, she had a tracheostomy and required a high level of nursing care such that she was deemed eligible for NHS Continuing Healthcare. She was not compliant with the tracheostomy and there were repeated incidents where she dislodged or removed it. A nursing home placement was found, but fell through due to the unpredictability of her presentation. Eventually a second nursing home was identified, and Mrs Esegbona was discharged there, around 4 months after being medically fit for discharge, and 8 months after being admitted. She died around 10 days later, having removed the tracheostomy tube and suffered a cardiac arrest.

The claim[2] was brought by Mrs Esegbona's daughter alleging negligence by failing to pass

[1] Note, Katie Scott having been instructed in this case, she has not been involved in preparing this note.

[2] Which was not a Human Rights Act claim, possibly because the limitation period had expired.

on information to the nursing home about the risk of the tracheostomy tube falling out or being removed on purpose and difficulties with obstruction of the tube, and false imprisonment for the period after Mrs Esegbona was fit for discharge and wanted to return home but remained in hospital.

In light of expert evidence that had been obtained by both sides, there was no disagreement that a failure to pass on information about the tracheostomy tube to the nursing home would have been negligent. It was also conceded by the Trust that there had been a period of false imprisonment, when a DOLS authorisation should have been in place. The issues that were disputed, were these:

Was it a breach of duty not to tell the nursing home that Mrs Esegbona had wanted to go home and did not want to be in the nursing home? The court decided that it was.

- Did the failure to pass on information about the tracheostomy and Mrs Esegbona's wishes materially increase the risk of her dying in the manner and environment that she did (albeit it could not be said on the balance of probabilities that she would have lived but for these failures)? The court held that causation was established, relying on findings that she had removed the tracheostomy tube deliberately when in hospital, that this had not been passed on but if it had, she would have been provided with 1:1 care at all times, and that her eventual death was due to a deliberate removal of the tube (contrary to the findings at the inquest into her death).
- The appropriate level of damages for the period of false imprisonment. The court awarded £130 a day (i.e. a total of £15,470), concluding that if the MCA processes had been followed correctly, Mrs Esegbona would either have been discharged home with a package of care or to a nursing home.
- Whether aggravated damages should be awarded in light of the alleged deliberate exclusion of the family in the decision-making process; the fact that the detention occupied the last months of Mrs Esegbona's life; and that the defendant failed to act upon the clear advice of its own psychiatrist about the need for a capacity assessment and a best interests meeting. The court awarded £5,000 in aggravated damages.

Comment

There are a number of surprising findings in this case, including that it is the treating NHS Trust which is responsible for deciding where a patient should be discharged to, rather than the CCG with responsibility for community services pursuant to the NHS Continuing Healthcare Framework, and that it would only have taken a month to fully investigate and decide whether Mrs Esegbona could safely return home with a package of care instead of being admitted to a nursing home.

The case is perhaps best explained by the failure to follow the MCA promptly, even when the need for capacity and best interests assessments were flagged up, and a breakdown in communication with the family which led to entries in the medical records noting that information should be withheld from them and the discharge to the nursing home effected without them being able to have a say in what

happened. The cumulative effects of the failings were clearly such as to lead the Trust to concede that Mrs Esegbona was falsely imprisoned. They were clearly right to do so in circumstances where the judge said:

> *The defendant made its decision and was determined to implement it without the family's involvement…I find that that behaviour falls squarely within the definition of "high-handed" and "oppressive". Taken together with the additional features in this case of the defendant's failure to follow the advice of its own psychiatrist on three occasions and their failure to call any evidence in this case to explain the tenor of the notes, I find that it is appropriate to make an award of aggravated damages.*

The events complained of took place in 2010 and 2011 – no doubt some 9 years later, we would like to hope the integration of MCA and the DOLS processes with discharge planning is more effectively embedded into hospital Trusts.

We note, finally, that whilst the case is undoubtedly important as a decision where the court has actually assessed damages for itself (rather than endorsing an agreement), the way in which the case unfolded leaves some questions open. In particular, given that the claim was expressly framed as a common law claim for false imprisonment, rather than an HRA claim for unlawful deprivation of liberty, it will not stand as a direct precedent for the award of damages in such a HRA claim, and we are still reliant in such claims on reading the runes from settlements such as that in the 'Fluffy' case.

The thinnest of legal ice – restricting contact and the MCA

SR v A Local Authority [2018] EWCOP 36 (HHJ Buckingham)

Best interests – contact

Summary

A couple had been married for 58 years, and were devoted to each other. The wife developed dementia. She initially attended a day care centre whilst living at home, but in November 2016 the decision was then taken by the local authority that she should remain at a care home, in part because of risks perceived by professionals arising from the husband's expressed view on euthanasia. She was made the subject of a DOLS authorisation at that point. Her family objected to her continuing placement at the current placement and wished for her to return home. The woman was reported to have frequently expressed a wish to be with her husband. Attempts to mediate with the family proved abortive, and "*the process of seeking to resolve issues surrounding* [the woman's] *residence and contact, without recourse to the court,* [was] *elongated*." In May 2017, the local authority imposed a restriction on the husband's ability to take his wife away from the placement unaccompanied. No application was made by the local authority either in relation to restricting contact or in relation to the question of where the woman should live; but ultimately the woman's RPR made a s.21A application. Notwithstanding the absence of authority to restrict contact, the husband complied with the restriction imposed save for a day when there had been a bereavement at the care home and a considerable degree of upset in the home in

consequence from which the husband had decided to remove his wife temporarily. The care home alerted the police and it appears that armed police were called in consequence.

In the s.21A proceedings, the local authority applied orally for orders restricting contact between the woman and her husband, so as to prevent him taking her out of the care home where she resided unless accompanied by a member of staff or relative. The basis for this application were the local authority's concerns about the husband's expressed views about euthanasia. The court directed that the local authority file a schedule of findings and supporting evidence relied upon to justify the imposition of the restriction sought.

HHJ Buckingham then undertook a detailed examination of the comments made by the husband, noting that he was a man who held and expressed forthright views about matters, restating his support for euthanasia at a best interests meeting in April 2018 and in court. However:

> *44. Whilst I accept that JR's comments have given rise to legitimate anxiety on the part of the professionals, I do not consider that there was adequate investigation into the reasons why JR has made such comments and what he understands by the notion of supporting euthanasia, which from his evidence related to the right to self-determination and dignity. I consider that JR's intransigence at times as relations with professionals became increasingly strained may also not have assisted constructive enquiry and resolution of issues.*
>
> *45. At times JR's evidence was contradictory. He lacks insight to appreciate fully the reasons why his remarks cause such consternation. However, he was consistent that he would never dream of hurting his wife. Is it safe for the court to take that assertion at face value in the light of his expressed views and comments, some of which have been unpalatable? I take note of the fact that following the first comments in August 2016, SR returned home to live with JR until 9th November 2016. Between 9th November 2016 and 27th May 2017, extensive unsupervised contact took place within the care home and outside the care home. To date, JR remains alone with SR for approximately two hours per evening in a closed room. SR has remained safe and subject of devoted affection and attention from her husband.*
>
> *46. I have reached the conclusion that the restriction sought by A Local Authority is neither justifiable, proportionate or necessary. JR will need to have regard to his wife's settled routines and what is in her best interests when considering how he would wish to revert to more relaxed contact with his wife. He will need to communicate openly with the professionals about proposed contact arrangements and contingency plans, should SR become upset or agitated or behave in an unpredictable way in his sole care. JR and professionals will need to ensure that he is alert to what situations may arise and how best to deal with them. JR will also need to have continuing regard to his own health and how that impacts upon his ability to provide safe care for SR as well as his driving competence.*

Comment

It was, as HHJ Buckingham put it:

> *regrettable that tensions and dispute between professionals and the family have been building up since at least January 2017 over the care and contact arrangements for SR. When it became clear that the family did not support the care or contact arrangements, the matter should have been referred to the court.*

Although overlain with the particularly emotive issue of views about euthanasia, this case is in many ways sadly not unusual. It highlights, or should highlight, the thinness of the legal ice afforded to public bodies seeking to restrict contact without the authority of the court given the clear interference with the Article 8 rights of the woman (and her husband).[3] Although "*Article 8 of the Convention contains no explicit procedural requirements, the decision-making process involved in measures of interference must be fair and such as to ensure due respect of the interests safeguarded by Article 8," very serious limitations of private and family life calling for strict scrutiny (see, amongst others, AN v Lithuania [2016] ECHR 462). The Supreme Court in NHS Trust v Y* [2018] UKSC 46*considered that s.5 MCA 2005 could in principle provide a sufficiently robust basis upon which decisions in relation to life-sustaining treatment could be constructed without the need for automatic recourse to the court, where there is agreement as to what is in the best interests of the person. This suggests that, if restriction on contact could be levered into the definition of an act in connection with care and treatment, s.5 MCA 2005 could, in principle, provide a basis upon which contact could be restricted without incurring liability. However, the quid pro quo must be that "[i]f, at the end of the […] process, it is apparent that the way forward is finely balanced, or there is a difference of* [professional] *opinion, or a lack of agreement to a proposed course of action from those with an interest in the* [person's] *welfare, a court application can and should be made*" (Lady Black in *An NHS Trust v Y*).

The Supreme Court and the MHA in the community (1) conditional discharge

Secretary of State for Justice v MM [2018] UKSC 60 Supreme Court (Lady Hale, President; Kerr, Hughes, Black and Lloyd-Jones SCJJ)

Article 5 – Deprivation of liberty

Summary

The Supreme Court (Lord Hughes dissenting) has upheld the ruling of the Court of Appeal that neither the Secretary of the State nor the Mental Health Tribunal has the power to impose conditions on the discharge of a restricted patient which would amount objectively to a deprivation of the patient's liberty.

The parameters of the problem are clearly defined: the patient, MM, "*is anxious to get out of hospital and is willing to consent to a very restrictive regime in the community in order that this can happen. The Secretary of State argues that this is not legally permissible*." It was agreed that MM had capacity to consent to the restrictions, which undoubtedly satisfied the 'acid test' set

[3] As had been flagged by the Law Commission in its Mental Capacity and Deprivation of Liberty report in its proposals in relation to s.5 MCA. The Government's approach to these issues is explained here.

down in *Cheshire West*.

As Lady Hale (for the majority) noted (at paragraph 24) that:

> *It is, of course, an irony, not lost on the judges who have decided these cases, that the Secretary of State for Justice is relying on the protection of liberty in article 5 in support of an argument that the patient should remain detained in conditions of greater security than would be the case were he to be conditionally discharged into the community.*

However, Lady Hale considered that there were three key reasons why MM could not consent to conditions amounting to confinement.
The first was one of high principle. As the power to deprive a person of his liberty is by definition an interference with his fundamental right to liberty of the person, it engaged the rule of statutory construction known as the principle of legality, as explained by Lord Hoffmann in *R v Secretary of State for the Home Department, Ex p Simms* [2000] 2 AC 115, at 131:

> *… the principle of legality means that Parliament must squarely confront what it is doing and accept the political cost. Fundamental rights cannot be overridden by general or ambiguous words. This is because there is too great a risk that the full implications of their unqualified meaning may have passed unnoticed in the democratic process. In the absence of express language or necessary implication to the contrary, the courts therefore presume that even the most general words were intended to be subject to the basic rights of the individual.*

Lady Hale took the view that Parliament had not been asked – as they would have to have been – as to whether the relevant provisions of the MHA:

> *Included a power to impose a different form of detention from that provided for in the MHA, without any equivalent of the prescribed criteria for detention in a hospital, let alone any of the prescribed procedural safeguards. While it could be suggested that the FtT process is its own safeguard, the same is not the case with the Secretary of State, who is in a position to impose whatever conditions he sees fit.* (paragraph 31)

The second was one of practicality. The MHA confers no coercive powers over conditionally discharged patients; as Lady Hale noted (although many may not realise): "*[b]reach of the conditions is not a criminal offence. It is not even an automatic ground for recall to hospital, although it may well lead to this.*" The patient could therefore:

> *… withdraw his consent to the deprivation at any time and demand to be released. It is possible to bind oneself contractually not to revoke consent to a temporary deprivation of liberty: the best-known examples are the passenger on a ferry to a defined destination in Robinson v Balmain New Ferry Co Ltd [1910] AC 295 and the miner going down the mine for a defined shift in Herd v Weardale Steel, Coal and Coke Co Ltd [1915] AC 67. But that is not the situation here: there is no contract by which the patient is bound.* (paragraph 32).

That led on to what Lady Hale identified as the third and most compelling reason, namely that she considered that to allow a person to consent to their confinement on conditional discharge would be contrary to the whole scheme of the MHA. The MHA provided in detail for only two

forms of detention (1) in a place of safety; and (2) in hospital. Those were accompanied by specific powers of conveyance and detention, which were lacking in relation to conditionally discharged patients – "*[i]f the MHA had contemplated that such a patient could be detained, it is inconceivable that equivalent provision would not have been made for that purpose*" (paragraph 34). There was, further, no equivalent to the concept of being absent without leave to that applicable where a patient is on s.17 leave, it again being "*inconceivable*" that "*if the MHA had contemplated that he might be detained as a condition of his discharge […] that it would not have applied the same regime to such a patient as it applies to a patient granted leave of absence under section 17*" (paragraph 36). Finally, the ability of a conditionally discharged patient to apply to the tribunal is more limited than that of a patient in hospital (or on s.17 leave), this being *"[a]t the very least, this is an indication that it was not thought that such patients required the same degree of protection as did those deprived of their liberty; and this again is an indication that it was not contemplated that they could be deprived of their liberty by the imposition of conditions."*

Lord Hughes, dissenting, took as his starting proposition that what was in question was not the removal of liberty from someone who is unrestrained. Rather:

> *The restricted patient under consideration is, by definition, deprived of his liberty by the combination of hospital order and restriction order. That deprivation of liberty is lawful, and Convention-compliant. If he is released from the hospital and relaxed conditions of detention are substituted by way of conditional discharge, he cannot properly be said to be being deprived of his liberty. On the contrary, the existing deprivation of liberty is being modified, and a lesser deprivation substituted. The authority for his detention remains the original combination of orders, from the consequences of which he is only conditionally discharged.*

He then took on each of the set of reasons given by Lady Hale for the majority before concluding at paragraph 48 that:

> [i]*t seems to me that the FTT does indeed have the power, if it considers it right in all the circumstances, to impose conditions upon the discharge of a restricted patient which, if considered out of the context of an existing court order for detention, would meet the Cheshire West test, at least so long as the loss of liberty involved is not greater than that already authorised by the hospital and restriction orders. Whether it is right to do so in any particular case is a different matter. The power to do so does not seem to me to depend on the consent of the (capacitous) patient. His consent, if given, and the prospect of it being reliably maintained, will of course be very relevant practical considerations on the question whether such an order ought to be made, and will have sufficient prospect of being effective. Tribunals will at that stage have to scrutinise the reality of the consent, but the fact that it is given in the face of the less palatable alternative of remaining detained in hospital does not, as it seems to me, necessarily rob it of reality. Many decisions have to be made to consent to a less unpalatable option of two or several: a simple example is where consent is required to deferment of sentence, in a case where the offence*

would otherwise merit an immediate custodial sentence.

Comment

It is clear that this is not a judgment that the majority wished to reach, for the self-evident reason that it will both prevent restricted patients from being discharged from hospital and (worse) require the (technical) recall of any patients who are out of hospital on conditions amounting to a confinement, at least where they have capacity to consent to those conditions. Despite Lord Hughes' heroic efforts to find a way through to a different answer, it is in reality difficult to see how the majority's iron logic was not correct. One cannot help but wonder, however, whether Parliament in 1982 perhaps assumed that a conditionally discharged patient would not be deprived of liberty which is why there are no express provisions for it.

Of course, in at least some situations, the judgment will prompt very careful consideration of whether all of the actual or proposed conditions are in fact strictly necessary, which can only be a good thing. But the combination of this decision and the earlier decision in *Cheshire West*, making clear how low the bar for the test of confinement is set, does seem to lead to an odd outcome. The only way in which that outcome could be reversed, it is clear, is by way of legislation, and the independent Review of the MHA review 1983 has recommended that the Tribunal be given the power to discharge patients with conditions that restrict their freedom in the community, potentially with a new set of safeguards.

In the interim, the Mental Health Casework Section of HM Prison and Probation Service has issued guidance suggesting that there should be greater use of long-term s.17(3) leave. Those already conditionally discharged into confinement will need to be technically recalled to hospital (without physically have to go there) and given escorted s.17(3) leave (perhaps up to 12 months at a time). Whilst a temporary fix, this may give rise to a number of problems. Who will be the responsible clinician? Will the hospital bed still be commissioned whilst the patient is on leave? The impact for the Transforming Care Agenda could be noticeable.

The guidance usefully seeks to address the position of those lacking capacity to consent to conditions amounting to confinement. In *MM*, Lady Hale for the majority expressly declined to engage with the question of whether "*the Court of Protection could authorise a future deprivation, once the FtT has granted a conditional discharge, and whether the FtT could defer its decision for this purpose*." The guidance suggests that the approach to obtaining authorisation will depend upon whether the primary reason for confining the individual with impaired capacity is:

1. their own interests, in which case, conditional discharge together with authorisation under DoLS/by way of the Court of Protection is suggested: or

2. risk to others, in which case the suggestion is that conditional discharge is inappropriate, but long-term s.17 leave should be used.

The guidance expressly deprecates the use of the inherent jurisdiction of the High Court, as had been invoked in *Hertfordshire County Council v AB* [2018] EWHC 3103 (Fam). It is unfortunate that the Secretary of State had not responded to the

invitation from the court in that case to participate, and we suspect that it will not be long before the Secretary of State intervenes in another case on similar facts.

The Supreme Court and the MHA in the community (2) CTOs

Welsh Ministers v PJ [2018] UKSC 66 Supreme Court (Lady Hale, President; Mance, Wilson, Hodge and Black SCJJ)

Article 5 – Deprivation of liberty

Summary

The Supreme Court has reversed the curious and controversial decision in *PJ*, in which the Court of Appeal had held that the MHA 1983 contained within it by necessary implication the power for the patient's responsible clinician to set conditions on a community treatment order ('CTO') that amounted to a deprivation of liberty, so long as it was a lesser restriction on their freedom of movement than detention for treatment in hospital.

Until shortly before the hearing, the Welsh Ministers' principal argument was that the Court of Appeal had been correct. Lady Hale, giving the unanimous judgment of the court, noted that:

> [i]*t would, to say the least, have been helpful to this court to have the views of the Secretary of State for Health, no doubt after consultation with the Secretary of State for Justice, on an issue which affects England as much as it affects Wales. It may, however, be possible to deduce the views of the Secretary of State from the Mental Health Act Code of Practice, which he is required to draw up and lay before Parliament under section 118 of the MHA. The current edition (revised 2015) states quite clearly that "The conditions must not deprive the patient of their liberty" (para 29.31)*

Shortly before the hearing however, and to the visible surprise of the Supreme Court, the Welsh Ministers advanced an entirely an alternative and diametrically opposed argument. This was, in short, that because the conditions in a CTO cannot be enforced, they could not in law amount to a deprivation of liberty and it was therefore permissible to impose them.

Lady Hale had little truck with this argument:

> *18. The Welsh Ministers are entirely correct in what they say about the legal effect of a CTO. But it does not follow that the patient has not in fact been deprived of his liberty as a result of the conditions to which he is subject. The European Court of Human Rights has said time and time again that the protection of the rights contained in the European Convention must be practical and effective. When it comes to deprivation of liberty, they and we must look at the concrete situation of the person concerned: has he in fact been deprived of his liberty? Otherwise, all kinds of unlawful detention might go unremedied, on the basis that there was no power to do it. That is the antithesis of what the protection of personal liberty by the ancient writ of habeas corpus, and now also by article 5 of the Convention, is all about.*

As the case had always proceeded on the basis that PJ's factual circumstances amounted to a deprivation of liberty, Lady Hale held that this was enough for the Supreme Court's purposes

to proceed on the basis that there was a deprivation of liberty on the ground. The question was therefore whether the RC had power, under the MHA, to impose conditions which have that effect.

The Welsh Ministers had a further argument as to why PJ's circumstances should not be seen in law as a deprivation of liberty, namely that the 'acid test' from *Cheshire West* "*should be modified for cases of this sort where the object is to enhance rather than further curtail the patient's freedom.*" They relied, in particular, upon the observations of the European Court in *Austin v United Kingdom* to the effect that "[i]*n order to determine whether someone has been 'deprived of his liberty' within the meaning of article 5(1), the starting point must be his concrete situation and account must be taken of a whole range of criteria such as the type, duration, effects and manner of implementation of the measure in question. The difference between deprivation of and restriction upon liberty is one of degree or intensity, and not of nature or substance*."

However, Lady Hale somewhat tartly dismissed this contention:

> *21. This is indeed the test which has been propounded by Strasbourg for many years, beginning with Guzzardi v Italy (1980) 3 EHRR 333. The jurisprudence was examined in detail in Cheshire West, where all members of the court agreed that the "acid test" of a deprivation of liberty was whether the person was under continuous supervision and control and not free to leave. The concrete circumstances of PJ in this case are much the same as those of P in the Cheshire West case, although PJ is not as seriously disabled as was P. And in both cases, the object of the care plan was to allow them as much freedom as possible, consistent with the need to protect their own health or safety or, at least in PJ's case, that of others. But, as Lord Walker pointed out in the House of Lords in Austin v Comr of Police of the Metropolis [2009] AC 564, at para 43, "It is noteworthy that the listed factors, wide as they are, do not include purpose". There is no reason to distinguish this case from Cheshire West and we are not - and could not be as a panel of five - asked to depart from it.*

Lady Hale therefore turned to the real issue, namely whether the power to impose conditions amounting to a deprivation of liberty could be read into the MHA by necessary implication. She considered that the approach of the Court of Appeal had been to put before the cart before the horse, taking the

> *assumed purpose of a CTO - the gradual reintegration of the patient into the community - and works back from that to imply powers into the MHA which are simply not there. We have to start from the simple proposition that to deprive a person of his liberty is to interfere with a fundamental right - the right to liberty of the person.*

Applying very similar analysis that that undertaken in the *MM* case with which PJ had been linked at the Court of Appeal stage, and observing the pre-history of CTOs, Lady Hale found that:

> *29. […] the MHA does not give the RC power to impose conditions which have the concrete effect of depriving a community patient of his liberty within the meaning of article 5 of the European Convention. I reach that conclusion without hesitation and in the light of the*

> *general common law principles of statutory construction, without the need to turn further to the jurisprudence of the European Court of Human Rights or to resort to the obligation in section 3(1) of the Human Rights Act 1998 to read and give effect to legislation in a way which is compatible with the Convention rights. However, it is doubtful, to say the least, whether the European Court of Human Rights would regard the ill-defined and ill-regulated power implied into the MHA by the Court of Appeal as meeting the Convention standard of legality.*

In relation to the subsidiary question of the powers of the Mental Health Tribunal (or in PJ's case, the Mental Health Tribunal for Wales) if it finds on the facts that the community patient is being deprived of their liberty, Lady Hale held that:

> *33. […] The MHRT has no jurisdiction over the conditions of treatment and detention in hospital, but these can be relevant to whether the statutory criteria for detention are made out, especially in borderline cases. The RC's report to the tribunal must cover, inter alia, full details of the patient's mental state, behaviour and treatment; and there will also be a nursing report and a social circumstances report (Tribunals Judiciary, Practice Direction, First-tier Tribunal Health Education and Social Care Chamber, Statements and Reports in Mental Health Cases, 2013). His treatment and care may well feature in the debate about whether he should be discharged. The tribunal may recommend that the RC consider a CTO and "further consider the case" if the recommendation is not complied with (section 72(3A)(a)). Similarly, the tribunal has no power to vary the care plan or the conditions imposed in a CTO, but the tribunal requires an up to date clinical report and social circumstances report, including details of any section 117 aftercare plan. The patient's actual situation on the ground may well be relevant to whether the criteria for the CTO are made out. Furthermore, if the tribunal identifies a state of affairs amounting to an unlawful deprivation of liberty, it must be within its powers to explain to all concerned what the true legal effect of a CTO is. But the patient can only apply to the tribunal once during each period for which the CTO lasts (six months, six months, then once a year). If the reality is that he is being unlawfully detained, then the remedy is either habeas corpus or judicial review.*
>
> *34. Furthermore, once it is made clear that the RC has no power to impose conditions which amount to a deprivation of liberty, any conscientious RC can be expected not to do so. This is reinforced by section 132A(1) of the MHA, under which it is the duty of the hospital managers to "take such steps as are practicable to ensure that a community patient understands … the effect of the provisions of this Act applying to community patients". Those steps must include giving the information both orally and in writing. The Mental Health Act Code of Practice makes it quite clear that community patients must be informed - in a manner which they can understand - of the provisions of the Act under which they are subject to a CTO and the effect of those provisions and of the effect of the CTO, including the conditions which they are required to keep and the circumstances in which their RC may recall them to hospital (para 4.13). This information should be copied to the patient's nearest relative, unless the*

patient requests otherwise (para 4.31). Patients should be told of this and there should be discussion with the patient as to what information they are happy to share and what they would like to be kept private (para 4.32).

Comment

This decision is hardly surprising, especially in light of the *MM* decision from an almost identical panel. The last-minute change of tack by the Welsh Ministers was brave, but doomed – PJ's circumstances (as described in paragraph 8) were factually not far off those in a medium secure unit, and to describe them as anything other than a deprivation of liberty would have been deeply problematic.

Unlike *MM*, this decision does not cause head-scratching in terms of its practical consequences, but rather represents the re-aligning of the law as interpreted by the courts with that set down in the 'soft law' of the Code of Practice (at least for England) and what has always been good practice for RCs. Following this decision and that of *MM*, and in light of *Cheshire West*, it is now absolutely clear that the spade of confinement must be called a spade, and powers to impose it must be express. It does, though, put added pressure on the government to think through with care precisely what level of coercion it thinks should occur in the community when it comes to respond to the recommendations of the MHA Review.

Another issue remains. The discretionary CTO conditions in PJ's case expressly required compliance with his care plan, in which the deprivation of liberty was to be located. What if that condition was absent, but the concrete situation of the care plan amounted to a deprivation of liberty? Our view is that, as PJ had capacity, he should logically have been entitled to agree to or refuse those care arrangements. And if he lacked capacity to do so, the MCA could be used to authorise the deprivation of liberty.

PROPERTY AND AFFAIRS

Neglect and attorneys – (yet another) problem with the criminal law

Kurtz v R [2018] EWCA Crim 2743 Court of Appeal (Criminal Division) (Macur LJ, Knowles J and HHJ Wall QC)

Criminal offences – ill-treatment/willful neglect

Summary

A solicitor specialising in mental capacity was charged with the offence of wilfully neglecting her mother in respect of whom she was the donee of an enduring power of attorney ('EPA'), contrary to s 44(1)(b) MCA 2005. Her mother, with whom the solicitor lived, had a history of mental illness including bipolar disorder, depression and obsessive-compulsive disorder. She also had a history of failing to co-operate with medical professionals when they tried to help her. The mother had refused to see her GP or to have a Mental Health Act 1983 assessment in 2004, and thereafter had had nothing to do with doctors. There was evidence that in the past when her mother had availed herself of medical assistance it had temporarily alleviated her mental health conditions. There was also evidence that the mother could be difficult with anyone within the family who tried to persuade her to seek medical attention. When paramedics, called by the solicitor, attended the home, her mother was pronounced dead at the scene. She was 79 at the time of her death. Her body was in a seated position on a sofa in the living room which had an indent in it suggestive of her having sat there in the same position for some considerable time. She was sitting in her own urine and faeces, and had urine burns and sores on her buttocks and legs. She was malnourished (weighing only about six stone) and was covered in dirt. Her hair was matted and her nails were unkempt, suggesting that they had received no attention for over a year. When the paramedics tried to lift her body from her seat, her clothes fell apart. She had not changed her clothing for many, many months.

The prosecution originally charged the solicitor with the offence under s.44(1)(a) MCA 2005, on the basis that she had care of her mother. However, the prosecution then changed the indictment to the offence of s.44(1)(b), on the basis that she was the donee of an EPA. This was on the basis that the prosecution considered that this obviated the need for the prosecution to prove either that her mother lacked capacity, or that the solicitor had care of her; and, hence that this made the prosecution's task simpler.

At the trial, the judge had agreed with the prosecution and ruled that the prosecution did not need to prove that the woman's mother lacked capacity. The judge therefore did not direct the jury in relation to capacity. The solicitor was convicted and sentenced to 30 months' imprisonment. She appealed to the Court of Appeal on the basis that the existence of the EPA was not sufficient of itself to render the Appellant guilty of the offence contrary to s 44(1)(b) of the MCA 2005, even if she had wilfully neglected her mother. Two points were advanced in support of this ground:

1. The offence created by s.44(1)(b) only applied where the EPA had been registered.
2. Section 44(1)(b) had to be read as requiring the prosecution to prove that the victim

> lacked capacity at the time of the offence; as the judge had directed to the contrary, the solicitor's conviction was unsafe.

Prefacing their consideration of the grounds, the Court of Appeal expressed their sympathy for the judge, faced with the task of interpreting s.44(1)(b) in the absence of Court of Appeal authority and against the background of criticism by the Court of Appeal of the drafting of s.44 in connection with appeals against conviction for the offence contrary to s.44(1)(a) of the MCA 2005 (see here and here).

The Court of Appeal had no hesitation in rejecting the first limb of the solicitor's appeal,[4] not least because:

> [u]*nder paras 4 and 13 of Sch 4, only the donee of an EPA can register it. If the s 44(1)(b) offence required the EPA to be registered, then the donee could avoid liability for the offence, no matter much they ill-treated a non-capacitous donor, by not registering the EPA. This would hardly further the principal aim of the MCA 2005 to provide protection for those who are vulnerable through a lack of capacity.*

As to ground 2, the Court of Appeal identified the essential question as being as whether:

> *on a prosecution for the offence contrary to s 44(2) read with s 44(1)(b), the prosecution must prove that the person said to have been wilfully neglected or ill-treated lacked capacity, or that the defendant reasonably believed that s/he lacked capacity. We shall refer to this as 'the lack of capacity requirement'.*

Having conducted an extensive examination of the pre-history to s.44, statements made during its legislative passage, and the Code of Practice, the Court of Appeal concluded that the answer must be 'yes,' rejecting the broader construction that the judge had adopted, which could give rise to criminal liability merely because the victim had granted the EPA (and hence even if they, in fact, had capacity at the time). The court recognised that:

> *possibly there might be circumstances when a donee of an EPA with authority for property and affairs could wilfully neglect a donor who has the relevant mental capacity regarding his/her property and affairs, but with physically restricted access to funds, for whatever reason. However, we find it difficult to contemplate how a capacitous donor of an EPA could be wilfully neglected in terms of their personal welfare, if that donor refuses medical treatment and why the donee of an EPA, restricted as it is to property and financial affairs, should be made criminally liable in those circumstances. We do not believe that this result, which would be a consequence of the broader interpretation, could represent the will of Parliament, which was careful to preserve the autonomy of the individual by the principles expressed in s 1 of the MCA 2005.*

As the judge had failed to direct the jury that it had been for the prosecution to prove that the

[4] Note, there is what must be a typographical error at paragraph 36, where the Court of Appeal refer to the donee of an LPA; they clearly mean EPA.

victim lacked capacity, the solicitor's appeal was allowed.

Comment

It is clear that the Court of Appeal had some considerable reservations about the outcome of the appeal on its facts. It observed that:

> *The state of* [the victim] *in the months leading up to her death, and the conditions in which she spent the last weeks and months of her life, might well have been sufficient, without more, for the jury to have been satisfied that she lacked capacity. Also, given that the Appellant was a solicitor specializing in mental capacity matters, and given that she lived with her elderly and infirm parents, the prosecution would have had little difficulty in showing that she had the care of her mother for the purposes of s 44(1)(a). We consider that had the prosecution proceeded on the indictment as originally drafted then the complications of this case might never have arisen.*

As to the law, the case only reinforces how poor is the drafting of s.44, as the Court of Appeal had to undertake what amounted to a wholesale rewriting of s.44(1)(b). After all, on its face, there is nothing to suggest that s.44(1)(b) is limited by the capacity requirement, and it would have been equally plausible (absent the legislative archaeology exercise undertaken) to have construed s.44(1)(b) as applying where a person is abused or wilfully neglected by someone they trusted sufficiently to make their attorney. This is particularly so given that an LPA (unlike an EPA) is not registered upon incapacity, but rather from the outset. On one view, therefore, the registration of an LPA (and hence its creation for purposes of the MCA[5]) automatically puts the donor in a potentially vulnerable position, as the donee could manipulate or otherwise misrepresent the donor's capacity to take relevant decisions.

Given that the capacity requirement has been held to be the person's capacity to make decisions concerning his/her care (under s.44(1)(a) but now, apparently, also to be read across to s.44(1)(b)) it seems that the offence under s.44(1)(b) is very much narrower, and more difficult to establish, than we might have thought.

When not telling is in a person's best interests

EXB v FDZ [2018] EWHC 3456 (QB) High Court (Queen's Bench Division) (Foskett J)

CoP jurisdiction and powers – interface with civil proceedings – deputies – financial and property affairs

Summary[6]

In this personal injury case, Foskett J had to grapple with a question that has apparently never been considered (or, more likely, never been the subject of a reported case). Should the deputy appointed to manage the substantial personal injury payment made to the brain-injured claimant be permitted not to tell the claimant the precise sum awarded him?

The matter arose because the claimant's mother (his litigation friend) and his solicitor considered

[5] See s.9(2)(b).

[6] Tor having been involved in this case, she has not contributed to this note.

that it was in his best interests for him not to be told the settlement sum. Rightly, they, and the court, recognised that this represented a substantial interference with his rights, and Foskett J adjourned, including for pro bono assistance from Tor Butler-Cole as amicus curiae.

The evidence reviewed in detail by the judge included the following from his treating neuropsychologist (who did not know the settlement sum):

> *The first issue, to my mind, would be his vulnerability. If he were to have knowledge of a specified sum he would have a significantly compromised and basic appreciation of its intended purpose. Such knowledge would translate and impact upon his behaviour. In plain terms I know that if EXB knows that he has a specific sum of money he (a) perseverates over it and cannot move beyond thinking about what he's going to spend it on, and (b) he will seek to spend money that he has in his head – even if he doesn't physically have it. It would, in my view, escalate his existing vulnerabilities to himself and his own actions. It would also escalate his vulnerability to others.*
>
> *In my clinical opinion knowledge of a crystallised figure from his perspective would cause him to be more vulnerable to his own impulses, and increase his vulnerability to other people who might, for example, propose to borrow money from him …*
>
> *He, in my experience, constantly lives beyond his means. This situation is not mediated by the amount he receives. It results in him borrowing money, and him being in a seemingly unbreakable cycle of what he refers to as "owing money out". There is a culture within EXB's peer group of lending money to one another and helping each other out financially. Clearly there is nothing wrong with this per se, but there is clearly a risk of exploitation if there is a perceived imbalance within that group of their respective means.*
>
> *In my opinion EXB is likely to conceptualise a crystallised figure as a pot of gold or lottery win. Upon the assumption that it is a substantial sum, it is likely to distort his perception of his own means, and exacerbate his preoccupation over money. It is likely to encourage "Well it's my money - I've got this amount - Why can't I have £x for whatever?". In my view it is likely to exacerbate EXB's existing difficulty with money and his finances, and consequently also significantly exacerbate his frustration. It would further limit his insight into situations that he already finds himself in, such as misallocating and spending money on items that he had not planned. The coherent sense that his support team are trying to employ with EXB by, for example saying if you ask for £100 for x, you need to spend it on x, would largely become missing on EXB as he would simply be preoccupied by the conceptualised pot of gold. EXB does not have an overall coherent sense and appreciation of his finances, his preoccupation with money, his behaviour, and how all of these are linked together. In my view it is therefore important to appreciate that a specified figure is not just likely to affect his actions and decision making, but also his frustration and behaviour to the detriment of himself and those around him.*

Interestingly, but not entirely surprisingly given that many with brain injuries are frequently able to grasp at least part of their deficits, EXB himself seems to have had some appreciation of his position and expressed views both to his own solicitor and to the court that it was better that he did not know the sum, although (after having said this to the court) apparently expressed the view that he had been conned into doing so.

In approaching the question of what was in EXB's best interests, Foskett J noted the difficulty posed by the fact that, logically, this could only be asked having assessed EXB's own capacity in this domain – when this would be entirely to defeat the exercise. He found he was able to conclude, however, that he lacked the relevant decision-making capacity. He further found that it was in EXB's best interests not to be told the sum, relying in part upon the fact that:

> *the conclusion to be drawn from all the evidence is that when the Claimant is capable of sitting down and weighing up the competing considerations calmly, possibly with the assistance of others, he considers that it would be in his best interests not to know the amount of the award.*

Foskett J left for another day the question of whether a decision not to tell a person in the Claimant's position a sum that they had been awarded lay within the scope of the normal deputyship order made by the Court of Protection. He was, in this, particularly persuaded by the fact that it would make the deputy's life much more difficult if it perceived to be the deputy's decision not to tell the person; conversely, it would be significantly easier for the deputy if they could tell the person that the court prevented them from doing so.

Foskett J endorsed an order which is likely to be assistance in any future case in which this issue arises, and held that the costs of the exercise that he had undertaken had to be borne by the relevant defendants, as the need to make the application arose directly out of their actions.

Finally, Foskett J noted that:

> *53. If it is the case that it is an issue that might arise for consideration more frequently than hitherto, I think there is at least the makings of a case that the inter-relation of the normal rules of civil practice and the rules of the CoP is considered with a view to trying to streamline a way of dealing with the issue, if it arises, in a convenient and fair way. As I have already said, I have been greatly assisted by both Counsel in this case and, in particular, by Ms Butler-Cole who kindly agreed to act on a pro bono basis. However, that cannot be expected in every case, but it is possible that the issue (or some other welfare issue) will arise at the time when the case is still proceeding in the High Court. Whilst some QB Judges will have experience of the CoP jurisdiction, many will not. (There is also the question of what happens where an action in the County Court raises a similar question.)*
>
> *54. All I can do is to flag up the issue and invite the appropriate bodies to consider it. I will send a copy of this judgment to the Deputy Head of Civil Justice and to the Vice-President of the Court of Protection so that they can consider whether any consultation on this issue is required and whether any action needs to be taken as a result.*

Comment

Foskett J was undoubtedly right to conclude that the principles both of the MCA and of the CRPD suggest that, ordinarily, a person in the Claimant's position should be informed of the details of a settlement award because this would be to treat him in the same way as a person without a disability. In some ways, this was a relatively easy case for him to determine, because there was at least some evidence upon which he could rely in order to conclude that the person did not wish to be told the settlement sum (in CRPD language, to withhold it from them was to respect their rights, will and preferences). It would have been significantly more difficult for him to have taken the course that he did if EXB had been demanding consistently to know the sum; now that this issue is squarely on the radar of practitioners, it will no doubt only be a matter of time before such a case does arise.

Attorneys and personal representatives

Whittaker v Hancock [2018] EWHC 3478 (QB) High Court (Chancery Division) (Master Shuman)

Other proceedings - Chancery – lasting powers of attorney

The case provides clarification of the application of s.50 of the Administration of Justice Act 1985 ("the 1985 Act") – the power of the High Court to substitute or remove a personal representative. In doing so guidance was given on the interaction between powers of attorney and those of a personal representative.

The deceased had made a will which appointed his wife and niece as joint executrices, with his wife as the sole beneficiary. No provision was made for the deceased's daughter (the Third Defendant) who subsequently questioned the will's validity.

Before his death the deceased's wife executed a lasting power of attorney in favour of her daughter (the wife's daughter as opposed to the deceased's daughter and Third Defendant), who was the Claimant. The wife was subsequently moved into full time residential care as a result of her dementia.

In these proceedings the Claimant applied under s.50 of the 1985 Act to be substituted as personal representative for the deceased's estate in place of the deceased's wife. The wife lacked capacity to consent to this. The claim was resisted by the deceased's daughter who argued that the LPA did not give the Claimant power to represent the wife in this way – it was said that the LPA only permitted the Claimant to deal with the wife's property and financial affairs, not the deceased's financial affairs.

Master Shuman rejected that argument, observing that the LPA was not subject to any limitations. As a result, the Claimant's authority was subject only to the provisions of the Mental Capacity Act 2005, notably the requirement to act in the wife's best interests. This means that the Claimant was empowered to make decisions about the wife's "property and financial affairs", which included the deceased's estate given that the wife was the sole beneficiary. The Claimant could also have brought the application as attorney for the wife who was a joint executrix. Importantly, the Claimant was not seeking to act in her own right but in a representative capacity as attorney.

In the event that the above approach was found to be incorrect, Master Shuman held that the

wife could be added as the Claimant and the current Claimant appointed as her litigation friend.

Comment

This case is a useful reminder of the breadth of authority contained in most property and affairs LPAs. It is now clear that this covers the administration of an estate where P is a sole beneficiary.

A statutory will at speed

LCN v CJF [2019] EWCOP 1 (District Judge Beckley)

Summary

In this case P (CIF) was seriously injured at birth. By a litigation friend, he brought a claim for damages against the hospital trust responsible for his care at birth. That resulted in an award of damages consisting of a lump sum of over £800,000 plus substantial periodical payments.

He was born on 2 October 2005 and by November 2018 it was clear that he was critically ill. At that time, he was living in a home bought with his award, being cared for by a couple (AH and EH) who were his special guardians.

P was too young to make a will and the MCA mirrors that restriction in relation to statutory wills (section 18(2)). On intestacy, P's estate would be divided between KF (his mother) and his biological father who had denied paternity, played no part in P's life and whose whereabouts were unknown.

P's deputy (LCN) thus applied as a matter of urgency on 20 November 2018 for the court to authorise the execution of a settlement by P of his estate, on P for life and thereafter the property where he lived to pass free of inheritance tax to EH and AH, the residue to KF.

The application was heard and determined on 26 November and P died on 4 December.

All parties agreed that a settlement was in P's best interests and that the appropriate guidance was to be found in cases on statutory wills. So far as service on the biological father was concerned, that had not been attempted as his whereabouts were unknown and he was not a party. By reason of the urgency, the application continued without any attempt to notify him. The final order required an attempt to serve him with the order and gave him permission to apply within 21 days of service.

The only issue between the parties that the court had to decide was the incidence of inheritance tax. KF, AH and EH were unable to agree that partly because of the emotional trauma caused by P's condition and prognosis. In the end the court decided that P would have wanted EH and AH (and their children) to have the security of the home without the worry of having to raise the tax so the gift to them was tax free.

Comment

This shows how the Court of Protection can move swiftly in cases where P's life expectancy is short and a statutory will is needed (or in this case a settlement). It also illustrates the rare type of case where the court will proceed even though a person who would benefit under an intestacy (as here) or a previous will has not been given the chance to be heard.

Updated guidance on searching the OPG register

The OPG for England and Wales has published a new practice note on searching the register of lasting powers of attorney (LPAs), enduring powers of attorney (EPAs) and deputyship orders which the OPG has a duty to maintain under the Mental Capacity Act 2005.

While it has been possible to request a search of the register since 2013, the new form OPG100 now allows applicants to request any additional information to that held on the register. The OPG will consider such requests on a case by case basis, only disclosing additional information when the request is reasonable and justified, or when legally required to do so. The OPG will prioritise requests made by public authorities, in particular sharing information where there may be a safeguarding concern.

Alan Eccles to retire

The Public Guardian for England and Wales and Chief Executive of the Office of the Public Guardian, Alan Eccles, has announced his intention to retire in June 2019, after 7 years in post.

PRACTICE AND PROCEDURE

Where does the inherent jurisdiction end?

A Local Authority v BF [2018] EWCA Civ 2962
Court of Appeal (Civil Division) (Baker LJ)

COP jurisdiction and powers – interface with inherent jurisdiction

Summary

This case was an application for permission to appeal from an interim judgment of Hayden J concerning the difficult question of the nature and reach of the inherent jurisdiction and the extent to which unwise decisions made by capacitous adults can and should be overridden by the courts.

BF was a 97 year old man who sufferd from diabetes, osteoarthritis and as blind in both eyes. At the time of the appeal he was residing in residential care against his wishes, rather than at home with his son KF. The history of the case is long and involved, but in short BF lived in a bungalow with his son KF following the death of his wife. KF suffered with drug and alcohol addiction and was noted to intimidate visiting care staff such that all ultimately refused to provide BF with care at home. Over the course of 2 years of proceedings initiated by the local authority, BF and KF had moved out of and back into BF's property while extensive renovations were carried out to return it to habitability after it fell into squalor.

The appeal arose out of events in late 2018 when, having returned home to live with KF in his renovated bungalow, BF once more contacted the local authority and was discovered in abject squalor, partially clothed and having neither eaten nor drunk for a number of days. BF was removed by the local authority into respite care, who were concerned that he had lost capacity to make decisions about his residence. An ex parte order was granted by Francis J, restraining BF from returning home and requiring him to live in residential care provided by the local authority pending further order of the court. In October of 2018 BF agreed to abide by the court's order; he maintained that he was content not to return home, not to live with KF, and to submit to a capacity assessment. The local authority in due course prepared a notice terminating KF's licence to reside at BF's property.

A capacity report by a consultant psychiatrist provided in November 2018 confirmed that BF *had* the requisite capacity to make decisions on where he should live including whether KF should live at the property. The matter was returned urgently to court before Hayden J as the urgent applications judge. Hayden J heard evidence and submissions on capacity and enabled BF to participate in proceedings by telephone. BF reiterated that he wished to return home to his bungalow to live with KF. The local authority accepted the evidence that BJ had capacity in the material domains, and applied to lift the injunction. However, Hayden J declined the application and extended the injunction until further order, binding BF not to live or reside in his bungalow, not to live with his son KF and to reside at a care home specified by the local authority. Hayden J held that:

> *23. …It was submitted that once an individual had capacity the inherent jurisdiction had no reach. The Court of Appeal [in Re DL] roundly and unequivocally rejected that and did not*

attempt to circumscribe the scope/ambit of the inherent jurisdiction. Whether it extends to the kind of protection that BF needs is moot…It strikes me as an important application of the law to the facts of this case. It requires an analysis of the scope of the law to impose welfare decisions on vulnerable adults who otherwise have capacity.

24. I am driven to adjourn this application so I can receive full argument on this point. All parties, not just BF and the local authority, are entitled to nothing less. In the meantime, and on an interim basis, BF should remain where he is. I know he is eager to go home and I do not discount the possibility that that he might be able to as a result of my final decision. At the moment and in the present circumstances, I am satisfied that the inherent jurisdiction reaches that far."

This decision was appealed by both the local authority and BF who maintained *inter alia* that the said order was in breach of BF's Article 5 rights.

Baker LJ rehearsed the law on the survival of the inherent jurisdiction since the coming into force of the Mental Capacity Act 2005, summarising the position (at paragraph 23) thus:

(a) The inherent jurisdiction may be deployed for the protection of vulnerable adults.

(b) In some cases, a vulnerable adult may not be incapacitated within the meaning of the 2005 Act, but may nevertheless be protected under the inherent jurisdiction.

(c) In some of those cases, capacitous individuals may be of unsound mind within the meaning of Article 5(1)(e) of the Convention.

(d) In exercising its powers under the inherent jurisdiction in those circumstances, the court is bound by ECHR and the case law under the Convention, and must only impose orders that are necessary and proportionate and at all times have proper regard to the personal autonomy of the individual.

(e) In certain circumstances, it may be appropriate for a court to take or maintain interim protective measures while carrying out all necessary investigations.

Baker LJ upheld Hayden J's decision and refused the appeal on the basis that:

1. BF was a vulnerable adult by virtue of his age, blindness and the trauma of having lived in squalid and dangerous conditions his relationship with his son appeared to have *"elements of the insidious, persuasive undue influence"* which would bring it within the jurisdiction of the inherent jurisdiction as per *Re SA*; BF was unquestionably in need of protection for a variety of reasons (para 32);
2. expert evidence of his capacity notwithstanding, there was prima facie evidence of an unsound mind by reason of his infirmity and the other "*extraneous circumstances*" identified, and "*manifestly*," the test of "unsound mind" is different from the test of capacity under the Mental Capacity Act;

3. in an emergency situation someone may be deprived of their liberty in the absence of medical evidence of mental disorder without infringing Article 5; and

4. overall, that:

> *in circumstances where someone is found not to be of unsound mind, they cannot, of course, be detained in circumstances which amount to a deprivation of a liberty, but a move home in these circumstances is something which requires very careful planning and support. This is a crucial component of the protection afforded by the inherent jurisdiction and, in my judgment, entirely consistent with BF's overall human rights* (paragraph 35)

He further held that decision of this nature should not be made summarily and that Hayden J was thus entirely justified in adjourning the matter for some weeks pending further argument.

Comment

On one view, this was a helpful confirmation[7] that deprivation of liberty in this context cannot take place in the absence of unsoundness of mind[8] (a term which has caused upset in the context of the Mental Capacity (Amendment) Bill but derives from Article 5(1)(e)).

However, many might find it surprising that it would be possible for a court to direct (even if only temporarily) that an individual with capacity be prevented from returning to their own home, be prevented from living with a person they chose to, and be required to live at a place selected for them by someone else in circumstances amounting to a deprivation of their liberty.

At that point, one might ask, why bother with the (sometimes complicated) exercise of assessing capacity? Why not simply proceed on the basis of the necessity and proportionality of securing the protection of a vulnerable person (and, where a deprivation of liberty might result, providing evidence of "mental disorder," a very expansive term).

The case might therefore usefully stand as an example to test how one feels about removing mental capacity from the equation (as we have been urged to by the CRPD Committee). And/or it may stand as a reminder of why we might want to give some statutory steer to judges exercising this wide inherent jurisdiction so that they (and society) can be clear as to how it should be deployed. By way of example of such a steer, we could do worse than look at the Vulnerable Adults Act that recently came into force in Singapore.

The case also stands as a clear reminder of the inquisitorial nature of the jurisdiction exercised by the courts in this arena. Perhaps unusually, both the local authority and the person before Hayden J were arguing for the same outcome – a finding of capacity and the grant of relief to enable the person to return home, but Hayden J took (and was found to be have been entitled to take) an entirely different course, at least on an interim basis. We will await the final judgment

[7] Although not, strictly, a precedent as solely a decision on an application for permission to appeal.

[8] There are other grounds upon which it could be justified in the exhaustive list contained in Article 5(1), but none of them could apply here.

from Hayden J with interest.

Court of Protection statistics

The statistics for July-September 2018 show a continued increasing trend in applications made in relation to deprivation of liberty but a decrease in the number of orders made. There were 1,126 applications relating to deprivation of liberty made in the most recent quarter, up 5% on the number made in July to September 2017. Those applications were: 125 for Section 16 orders, 293 21A applications and 708 COPDOL11 applications (down from 728 in the previous quarter and 769 in the first quarter of 2018). Orders made decreased by 7% over the same period, from 639 in July 2018 to 610 in October 2018.

Interestingly, the sharp increase in registration of LPAs has slowed over the last 18 months. One wonders whether there has been a 'Denzil Lush' effect following the widely-publicised concerns the former Senior Judge expressed upon his retirement as to the potential for abuse of property and affairs LPAs.

Anonymisation guidance

The President has expressly approved checklists contained in the report of Dr Julia Brophy on the anonymisation of judgments. They deal with two aspects of anonymisation and the avoidance of identification of children in judgments placed in the public arena: (a) personal and geographical indicators in judgments, and (b) the treatment of sexually explicit descriptions of the sexual abuse of children. The approval is for purpose of family proceedings, but will be equally relevant in Court of Protection proceedings.

THE WIDER CONTEXT

MCA Code of Practice update

The Ministry of Justice is starting the task of updating the main MCA Code of Practice (nb, this is a task which is coordinated with, but is at this point not the same as the creation of a new Code to accompany the LPS). As part of the process, it has put out a call for evidence, which can be found here. The deadline for responses is 7 March.

Mental Capacity Action Day

This year's action day will be held on 15 March at the Royal College of Nursing in London. For details, and how to apply to attend, see here.

CANH decision-making

The British Medical Association (BMA) and Royal College of Physicians (RCP) have published joint guidance, endorsed by the General Medical Council (GMC), covering decisions to start, re-start, continue or stop clinically-assisted nutrition and hydration (CANH) for adults in England and Wales who lack the capacity to make the decision for themselves. The guidance covers previously healthy patients in vegetative state (VS) and minimally conscious state (MCS) following a sudden onset brain injury, as well as the much larger group of patients who have multiple comorbidities, frailty, or neurodegenerative conditions in whom decisions about CANH are needed.

The guidance is primarily aimed at clinicians but it is extremely useful for legal practitioners, advocates, carers and others seeking to understand the framework for decision-making in this important area. The recent decision of the Supreme Court in *An NHS Trust and others v Y* [2018] UKSC 46, looms large and it is apparent that the case has had a significant impact in this area. As stated in the guidance, "*there is no requirement for decisions to withdraw CANH to be approved by the court, as long as there is agreement upon what is in the best interests of the patient, the provisions of the Mental Capacity Act 2005 have been followed and the relevant professional guidance has been observed*". The "*relevant professional guidance*" would no doubt include this joint guidance published by the BMA and RCP, and it will surely become indispensable in this field.

In addition to the clear exposition of the legal framework set out in the guidance, there are useful practical tools that can be utilised as part of everyday good practice, such as the decision-making flowchart at Figure 1, and the checklist of evidence for best interests' decision-making in relation to CANH at Appendix 2. Although the guidance focuses on decisions about CANH, much of the general guidance for best interests' decision-making (such as who should be consulted, ascertaining P's wishes and feelings, and documenting/sharing information) can be applied across the board to all types of decisions.

Independent Review of the Mental Health Act 1983

The independent Review of the Mental Health Act has reported; amongst its recommendations are both a hefty injection of MCA-style thinking into the MHA 1983 and a new approach to the interface between the MHA and the MCA. A useful summary can be found here. At Committee stage of the Mental Capacity

(Amendment) Bill in the Commons, the Care Minister, Caroline Dineage MP,

> *welcomed Sir Simon Wessely's landmark report* [which] *will very much set the direction for improving the way the Mental Health Act works for thousands of vulnerable people. The Government have already committed to bringing forth mental health legislation when parliamentary time allows, taking that very important report into account. We have already accepted two important recommendations,* [9] *which will give service users more choice and control, but it will take time for us to consider the rest of the recommendations, of which there are 152. We will respond to the remaining recommendations in due course, but Sir Simon said that the Government would need to consider the "practical implications" of the interface recommendations, and that it would be "problematic" to introduce those recommendations in this Bill.*

Real enthusiasts may wish to do a compare and contrast with the Report of the Government Inquiry into Mental Health and Addiction published a month later in New Zealand.

Article round-up

For those of you wanting more reading, we can recommend:

1. An article by Professor Anselm Eldergill asking whether all incapacitated people confined in a hospital, care home or their own home are deprived of liberty?

2. A paper (an output of the Mental Health & Justice project) surveying experiences of attitudes towards advancing decision-making amongst people with bipolar.

We are always happy to highlight open access research/articles of interest.

[9] Replacing nearest relatives with nominated persons, and creating statutory advance choice documents.

SCOTLAND

Voting Rights

The Mental Health and Disability Committee of the Law Society of Scotland has been instrumental in achieving an alteration by the Electoral Commission to guidance which previously had the effect of disqualifying some people with cognitive impairments from voting. This nullified the previous success of campaigners, including People First (Scotland), to persuade Parliament to remove the previous disqualification from voting of some people with mental and intellectual disabilities, contrary to the UN Convention on the Rights of Persons with Disabilities. The barrier erected by the Electoral Commission took the form of advice to electoral registration officers that the declaration of truth, required to be signed in order to register to vote, could not be signed on behalf of an elector by an attorney. Strangely, that discrimination was compounded by advice to the contrary in England & Wales. The Electoral Commission originally suggested that registering to vote was neither a personal nor a property matter covered by the Adults with Incapacity (Scotland) Act 2000. The Law Society Committee disagreed on a range of grounds, including that the only powers which cannot competently be conferred upon an attorney are those set out in section 16(6) of the 2000 Act, or matters from which an attorney is expressly excluded from acting under any other statute or rule of law. At the request of the Law Society Committee, the Equality and Human Rights Commission took the matter up with the Electoral Commission, and successfully persuaded the Commission that its original view of the law was incorrect. The revised guidance is available here. *Adrian D Ward*

Glasgow City Council v Scottish Legal Aid Board

We reported aspects of the decision at first instance in this case in the March 2018 Report. In a separate case, the Lord Ordinary had dismissed petitions by a man for judicial review of certain decisions by Glasgow City Council concerning the care of the man's mother, for whom he held power of attorney. The man sought Legal Aid to appeal against that decision. Scottish Legal Aid Board granted Legal Aid, but the Council maintained that the Board had acted unfairly towards the Council in determining the man's Legal Aid applications. The Council applied to the Lord Ordinary, who held that the Board had acted unfairly towards the Council in determining the applications, and quashed the Board's decision to grant Legal Aid. The Board appealed to the Inner House against that decision. The Inner House allowed that appeal: [2018] CSIH 37; 2018 SLT 935.

The Inner House acknowledged that, in determining whether to grant a person Legal Aid to pursue a civil action, the Board are under an obligation to act fairly, not only to the applicant but also to the "opponent" who may be affected by the decision. However, what fairness requires in different situations is variable. Sometimes fairness may dictate that the level of notice required should be the equivalent of that in a civil action and that both parties be afforded an equal opportunity to present their cases. In other cases it may be sufficient that the opponent is advised of the general nature of the matter under consideration by the Board, and should be allowed to make representations, which the Board will be required to take into account. The Inner House considered carefully the nature of

the Legal Aid system and the statutory framework of the Legal Aid (Scotland) Act 1986. The statute permits an opponent to make written representations about the application. However, that does not confer a right to launch a full defence to the merits of the applicant's case. The Act does not "create pre-litigation litigation". In the present case, the Inner House commented that: "The facts and circumstances, although already known to the council, were set out in full, as were the legal considerations which formed the basis of both the submissions to the Lord Ordinary and his opinion on the merits. The council had more than sufficient notice of what the case was about, although they hardly required much given their existing state of knowledge. They ought to have been able to grasp that the argument in the appeal was, as it in the event transpired, that the Lord Ordinary had erred in law in deeming that the assessment had met the relevant statutory tests." The review of the Board's decision requested by the man, and the fact of such review, "adds nothing", the Board apparently having sought a supporting opinion from Counsel "which they presumably obtained and which would not have been disclosable to the council". The Inner House concluded that there was no unfairness.

Adrian D Ward

Dr Jim Dyer

We go to press immediately following the funeral on 11th February of Dr Jim Dyer, former Director of the Mental Welfare Commission for Scotland, who died peacefully on 24th January 2019 after a prolonged illness borne typically with quiet fortitude and even at times good humour.

Jim practised as a consultant psychiatrist at the Royal Edinburgh Hospital from 1981 until joining the Commission as Medical Director in 1991. In 1993, he became the first full-time Director of the Commission, and led the organisation until retiring in 2003. He went on to become the first ever Scottish Parliamentary Standards Commissioner, serving for 6 years, and a medical member of the Mental Health Tribunal for Scotland. In his decade at the Commission, he did much to increase its impact, including its work to end the entrapment of patients at Scotland's high secure hospital, and major investigations into the ill-treatment of adults with learning disabilities. He championed reform of incapacity law in the years leading up to the Adults with Incapacity (Scotland) Act 2000, and was an influential member of the Millan committee, whose landmark report led to the Mental Health (Care and Treatment) (Scotland) Act 2003.

He was a thoughtful, hugely knowledgeable and in his mild-mannered way highly effective leader, highly regarded by all who knew him.

Adrian D Ward with input from Colin McKay

New Chair sought for the Mental Welfare Commission

The Very Reverend Dr Graham Forbes CBE will have served for eight years in the vital role of Chair of the Mental Welfare Commission for Scotland when he steps down in March 2019. The process of recruiting his successor is proceeding.

Adrian D Ward

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Alex is recommended as a 'star junior' in Chambers & Partners for his Court of Protection work. He has been in cases involving the MCA 2005 at all levels up to and including the Supreme Court. He also writes extensively, has numerous academic affiliations, including as Wellcome Research Fellow at King's College London, and created the website www.mentalcapacitylawandpolicy.org.uk. To view full CV click here.

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Victoria regularly appears in the Court of Protection, instructed by the Official Solicitor, family members, and statutory bodies, in welfare, financial and medical cases. Together with Alex, she co-edits the Court of Protection Law Reports for Jordans. She is a contributing editor to Clayton and Tomlinson 'The Law of Human Rights', a contributor to 'Assessment of Mental Capacity' (Law Society/BMA 2009), and a contributor to Heywood and Massey Court of Protection Practice (Sweet and Maxwell). To view full CV click here.

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Neil has particular interests in human rights, mental health and incapacity law and mainly practises in the Court of Protection. Also a lecturer at Manchester University, he teaches students in these fields, trains health, social care and legal professionals, and regularly publishes in academic books and journals. Neil is the Deputy Director of the University's Legal Advice Centre and a Trustee for a mental health charity. To view full CV click here.

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Annabel has experience in a wide range of issues before the Court of Protection, including medical treatment, deprivation of liberty, residence, care contact, welfare, property and financial affairs, and has particular expertise in complex cross-border jurisdiction matters. She is a contributing editor to 'Court of Protection Practice' and an editor of the Court of Protection Law Reports. She sits on the London Committee of the Court of Protection Practitioners Association. To view full CV click here.

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Nicola appears regularly in the Court of Protection in health and welfare matters. She is frequently instructed by the Official Solicitor as well as by local authorities, CCGs and care homes. She is a contributor to the 4th edition of the *Assessment of Mental Capacity: A Practical Guide for Doctors and Lawyers* (BMA/Law Society 2015). To view full CV click here.

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Katie advises and represents clients in all things health related, from personal injury and clinical negligence, to community care, mental health and healthcare regulation. The main focus of her practice however is in the Court of Protection where she has a particular interest in the health and welfare of incapacitated adults. She is also a qualified mediator, mediating legal and community disputes. To view full CV click here.

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Katherine has a broad public law and human rights practice, with a particular interest in the fields of community care and health law, including mental capacity law. She appears regularly in the Court of Protection and has acted for the Official Solicitor, individuals, local authorities and NHS bodies. Her CV is available here: To view full CV click here.

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Simon has wide experience of private client work raising capacity issues, including *Day v Harris & Ors* [2013] 3 WLR 1560, centred on the question whether Sir Malcolm Arnold had given manuscripts of his compositions to his children when in a desperate state or later when he was a patient of the Court of Protection. He has also acted in many cases where deputies or attorneys have misused P's assets. To view full CV click here.

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Adrian is a recognised national and international expert in adult incapacity law. He has been continuously involved in law reform processes. His books include the current standard Scottish texts on the subject. His awards include an MBE for services to the mentally handicapped in Scotland; national awards for legal journalism, legal charitable work and legal scholarship; and the lifetime achievement award at the 2014 Scottish Legal Awards.

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Jill Stavert is Professor of Law, Director of the Centre for Mental Health and Capacity Law and Director of Research, The Business School, Edinburgh Napier University. Jill is also a member of the Law Society for Scotland's Mental Health and Disability Sub-Committee. She has undertaken work for the Mental Welfare Commission for Scotland (including its 2015 updated guidance on Deprivation of Liberty). To view full CV click

Conferences

Conferences at which editors/contributors are speaking

Edge DoLS assessor conference

Alex is speaking at the Edge DoLS assessor conference on 8 March, alongside other speakers including Lord Justice Baker and Graham Enderby. For more details, and to book, see here.

Essex Autonomy Project summer school

Alex will be a speaker at the annual EAP Summer School on 11-13 July, this year's theme being: "All Change Please: New Developments, New Directions, New Standards in Human Rights and the Vocation of Care: Historical, legal, clinical perspectives." For more details, and to book, see here.

Advertising conferences and training events

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

Our next edition will be out in March. 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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