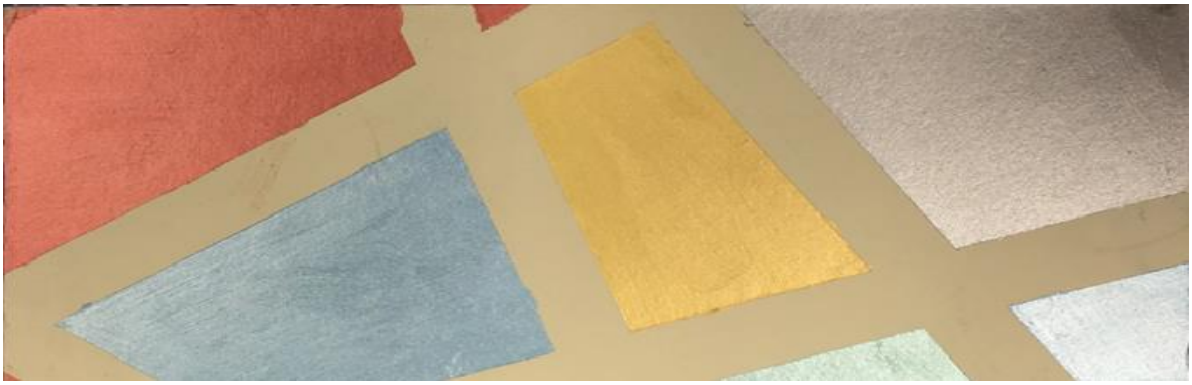
MENTAL CAPACITY REPORT: THE WIDER CONTEXT

November 2019 | Issue 99



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

(1) In the Health, Welfare and Deprivation of Liberty Report: two deprivation of liberty cases making clear what should (and should not) happen before the court; two important cases about reproductive rights and capacity, and capacity under stress in different contexts;

(2) In the Property and Affairs Report: welcome clarity as to how to make foreign powers of representation effective; and capacity and the financial implications of marriage;

(3) In the Practice and Procedure Report: two important judgments from the Vice-President highlighting different aspects of case management and confirmation as to the procedural rules governing inherent jurisdiction applications in relation to adults;

(4) In the Wider Context Report: news from the National Mental Capacity Forum (and a survey they need completing); an important case about the intersection of capacity, the inherent jurisdiction and the Mental Health Act 1983 in the context of force-feeding; and when you can rely upon your own incapacity to your benefit.

(5) In the Scotland Report: four important publications from the Mental Welfare Commission.

You can find all our past issues, our case summaries, and more on our dedicated sub-site here. If you want more information on the Convention on the Rights of Persons with Disabilities, which we frequently refer to in this Report, we suggest you go to the Small Places website run by Lucy Series of Cardiff University, where you can also find clear guidance as to the (non) place of mental capacity in relation to voting, ahead of the deadline for registration in the General Election of 26 November.

Editors
Alex Ruck Keene
Victoria Butler-Cole QC
Neil Allen
Annabel Lee
Nicola Kohn
Katie Scott
Katherine Barnes
Simon Edwards (P&A)

Scottish Contributors
Adrian Ward
Jill Stavert

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

National Mental Capacity Forum news

In order to widen its reach, and to ensure consistent access to its work, the National Mental Capacity Forum (NMCF), led by Baroness Finlay, has migrated its content from a members-only website to the main pages of the website of the Social Care Institute for Excellence. It has also launched a (free) survey to assess whether there have been improvements in empowering and supporting those with impaired mental capacity to live as fully and independently as possible. The survey can be found here, and we urge readers to take part – and, in particular, to highlight the fact, for all its sterling work, the NMCF is simply no substitute for the statutory champion of the MCA that the House of Lords recommended in 2014. Addressing poor implementation of the Act, which still remains the case some 5 years after its post-legislative scrutiny report, the House of Lords Select Committee recommended as follows:

> *11. Recommendation 3: We recommend that overall responsibility for implementation of the Mental Capacity Act be given to a single independent body. This does not remove ultimate accountability for its successful implementation from Ministers, but it would locate within a single independent body the responsibility for oversight, co-ordination and monitoring of implementation activity across sectors, which is currently lacking. This new responsibility could be located within a new or an existing body. The new independent body would make an annual report to Parliament on the progress of its activities.*
>
> *12. The proposed independent oversight body would not act as a regulator or inspectorate, but it would work closely with such bodies which have those responsibilities in relation to the Mental Capacity Act. The body should act as a support to professionals required to implement the Act.*
>
> *13. The composition of the new independent body should reflect the professional fields within which the Act applies, and it should contain professional expertise. It should also*

> *include representation from those directly affected by the Act as well as their families and carers. This is vital to ensure credibility. Other key features of the independent body will be continuity, expertise, accountability and accessibility.*
>
> *14. Recommendation 4: The Mental Capacity Act Steering Group is a welcome first step in this direction, and we recommend that it be tasked with considering in detail the composition and structure of the independent oversight body, and where this responsibility would best be located. The former Mental Health Act Commission strikes us as an effective, cost-efficient and credible model from which lessons may be learned.*

We suggest that these recommendations remain just as valid now as they did 5 years ago.

NICE Consultation: Decision-making and mental capacity

NICE is consulting on a quality standard will cover decision-making in people using health and social care services who are 16 years and over and may lack capacity to make their own decisions (now or in the future).As the NICE briefing paper, the quality standard aims to support implementation of the ethos and principles introduced by the MCA 2005 and relevant codes of practice but does not substitute these. The consultation closes on **4 December**, and the relevant materials can be found here. Our thoughts on the underlying NICE guidance (NG 108) on decision-making and capacity can be found here.

Learning disability and autism – the Joint Committee on Human Rights reports

In a very hard-hitting report published just before the dissolution of Parliament, the Joint Committee on Human Rights both highlighted the entirely unacceptable position of young people with learning disability and autism detained in mental health hospitals, and set out detailed recommendations for urgent changes to practice and the law. The (now former) Government response was to announce that all 2,250 patients with learning disabilities and autism who are inpatients in a mental health hospital will have their care reviewed over the next 12 months. Further, for those in long-term segregation, an independent panel, chaired by Baroness Sheila Hollins, will be established to oversee their case reviews to further improve their care and support them to be discharged back to the community as quickly as possible. The Government also published on 5 November proposals for mandatory training for all health and social care staff in autism and learning disability. We will watch with interest whether and how the new Government acts further after the election, and as for its response to the recommendations of the Independent Review of the Mental Health Act 1983, which the JCHR said that the Government must act upon.

Separately, Community Care reports that a settlement has been reached in the case brought on behalf of Bethany, the young woman with autism detained at St Andrew's hospital in Northampton.

An agreed public statement said:

> *At mediation on 25 September 2019, agreement was reached which has*

> *resolved matters, including the claim for damages, without the need for further litigation.*
>
> *St Andrew's Healthcare and NHS England have accepted that the care provided to Bethany did not always comply with the Mental Health Act Code of Practice and the NICE Guidelines on managing violence and aggression. This affected her wellbeing and made it harder for her to return to live in the community.*

Walsall Council and NHS Walsall Clinical Commissioning Group have accepted that there were unfortunate delays in moving Bethany from what became an unsuitable placement for her.

Force-feeding, the MHA and the inherent jurisdiction

JK v A Local Health Board [2019] EWHC 67 (Fam) (High Court (Family Division) (Lieven J)

Medical treatment – advance decisions - Mental Health Act 1983 – interface with MCA

Summary

In this case, Lieven J had to grapple with the intersection between the MCA, the MHA and the inherent jurisdiction in addressing the question of whether it would be lawful to force feed a person detained under the Mental Health Act 1983 who was refusing to eat and had made an advance decision to refuse any medical intervention.

The case concerned JK, a 55-year-old man with a diagnosis of Autism Spectrum Disorder (ASD) made late in life. He was currently on remand for the alleged offence of having murdered a close relative, the index offence having taken place in September 2019. He was transferred from prison to hospital, a medium secure psychiatric hospital on 23 October 2019 under s.48 MHA 1983, two medical practitioners having assessed him as suffering from a mental disorder which made it appropriate for him to be detained under the MHA 1983.

Since shortly after arriving at the prison, JK had been saying consistently that he wanted to die, and that he intended to starve himself to death. He refused food for 23 days, then ate limited food for a few days because he was concerned that he might be found not to have capacity to make a decision (the context suggests about eating) if he was in a weakened state. He then returned to refusing food, but he did started eating again at the prison because he wished to be able to attend and give evidence before the court.

His clinical team, including those at the prison and at the hospital, were very concerned about the impact of his refusal to eat and drink, including the risk of re-feeding syndrome developing even if he did decide to eat at some later point. On 28 September 2019 JK made an Advance Decision stating that he did not wish for any medical intervention to occur even if his life is at risk. Subject to questions as to JK's capacity to make it, there was ultimately no issue that this was a valid and applicable Advance Decision (and, he made a further advance decision in effectively the same terms dated 31 October 2019).

The medical evidence before the court was that JK had capacity to make the decision to refuse food and medical treatment (including palliative care), and also that he had capacity to conduct the proceedings.

The Health Board responsible for JK applied to court in respect of possible future treatment of JK, seeking (at the outset of the hearing):

(1) a declaration that it would be lawful for treatment to be provided pursuant to s.63 of the Mental Health Act 1983 (MHA 1983) such that JK could be force fed;

(2) in the alternative, a declaration under the inherent jurisdiction that such treatment would be lawful; and a declaration under the MCA 2005 that the advance decision made by JK could be disregarded as a result of actions by him that were inconsistent with it.

The position of the Health Board evolved during the hearing, conceding that it could not seek a declaration under the inherent jurisdiction, and also that there was not, at that point, sufficient evidence for the court to be able to tell whether force-feeding would be in JK's best interests, appropriate and lawful.

As Lieven J noted, the primary issue in the case was whether the terms of s.63 MHA 1983 were met: i.e. whether force-feeding could be considered medical treatment for mental disorder in JK's case, because, if they were, JK's consent would not be required. This further raised the interaction between the Mental Capacity Act 2005; the Mental Health Act 1983 and the High Court's inherent jurisdiction, although some of the issues have narrowed during the hearings. Lieven J identified the following issues potentially arise, "*although some have become less important, and (e) does not yet arise;*

> *a) Does JK have capacity to make a decision to refuse food?*
>
> *b) Where the court is invited to make a declaration that a proposed course by the Health Board is medical treatment under s.63 MHA, what legal test should the Court apply?*
>
> *c) Is the proposed treatment, i.e. force feeding, treatment that falls within s.63?*
>
> *d) If the proposed treatment does not fall within s.63 can the court authorise the force feeding pursuant to its inherent jurisdiction? this raises two sub-issues;*
>
> > *i. Is there a lacuna in the statutory scheme which the inherent jurisdiction can appropriately fill?*
> >
> > *ii. Is JK a vulnerable person within the meaning of SA (Vulnerable Adult with Capacity: Marriage) [2006] 1 FLR 867?*
>
> *e) Is it appropriate on the facts to order that JK can be force fed?*

Against a starting point that every citizen of age and of sound mind has the right to make decisions about their treatment, even if those decisions bring about their death, Lieven J observed that there were three circumstances in which adults can have treatment imposed upon them without their consent: *"if they lack capacity under the Mental Capacity Act 2005; if they are detained under the Mental Health Act 1983 and the treatment falls within the terms of s.63 (or s.58); or if they can be categorised as "vulnerable" under the High Court's inherent jurisdiction."*

Lieven J conducted a brief, but comprehensive, survey of the relevant provisions of the MCA 2005 and the MHA 1983 and the relevant case-law. In relation to the inherent jurisdiction, Lieven J noted that:

> *The Health Board originally put its application to the Court on the alternative basis of either seeking a declaration*

> *under the section 63 of the MHA, or that if the Court found there was no power to force feed under s.63 then there was such power under the inherent jurisdiction. However, by the time of the hearing on 4 November 2019 the Health Board had accepted that there was no power under the inherent jurisdiction on the facts of this case to grant a declaration that JK could be force fed. The basis for this concession was that JK was not "vulnerable" within the meaning of SA (Vulnerable Adult with Capacity: Marriage) [2006] 1 FLR 867 and as further considered by the Court of Appeal in A Local Authority v DL [2012] 3 All ER 1064.*

Lieven J considered that this concession was correct:

> *56. In my view, relying on what McFarlane LJ said at [53] in DL some caution needs to be exercised over the extent of the category set out at [78iii] of SA* [i.e. "for some other reason deprived of the capacity to make the relevant decisions, or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent"] *given that some of those matters would go directly to mental capacity under the MCA and therefore are covered by that Act. In DL the gap in the statutory scheme was that the MCA covered those who lacked mental capacity to make the decision in issue, but not those whose will had been overborn in making that decision by reason of their vulnerability, for example by coercion.*
>
> *57. The inherent jurisdiction cannot be used to simply reverse the outcome under a statutory scheme, which deals with the very situation in issue, on the basis that the court disagrees with the statutory outcome. Here the vulnerability which the Health Board originally relied upon was JK's mental disorder, namely his ASD. Despite his ASD JK undoubtedly has capacity, so he cannot be compulsorily treated under the MCA. If I had found that his decision not to eat was not a manifestation of his mental disorder, then he could not have been compulsorily treated under the MHA. In my view that would have been the end of the matter, because the two statutory schemes deal precisely with someone in JK's situation, and there is no factor such as coercion which lies outside those considerations.*
>
> *58. Therefore, either it can be said that there is no lacuna in the statutory scheme which would leave space for the inherent jurisdiction; or alternatively, as the Health Board now accept, JK is not "vulnerable" within the meaning of SA. He is not "vulnerable" because this is not a case of JK's will being overborn by some factor outside the scheme of the statutes, but rather his decision having been made in circumstances entirely contemplated by the statutes. These two analyses reach the same end result, that JK's situation either allows treatment without consent under the MHA, or not at all.*

Lieven J therefore turned to consider, first, JK's capacity. She heard from JK, and having heard him, had no reason to doubt the assessment of the consultant psychiatrist who had reported.

The next issue was the test to apply under s.63 MHA 1983. As she noted:

> *66. The MHA gives the power to decide whether to compulsorily treat a patient to*

> *the responsible clinician and not to the Court. This is a fundamentally different scheme to that in the MCA where many decisions are given by statute to the court. The difference makes sense because the MHA is a statutory scheme for, inter alia, detention and compulsory treatment in the public interest, where the responsible clinician has a specific role in the statutory scheme. There is no statutory process in the MHA to question the decision of the clinician. However, if the clinician decides to impose treatment then the individual can judicially review that decision, as happened in R v Collins ex p ISB. However, in the present case what is in issue is a proposed future treatment where the clinicians have not yet drawn up a treatment plan, and not yet weighed up the factors for and against force feeding. In A NHS Trust v A Baker J at [80] said; that in cases of uncertainty under s.63 MHA "where there is doubt whether the treatment falls within section 145 or section 63, the appropriate course is for an application to be made to the court to approve the treatment". Baker J did not explain what jurisdiction the Court would be exercising in order to make any such declaration and judicial review would not be apposite at this stage as an actual decision to treat has not yet been made. However, the inherent jurisdiction can be used to make declaratory orders, and I can see no reason why a similar principle would not apply here. I therefore will consider the making of declaratory relief.*

Following the Court of Appeal decision in *R (JB) v Haddock* [2006] EWCA Civ 961 ,Lieven J noted that:

> *68. It therefore must follow that any decision under the inherent jurisdiction both as to whether proposed treatment falls within s.63, as being for a manifestation of the mental disorder; and as to whether it is "treatment" within s.145 under the MHA, must also involve a full merits review.*

The next question was whether the proposed force feeding did indeed fall within s.63. This was a decision for the court, although it was: "*necessarily a matter on which the Court will be heavily reliant upon medical, and in particular, psychiatric evidence. The interrelationship between the patient's mental disorder and the treatment which is proposed, is in my view one primarily of medical expertise rather than legal analysis*." Lieven J therefore set out the evidence before reaching her conclusion, thus:

> *70. It is Dr L's clear view that JK's refusal to eat is a manifestation of his autism. Dr L is not only a consultant psychiatrist but also one with a particular expertise in the assessment and treatment of patients with autism. Dr L appeared to me to be a measured, highly knowledgeable and careful witness, whose evidence I can give the maximum weight to. He had met JK twice, once for quite a prolonged interview, and had clearly listened carefully to what JK had said and the information he had gathered. It is true that Dr L and the court, have relatively little information about JK's mental health before the index offence and the fact that none of the clinicians have been able to speak to JK's family limits their understanding of his presentation outwith the highly traumatic recent circumstances. However, I do not accept Mr McKendrick's submission that without such "longitudinal evidence" it is not possible to conclude that the refusal to eat is not a manifestation of JK's autism.*

71. I take in particular from Dr L's evidence that JK's rigid and "shutting down" response of saying that he has nothing to live for and refusing to eat, is a not uncommon approach from a person with autism dealing with a crisis situation. JK has been through a quite exceptionally difficult and traumatic few weeks, and it should not be forgotten that the index offence only took place two months ago. It is hardly surprising given his mental disorder perhaps exacerbated by chronic depression, that his response is suicidal. Issues around food and eating appear to have been a feature of his autism, and possibly also OCD, and a refusal to eat therefore has an obvious relationship to his mental disorder.

72. I do accept that with a condition such as autism which is a fundamental part of JK's personality, it is exceptionally difficult to see how any decision making is not a manifestation of that disorder. I also accept that it is possible that many people faced with JK's situation would feel despair and potentially be suicidal. However, I do not think the task for me is to try to compare JK's response to his situation with that of a hypothetical person without autism. It is rather, to try to analyse the degree to which JK's own response relates to his condition, and the way his mind works because of that condition.

73. In my view his refusal to contemplate any alternative paths, and his rigid belief that refusing to eat is his only way forward, is a consequence of his autism and as such falls within s.63. The proposed force feeding is therefore certainly capable of being treatment for the manifestation of his mental disorder.

However, importantly, that was not the end of the matter:

74. However, that does not mean that I by any means accept that force feeding JK would be in his best interests, or critically would be "treatment" that falls within the definition in s.145(4) of the MHA, as being "to alleviate or prevent a worsening of the disorder…". It is apparent that force feeding is a highly intrusive process, which involves sedating the patient whilst the naso-gastric tube is inserted and potentially having to restrain the patient for fairly prolonged periods. This process would be extremely upsetting for any patient, but for JK with his ASD and his aversion to eating in front of other people, the process would be even more traumatic. JK said in oral evidence that he viewed the possibility as abhorrent, and it was clear from that response how incredibly upsetting for all concerned having to go through that process would be. If it came to that stage close consideration would necessarily have to be given to the terms of article 3 ECHR and the caselaw such as Herczegfalvy v Austria [1993] 15 EHRR 437 and the test of medical necessity.

Lieven J recorded that:

75. The position at the moment is that the Health Board are drawing up a detailed treatment plan and are in discussions with appropriate clinical experts. If JK reverts to refusing to eat, and the Health Board decide pursuant to s.63 that he should be force fed, then the matter will need to be restored to court. This could be done by way of a judicial review of the Health Board's decision at that stage, that force feeding is treatment which falls within s.145(4), the decision having

> *already been made by the court that it is capable of being treatment within s.63. However, given that this is a full merits review, and Baker J said that in cases of uncertainty it was appropriate to bring the matter before the court, it seems to me that the most straightforward route is to give JK liberty to apply to bring the matter back before me sitting in the Family Division, if needed. There is no benefit, and potentially additional cost and complication, by requiring a judicial review action to be commenced.*

Helpfully for future cases, Lieven J's judgment then set out the order that was made.

Comment

This case represents the paradigm example of how the law in this area is able to answer the question as to whether something "can" take place, but is not obviously well-placed to answer the question as to whether it "should." Lieven J's careful analysis of the law sets the framework within which the clinicians would have to decide whether to force feed JK (if he continued to refuse to at) by determining that force-feeding could on the facts of his case fall within the scope of s.63 MHA 1983. But the question of whether they *should* then decide to use s.63 to force feed-is one that is as much ethical as it is legal. It is of some interest that Lieven J appeared to assume that the clinicians in making that decision (and the court if it were to return to her) would be considering JK's best interests. Section 63 does not refer to best interests, and the test in s.58 (as amended in 2007) for a Second Opinion Appointed Doctor to consider is whether the treatment is "appropriate." Pre-2007 case-law (such as *Haddock*, referred to by Lieven J) had proceeded on the basis of "best interests," but – perhaps surprisingly – there has not been a case subsequent to the passage of the MHA 2007 in which the test has been considered by the courts. "Best interests" is undoubtedly a more calibrated test than "appropriate," and the Independent Review of the MHA 1983 recommended that the test be changed to "best interests." It did, so, however, in relation to those lacking capacity to make decisions about their medical treatment, and it is not perhaps immediately obvious how the test applies to someone, such as JK, who is considered to have such capacity.

In determining what course action to take, no doubt the clinicians will also have in mind – as will the court if it returns to it – the presence of JK's advance decision, Mostyn J having emphasised in *Nottinghamshire Healthcare NHS Trust v RC* [2014] EWCOP 137 the weight to be placed on advance decisions to refuse medical treatment for disorder even when they are not formally binding because the treatment is being delivered within the framework of the MHA 1983.

Lieven J's (obiter) observations about the inherent jurisdiction are also of interest as reinforcing the need to be clear as to whether or not there is, in fact, a gap in the statutory schemes in play. They sit at possible odds to the decision of Cobb J in *CD v London Borough of Croydon* [2019] EWHC 2943 (Fam), discussed elsewhere in this report, in which he contemplated the use of the inherent jurisdiction against a person in a situation of self-neglect, refusing access to carers and others.

Safeguarding, homelessness and self-neglect

The Policy Research Unit in Health and Social Care Workforce (part of the National Institute for Health Research) has recently published a fascinating paper which identifies, in the context of cases with a homelessness element, serious failings by local authorities in relation to self-neglect. The paper is entitled "Safeguarding, homelessness and rough sleeping: An analysis of Safeguarding Adults Reviews" and is freely available here.

The report analyses the findings from 14 Safeguarding Adults Reviews (the current mechanism for "learning lessons" where there is evidence that agencies have not worked well together in discharging their responsibilities towards those who have suffered abuse or neglect). One of the report's key conclusions is that agencies failed to understand self-neglect as a potential safeguarding issue, and that the difficulties were particularly acute when there was issues of alcohol and substance dependence and/or fluctuating mental capacity.

The report also found that local authorities were failing to comply with the low threshold for a needs assessment under s.9 Care Act 2014, apparently assuming that rough sleepers had housing problems rather than potential rights to care and support – including accommodation – under the Care Act.

Relying on your own incapacity

Fox v Wiggins & Anor [2019] EWHC 2713 (QB) High Court (QBD (Julian Knowles J))

Practice and procedure – other

Summary

In this case, Julian Knowles J had to consider what to do in civil proceedings when a party's capacity to conduct the proceedings is put in issue by the person themselves. The person in question was the Sixth Defendant in a libel action brought against her and a number of other former partners of a musician. She and her 'co-conspirators' were accused of making serious defamatory allegations about the Claimant and his violent conduct online. While all of the other Defendants filed defences to the Claimant's claim, the Sixth Defendant, despite engaging in the litigation to the extent of requesting extensions of time, failed to do so. As a result, judgment in default was entered against her.

The Sixth Defendant, in an application supported by her mother, sought a declaration that she lacked capacity within the meaning of CPR r 21.2(2)(c) as a result of Crohn's disease, depression, anxiety and post-traumatic stress disorder. She also sought an order setting aside the default judgment and granting relief from sanctions. Considering both the application of CPR Part 21 and s.3(1) MCA 2005 and the guidance set down by Baker J (as he then was) in *A Local Authority v P* [2018] EWCOP 10, and HHJ Hilder in *London Borough of Hackney v SJF and JJF* [2019] EWCOP 8, Julian Knowles J analysed whether the Sixth Defendant had adduced sufficient evidence to overcome the presumption of capacity as set out in s.1(2) MCA 2005.

Disregarding submissions that evidence from the Sixth Defendant's treating psychiatrist should be rejected on the grounds that it failed to meet the requirements of CPR Part 35, Julian Knowles J nonetheless did not consider the Sixth Defendant's psychiatric evidence sufficient

to set aside the presumption of capacity. Nor was he convinced by evidence from the Sixth Defendant's mother as to her daughter's lack of capacity on which he held at paragraph 81:

> *Her evidence does not establish that her daughter is never able to give instructions. It merely suggests that there are times when her daughter becomes very emotional and finds it hard to communicate with her. Again, there is no discussion of what other steps have been, or could be, taken in order to assist her daughter.* ***To find that an adult lacks capacity is a significant step with far reaching consequences. For example, it deprives her of civil rights, in particular her right to sue or defend in her own name, and her right to compromise litigation without the approval of the court****. These are important rights, long cherished by English law and safeguarded by the European Convention on Human Rights: Masterman-Lister, supra, [17]; In re Cumming (1852) 1 De GM & G 537, 557. Such a decision should therefore only be taken on the basis of cogent evidence. I find that cogency is lacking here. The evidence is sparse.* (emphasis added)

Furthermore, Julian Knowles J considered evidence such as the Sixth Defendant's social media presence on the extent to which she was unable to engage with life as alleged. He held at paragraph 84 that:

> *Having regard to the evidence that is before me, I am not satisfied that the Sixth Defendant has discharged the burden on her to show on the balance of probabilities that she currently lacks capacity, or did so between 4 May 2018 and now. I accept that she has a number of physical and mental ailments. I accept that being confronted with this litigation is stressful for her. However, at a minimum, I would have expected that Dr Inspector would have had a full consultation with the Sixth Defendant and considered the litigation with her, and then reported properly, fully and completely on his findings as to her ability to conduct litigation with reference to the tests for capacity under the MCA 2005 and the principles to which I have referred. He did not do that, but merely provided a brief opinion based upon what appears to have been a short discussion with his patient. Given the time which has passed since May 2018 (at the latest) when this issue first emerged I would also have expected expert evidence about the Sixth Defendant's mental state. There is none. I agree with the Claimant's submission that I am prevented from carrying out any detailed analysis of the evidence with regard to the tests under the MCA 2005, because there is no evidence to analyse other than Dr Inspector's bare assertions and* [the Sixth Defendant's mother's] *generalised evidence.*

His finding of capacity and that she had no realistic prospect of successfully defending the claim notwithstanding, Julian Knowles J did grant the application to set aside judgment, noting that the Sixth Defendant did indeed suffer from serious medical issues and was without legal representation at the time at which judgment in default was entered.

Comment

It is very unusual for a person, themselves, to assert that they lack capacity to conduct proceedings, as this is more often put in issue

either by another party or the court (sometimes at the instigation of their legal representative). Ms Dunhill did so, retrospectively, and the Supreme Court held that her (at the time unrecognised) lack of litigation capacity rendered subsequent steps in the proceedings void. It was to Ms Dunhill's benefit in that case for the settlement she had entered into to be set aside; similarly, it would have been to the Sixth Defendant's benefit, even if only temporarily, to have a finding made of incapacity so as to render steps taken against her – including the grant of default judgment – set aside.

It is quite understandable, therefore, that Julian Knowles J proceeded on the basis that the Sixth Defendant had, in essence, to prove her own incapacity, and that the Claimant's representatives sought to challenge that assertion on an adversarial basis. It is perhaps important to emphasise, however, that any court considering litigation capacity is, in fact, conducting an inquisitorial exercise, because it is for the court to be satisfied whether or not a party before it has capacity to conduct the proceedings. As Rimer J put it in *Carmarthenshire CC* v *Lewis* [2010] EWCA Civ 1567: "*once the court is possessed of information raising a question as to the capacity of a litigant to conduct the litigation, it should satisfy itself as to whether the litigant does in fact have sufficient capacity*." For further discussion of the issues, see also *Z v Kent County Council (Revocation of placement order - Failure to assess Mother's capacity and Grandparents)* [2018] EWFC B65.

Comparative capacity

In other news, the Family Law in Europe Academic Network have chosen as its first working field the Empowerment and Protection of Vulnerable Adults. Written by leaders across the 28 European Nations, it provides really helpful summaries of the capacity and protective measures in place to enable a rich comparative analysis of the differing European approaches to CRPD compliance. Well worth a read for those wishing to broaden their European capacity law horizons.

Editors and Contributors

Alex Ruck Keene: alex.ruckkeene@39essex.com

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.

Victoria Butler-Cole QC: vb@39essex.com

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), and a contributor to Heywood and Massey Court of Protection Practice (Sweet and Maxwell). To view full CV click here.

Neil Allen: neil.allen@39essex.com

Neil has particular interests in ECHR/CRPD human rights, mental health and incapacity law and mainly practises in the Court of Protection and Upper Tribunal. Also a Senior Lecturer at Manchester University and Clinical Lead of its Legal Advice Centre, he teaches students in these fields, and trains health, social care and legal professionals. When time permits, Neil publishes in academic books and journals. To view full CV click here.

Annabel Lee: annabel.lee@39essex.com

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. To view full CV click here.

Nicola Kohn: nicola.kohn@39essex.com

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 5th edition of the *Assessment of Mental Capacity: A Practical Guide for Doctors and Lawyers* (BMA/Law Society 2019). To view full CV click here.

Editors and Contributors

Katie Scott: katie.scott@39essex.com

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.

Katherine Barnes: Katherine.barnes@39essex.com

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.

Simon Edwards: simon.edwards@39essex.com

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.

Adrian Ward: adw@tcyoung.co.uk

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; honorary membership of the Law Society of Scotland; national awards for legal journalism, legal charitable work and legal scholarship; and the lifetime achievement award at the 2014 Scottish Legal Awards.

Jill Stavert: j.stavert@napier.ac.uk

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 here.

Conferences

Conferences at which editors/contributors are speaking

Mental Capacity Law Update

Neil is speaking along with Adam Fullwood at a joint seminar with Weightmans in Manchester on 18 November covering topics such as the Liberty Protection Safeguards, the inherent jurisdiction, and sexual relations. 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 – the 100th – will be out in December. Please email us with any judgments or other news items which you think should be included. If you do not wish to receive this Report in the future please contact: marketing@39essex.com.

Michael Kaplan
Senior Clerk
michael.kaplan@39essex.com

Sheraton Doyle
Senior Practice Manager
sheraton.doyle@39essex.com

Peter Campbell
Senior Practice Manager
peter.campbell@39essex.com

Chambers UK Bar
Court of Protection: Health & Welfare
Leading Set

The Legal 500 UK
Court of Protection and Community Care
Top Tier Set

clerks@39essex.com • DX: London/Chancery Lane 298 • 39essex.com

LONDON
81 Chancery Lane,
London WC2A 1DD
Tel: +44 (0)20 7832 1111
Fax: +44 (0)20 7353 3978

MANCHESTER
82 King Street,
Manchester M2 4WQ
Tel: +44 (0)16 1870 0333
Fax: +44 (0)20 7353 3978

SINGAPORE
Maxwell Chambers,
#02-16 32, Maxwell Road
Singapore 069115
Tel: +(65) 6634 1336

KUALA LUMPUR
#02-9, Bangunan Sulaiman,
Jalan Sultan Hishamuddin
50000 Kuala Lumpur,
Malaysia: +(60)32 271 1085