



Welcome to the March 2020 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: a cautionary tale about re-using material for DoLS assessment and capacity complexities in the context of medical treatment;

(2) In the Property and Affairs Report: an important case on the limits of powers of professional deputies to act without recourse to the Court of Protection;

(3) In the Practice and Procedure Report: medical treatment – delay, neglect and judicial despair, developments relating to vulnerable parties and witnesses, and Forced Marriage Protection Orders under the spotlight;

(4) In the Wider Context Report: Mental Capacity Action Days, when not to presume upon a presumption, and a number of important reports from bodies such as the CQC;

(5) In the Scotland Report: the DEC:IDES trial.

We have also recently updated our capacity guide and our guide to the inherent jurisdiction. You can find them, along with 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.

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The picture at the top, "Colourful," is by Geoffrey Files, a young man with autism. We are very grateful to him and his family for permission to use his artwork.

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### Mental Capacity Action Days

The National Mental Capacity Forum is holding three action days this year, focusing on the ‘support principle’ in the MCA 2005. The days are 1 April in Manchester (at which Alex will be speaking), 28 April in Cardiff and 3 June in Bournemouth. For more details, see [here](#).

### Brain death and the courts: update

Further to the analysis in our [February Report](#), the Court of Appeal dismissed on 14 February the appeal against the decision of Lieven J in *Manchester University NHS Foundation Trust v Namiq* [2020] EWHC 180 (Fam) (although varied her order to reflect the wording used in the earlier decision of Hayden J in *Re A (A Child)* [2015] EWHC 443 (Fam)) The Court of Appeal not only upheld the approach Lieven J took to the court’s

task, but also the approach she took to the naming of the treating clinicians, noting (at paragraph 102) that:

*in the decade since Sir James Munby considered this matter the world has changed. The manner in which social media may now be deployed to name and pillory an individual is well established and the experience of the clinicians treating child patients in cases which achieve publicity, such as those of Charlie Gard and Alfie Evans, demonstrate the highly adverse impact becoming the focus of a media storm may have on treating clinicians.*

This is also an opportunity to highlight the talk that Tor and Ben Tankel gave at the recent Chambers seminar on brain death and the courts, available [here](#).

## Short note: when not to presume upon a presumption

The correct application of the presumption of capacity in s.1(2) MCA is a perennially difficult question. On the one hand, we have the situation of rushing too quickly to question capacity – often in the context of a decision that does not ‘suit’ the concerns of professionals. On the other, we have the problem identified by the House of Lords Select Committee in its [post-legislative scrutiny](#) of the MCA 2005 in 2014:

*The presumption of capacity, in particular, is widely misunderstood by those involved in care. It is sometimes used to support non-intervention or poor care, leaving vulnerable adults exposed to risk of harm. In some cases this is because professionals struggle to understand how to apply the principle in practice. In other cases, the evidence suggests the principle has been deliberately misappropriated to avoid taking responsibility for a vulnerable adult. (para 105)*

In this context, the decision of the Employment Appeal Tribunal (Swift J) in *Royal Bank Of Scotland Plc v AB* [\[2020\] UKEAT 0266\\_18\\_2702](#) is a very useful contribution to the debate. The facts of the case are not relevant, save that they concerned a challenge to an Employment Tribunal's decision not to conclude that an assessment of the applicant's capacity to litigate was wrong. As Swift J held:

*22. Nevertheless, my conclusion is that in this case the Employment Tribunal was wrong to conclude that an assessment of AB's capacity to litigate was not necessary. It is right that any Tribunal must take care before concluding that*

*assessment of a litigant's capacity to litigate is necessary. Simler P's words of warning, at paragraph 38 of her judgment in Jhuti, are important. Tribunals must not permit arguments about litigation capacity to be used discriminately or unscrupulously. The risk of misuse must be carefully policed. However, where there is legitimate reason to doubt a litigant's capacity to litigate, that issue must be addressed. A litigant who lacks the capacity to litigate lacks the ability fairly to participate in legal proceedings. It is unfair to permit proceedings to continue in those circumstances until that litigant's interests are properly represented whether by a litigation friend or a court-appointed Deputy.*

*23. The way AB presented to the Employment Tribunal on the afternoon of 25 July 2017 did provide reason to suspect that she might not have had capacity to conduct the litigation. She did not appear to recognise her counsel; and she appeared unable to respond to simple questions. Although it is true that the presumption of capacity at section 1(2) of the 2005 Act can only be displaced by evidence that establishes a lack of capacity, the issue for the Employment Tribunal on 25 – 26 July 2017 was not to decide whether AB lacked capacity but whether there was good reason for concern that AB might lack capacity such that an assessment was required.*

*24. In reaching its decision that no such assessment was required, the Employment Tribunal relied on four matters: (a) the view of AB's lawyers that they were satisfied they were able to continue to act for AB; (b) the views of Dr Ornstein in a report dated 21 July 2017; (c) the fact that neither Dr Ornstein or Dr*

*Stein had notified the Employment Tribunal that their opinion was that AB lacked capacity; and (d) and the presumption at Section 1 (2) of the 2005 Act.*

*25. Reasons (a) and (c) do not withstand scrutiny. Dr Ornstein's capacity report dated 21 July 2017, even though written a matter of days before the remedies hearing commenced (on 24 July 2017), was written only on the basis of Dr Ornstein's prior engagement with AB. The last time he had examined AB was on 28 April 2017. More importantly Dr Ornstein had not been present at the Tribunal on the afternoon of 25 July 2017. Next, the Tribunal's reliance on the absence of a report from either Dr Ornstein or Dr Stein stating an opinion that AB lacked litigation capacity was illogical. As the Tribunal ought to have realised, neither Dr Ornstein nor Dr Stein had had the chance to examine AB or express an opinion in light of events of the afternoon of 25 July 2017. Moreover, this part of the Tribunal's reasoning indicates that it was failing to address the right question. The question at this stage was not whether AB lacked capacity to litigate but whether there was a permissible basis for enquiries to be made as to whether she lacked that capacity. Taken together, these points entirely undermine the Tribunal's reliance on the views expressed by AB's lawyers that they were "able to continue to act for AB". Given the way that AB had presented at the Tribunal hearing, and the obvious concern her lawyers had previously had in respect of capacity, which had led them to obtain Dr Ornstein's capacity report of 21 July 2017, and the lack of an up to date expert opinion, the Tribunal placed more weight*

*on the assertions of AB's lawyers than those assertions could rationally bear.*

*26. This leaves the Tribunal's reliance on the section 1(2) presumption of capacity. The presumption of capacity is important; it ensures proper respect for personal autonomy by requiring any decision as to a lack of capacity to be based on evidence. Yet the section 1(2) presumption like any other, has logical limits. When there is good reason for cause for concern, where there is legitimate doubt as to capacity to litigate, the presumption cannot be used to avoid taking responsibility for assessing and determining capacity. To do that would be to fail to respect personal autonomy in a different way. As Simler P pointed out in *Jhuti*, a litigant who lacks capacity is effectively unrepresented in proceedings since she is unable to take decisions on her own behalf and unable to give instructions to her lawyers. Thus, although any Tribunal should be alert to guard against attempts by litigants to use arguments about capacity improperly, if, considered objectively, there is good cause for concern that a litigant may lack litigation capacity, an assessment of capacity should be undertaken. What amounts to "good cause" will always require careful consideration, and it is not a conclusion to be reached lightly. For example, good cause will rarely exist simply because a Tribunal considers that a litigant is conducting litigation in a way with which it disagrees, or even considers unreasonable or vexatious. There is likely to be no correlation at all between a Tribunal's view of what is the "common-sense" conduct of a piece of litigation and whether a litigant has capacity to conduct that litigation. Something qualitatively different is required.*

27. *In this case, the Tribunal's reliance on section 1(2) of the 2005 Act was in error. The Tribunal relied on the section 1(2) presumption to create Catch-22: a conclusion that an assessment of AB's capacity to litigate would only be appropriate if there was already expert evidence that she lacked capacity to litigate. That was a misapplication of section 1(2) of the 2005 Act. Section 1(2) does require any lack of capacity to be "established"; but it does not require a lack of capacity to be established before a court can require an assessment of capacity. That proposition only has to be stated to be recognised as self-defeating. In the present case, the only issue for the Tribunal raised by RBS's application was whether there was good cause for concern that AB might lack capacity to conduct the litigation. In this case good cause for concern plainly did exist. The Tribunal ought to have concluded that an assessment of AB's capacity to conduct the litigation should have been undertaken.*

Paragraph 26, in particular, is hugely helpful in terms of finding its way through the presumption problem, not just in terms of litigation capacity but also more broadly.

### **New guidance on Prolonged Disorders of Consciousness**

New [guidelines](#) were published on 6 March by the Royal College of Physicians and endorsed or supported by a further 15 health bodies offer updated guidance on the diagnosis, assessment, care and management of patients with prolonged disorders of consciousness.

*Prolonged disorders of consciousness following sudden onset brain injury: National clinical*

*guidelines* is an updated version of the 2013 guidelines, incorporating guidance on the new legal situation (see below) and developments in assessment and management. It will support doctors, other clinicians, families and health service commissioners to ensure that everyone is aware of their legal and ethical responsibilities.

Prolonged disorder of consciousness includes vegetative state (VS) and minimally conscious state (MCS) but not short-term coma. There is no reliable information on how many people may be in prolonged disorders of consciousness being cared for at home or in nursing/care homes across the UK. Estimates vary widely between 4,000 and 16,000 patients with long-standing VS and perhaps three times that number in MCS. The guideline recommends that a national registry should be set up to collect details of patients with prolonged disorders of consciousness which would include a register of doctors experienced in managing these conditions.

The guidelines provide key information about assessment, diagnosis and management of VS and MCS as well as advice for supporting families.

In the early stages following severe brain injury, it is often unclear which patients will and will not regain consciousness or the level of recovery they might achieve. Proactive treatment and specialist assessment/management provide the best opportunity for maximising any potential. However, the longer a patient remains in VS/MCS, the less likely it is that they will recover a quality of life that they would value. This poses difficult questions for families and treating teams about whether the patient would

want to continue to receive life-sustaining treatment under certain circumstances.

While decision-making starts from the strong presumption that it is in the patient's best interests to prolong life, this presumption can be rebutted if there is evidence that the patient him/herself would not want to receive that treatment under the circumstances that have arisen.

Patients with prolonged disorders of consciousness may receive a number of life-sustaining treatment including clinically assisted nutrition and hydration (CANH). The guidance has been updated following the decision of the Supreme Court in *NHS Trust v Y* [2018] UKSC 42 that it is no longer necessary to apply to a court for approval to withdraw CANH provided certain conditions are met, specifically:

- the provisions of the Mental Capacity Act (MCA) 2005, which covers decision-making for those who lack capacity have been followed. The MCA highlights the responsibility of clinicians to ensure that any treatment or intervention is given in the patient's best interests taking into account their likely wishes; **and**
- relevant guidance is observed (including clinical/professional guidance); **and**
- there is agreement that continued treatment is not in the best interests of the patient.

The guidance addresses the practical workings out of this judgment, as well as the guidance in the recent Serious Medical Treatment Practice Guidance from the Vice-President, relating to potential conflicts of interest.

As it is the giving, not withdrawing of treatment that must be justified under the Mental Capacity Act (MCA) 2005, the new guidelines emphasise that it is the responsibility of clinicians to initiate best interests discussions. These should be started from an early stage following severe brain injury and re-visited on a regular basis. The guidelines offer helpful advice and resources to support this process. Nevertheless, many clinicians still feel under-prepared for these conversations, and there is need for widespread training and education to implement this practice effectively.

Importantly, this is not just an issue for healthcare professionals – hospitals, care homes and commissioning services need to understand that this is a legal requirement, binding on everyone concerned with the management of patients with prolonged disorders of consciousness as an aspect of their duties towards them.

[Full disclosure: along with Yogi Amin, Alex was one of the two legal advisers to the Guideline Development Group.]

### Promoting sexual safety through empowerment

*It is a basic human right for people to express their sexuality and to be empowered, supported and protected when using adult social care services. We want this report to encourage a conversation about sexual safety, sexuality and respectful relationships in adult social care.*

Developing its previous work, the CQC's latest report, Promoting sexual safety through empowerment: A review of sexual safety and the

*support of people's sexuality in adult social care* (February 2020) emphasises that talking about sexuality in adult social care should not be taboo. A 3-month review analysed 661 statutory notifications that described 899 sexual incidents/alleged sexual abuse that took place in adult social care services (3% of the total notifications of alleged/abuse). Almost half were categorised as sexual assault, and nearly 60% of incidents were alleged to be carried out by others using the services. In 16% of cases, the allegations were against employed staff or visiting workers.

### Lessons

The CQC identified the following lessons from its review:

- People are better protected when they are empowered to speak out about unwanted sexual behaviour and can speak openly about their sexuality
- Effective adult social care leaders develop a culture, an environment, care planning and processes that keep people and staff safe, and support people's sexuality and relationship needs
- People want to be able to form and maintain safe sexual relationships if they wish
- The impact of people's health conditions on sexual behaviour is not well understood
- Women, particularly older women, were disproportionately affected by sexual incidents in our findings
- There are some actions that providers in all care settings can carry out to help keep

people in their service safe from sexual harm

- There are emerging concerns about the use of social media, mobile phones and the internet in sexual abuse
- Joint-working with other agencies, such as local authorities and the police, is vital to keep people safe

The report highlights that a lack of awareness of good practice in sexual safety and sexuality can place people at risk of harm, and an open culture must be developed where people and staff feel empowered to talk about sexuality and raise concerns around safety. In some cases, the notifications related to consensual activity, indicating that staff did not fully understand the issues and risked inappropriate interference:

*Staff witnessed [the man] with his hands down the front of [the woman's] trousers and appeared to be making a stroking motion. She had her hands placed over his crotch area over his trousers and her head lay on his shoulder. Staff intervened immediately and assisted both residents to separate using distraction techniques.*

(Excerpt from notification)

### Good practice

The CQC identified the following principles of good practice to be used in all adult social care services:

- Leaders should promote a culture of openness that allows people to both discuss issues of sexuality and raise issues of sexual safety, as part of a holistic approach to good person-centred care.

- People receiving adult social care are entitled to the same human rights as anyone else, and should be afforded the same dignity, choice, family life, privacy and respect, and should be able to feel safe from sexual harm.
- People who use services should be central to conversations about their needs and choices. Where seen as supportive and agreed to, family members, carers and advocates can also be included.
- Assessments should include information about people's sexuality needs (including current relationships, sexual orientation and understanding of sexual health, where appropriate) as well as any past criminal or predatory behaviour. Care plans should accurately reflect these assessments and note the needs and wishes of people.
- Training should include supporting staff to have informal, everyday conversations about sexuality and sexual safety.
- Recruitment and organisational values should have a human rights focus.
- Providers should work with relevant community groups to give staff and people who use services support and access to information on sexual safety and sexuality.

### National Care Review of NHS learning disabilities hospital inpatient provision in Wales

NHS Wales National Collaborative Commissioning Unit has published "[Improving Care, Improving Lives](#)," a National Care Review of Learning Disabilities Hospital inpatient Provision

Managed or Commissioned by NHS Wales, as part of the Welsh Government Learning Disability – Improving Lives Programme. The Programme focuses on keeping individuals as independent as possible and out of long-term institutional care.

The Review was undertaken in 2019 and included all patients cared for in hospitals provided by NHS Wales or commissioned by NHS Wales from NHS England or the independent sector. It highlights key issues about the care and treatment of people who are inpatients in learning disability hospitals. Amongst the Review's key findings were:

- There is an aging patient cohort. The Review found that many patients with a learning disability have concurrent diagnosis such as dementia and autism and that required fit-for-purpose environments and trained, experienced staff to manage these complex presentations.
- Patients with long lengths of stay and many transferred between hospitals when alternatives could have been considered.
- Issues with some patients being deprived of their liberty and ensuring that the full protection of the legal safeguards were being applied.
- Not all patients had a care plan in place and not all care plans were being regularly reviewed.
- A high use of psychotropic medications and a scarcity of therapy staff.
- Many occurrences of behaviours that challenge, and ensuring that staff were

empowered, trained and present in sufficient numbers to take a positive patient-centred approach to preventing harm.

- Restrictive interventions were sometimes required and the Review found many occasions where they had been applied.
- Patients had been in regular contact with primary and urgent healthcare services and it was necessary to ensure that the physical well-being of patients was assessed, monitored and maintained.
- Many, but not all, patients were satisfied with their admission and felt that staff were supportive.
- A significant number of patients who may be considered for transition to the local community.

The Review makes 70 specific recommendations to be considered by providers and commissioners of care, as well as Welsh Government. Whilst not all 70 recommendations are set out here, they include:

- **Recommendation 9:** Commissioners should ensure that no hospital bed is classed as an individual's home and every endeavor should be made to see community care as the 'default option' for all patients.
- **Recommendation 10:** Commissioners should target resources at transitioning those patients in assessment and treatment units with a length of stay over one year, and those in other providers with a length of stay over five years.
- **Recommendation 11:** Providers should ensure that all patients, not subject to

detention under the Mental Health Act or to Deprivation of Liberty Safeguards, have the capacity to consent to being an inpatient.

- **Recommendation 12:** Providers should ensure that all patients subject to detention under the Mental Health Act or to Deprivation of Liberty Safeguards are aware of their rights.
- **Recommendation 13:** Commissioners should ensure that all patients subject to detention under the Mental Health Act or to Deprivation of Liberty Safeguards are subject to regular review.
- **Recommendation 16:** Commissioners should ensure that care plans are reviewed regularly, within a maximum time period of six months.
- **Recommendation 17:** Providers should ensure that hospital support plans are reviewed regularly, within a maximum time period of three months.
- **Recommendation 23:** Welsh Government should consider establishing a national campaign to support the reduction in the inappropriate use of psychotropic medication.
- **Recommendation 24:** Providers should ensure that all medication is prescribed at the minimum dosage to alleviate the verified symptoms.
- **Recommendation 27:** Providers must ensure that the patient, local care team and carers are involved in the decision to commence or discontinue any psychotropic medication.

- **Recommendation 35:** Providers should ensure that any restrictive intervention involves the minimum degree of force, for the briefest amount of time and with due consideration of the self-respect, dignity, privacy, cultural values and individual needs of the patient.
- **Recommendation 36:** Providers should ensure that all incidents of restrictive interventions are recorded, reviewed and reported.
- **Recommendation 53:** Commissioners should ensure that patients with low Levels of Care that demonstrate that a less restrictive environment could meet their care needs are considered for transition.
- **Recommendation 63:** Commissioners should ensure that all transition plans are enacted.

### Short note: capacity and representation before the Mental Health Tribunal

The Upper Tribunal (“UT”) decision of *SB v South London and Maudsley NHS Foundation Trust* [2020] UKUT 33 (AAC) considers the position where a patient involved in proceedings before the Mental Health Tribunal (“the Tribunal”) wishes to change the legal representative appointed for him by the Tribunal under Regulation 11(7)(b) of the Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care) Rules 2008. Reg 11(7)(b) empowers the Tribunal to appoint a legal representative where “the patient lacks the capacity to appoint a representative but the Tribunal believes that it is in the patient’s best interests for the patient to be represented”.

The UT found that, as the appointment was made under rule 11(7) by Tribunal staff under delegated powers, the recipient should have been advised that he was entitled to apply in writing within 14 days for the decision to be considered afresh by a judge pursuant to rule 4(3).

As for the refusal by the Tribunal to rescind the appointment, the UT confirmed that this can only be done by way of a case management decision under rule 5. However, in this regard the Tribunal had exercised its discretion unlawfully for various reasons. In particular, recent evidence that the patient had capacity to request a change of legal representative was not brought to the Tribunal’s attention despite the principle in s.1(2) Mental Capacity Act 2005 that a person must be presumed to have capacity unless it is established that he is incapacitous. Further, the Tribunal failed to give consideration to the fact that the relevant capacity test was a lower threshold than that required for conducting proceedings. In addition, the Tribunal seemed to accept as determinative the objection of the appointed legal representative to being discharged. However, this factor did not necessarily trump the need to have regard to the patient’s wishes and feelings and the need to ensure that the parties are able to participate fully in the proceedings.

### Short Note: compelling public authorities to act

*R (M) v London Borough of Newham* [2020] EWHC 327 (Admin) was a judicial review case brought by the father of a family which included a young woman, A, who had a range of physical disabilities and learning disabilities, who required

a considerable amount of care which was provided by her mother.

The local authority accepted it had a duty to house the family back in 2005 but had failed to find suitable accommodation for them. A house was offered in 2017 which the local authority said was suitable, but the bathrooms were not big enough for A to use them, because of the specialist equipment required.

The family moved in anyway, while the dispute rumbled on. The local authority accepted that the house was not suitable in the long term, but by the time of the hearing, 2 more years had passed, and still nothing suitable had been found for the family. There was medical evidence that A needed to move urgently because of the risk to her health from lack of adequate washing and toileting facilities.

Unusually, the Administrative Court made a mandatory order compelling the local authority to find suitable accommodation for the family within 12 weeks. The court found that the local authority had already admitted the current property was unsuitable and that it was therefore in breach of its statutory duties, but even if it was right that the local authority be allowed a reasonable time to find suitable accommodation, such a time period had clearly expired. The Court was unimpressed with the local authority's evidence which suggested they had not taken the case seriously and had no excuse for the delay in finding suitable accommodation.

The case contains a useful review of the relevant authorities and may be of assistance in Court of Protection cases where there are

public law failings to make available suitable accommodation to disabled people.

### Survey: online risk and adults with intellectual disabilities

The University of Suffolk and Cambridgeshire County Council are undertaking a collaborative research exercise (with Alex) on this difficult subject.

#### *Background*

Anyone who has worked with children and young people, will know that there are a range of resources and educational tools for children, young people and the professionals and families that support and enable them to engage with the online world safely. This all being supported by a plethora of academic research and supporting government schemes in this area.

However, there has been limited research internationally that has explored how the internet is used and accessed by adolescents and adults who have intellectual disabilities including Autistic Spectrum Disorder (ASD). As such, there has been little or no training or guidance specifically designed for health and social care practitioners to:

- enable adults with an ID to be digitally included/enabled,
- support adults with ID to manage online risks, and
- consider issues that give rise to concerns about a person's mental capacity to manage potential online risks.

#### *Research Summary*

The research will initially explore the experiences of professionals working in the adult social care sector, of supporting people with intellectual disabilities (including ASD) to engage with the online world and their experiences and perceptions of 'risk' in this area.

It will also explore what education and training health and social care professionals have accessed so far, what training tools or resources would improve professional knowledge in this area and include the development of initial guidance for professionals to access, based on the findings from the research.

#### *Getting involved in the research*

If you wish to take part in the research, the survey can be found [here](#).

At this stage, the survey is only aimed at professionals in England and Wales, and is not to be completed by family carers or individuals with an intellectual disability. It is open to any health and social care professional who supports people 16 years and over who also have an intellectual disability (including ASD). This could include all health and social care professionals working for a local authority, best interest assessors, local learning disability and specialist ASD care services. It is also open to members of the police.

The survey is entirely anonymous and non-attributable to any identifying information. Any data is stored securely in a password protected, GDPR compliant, data store with access available only to researchers at the University of Suffolk. It has been evaluated by the University of Suffolk research ethics committee and has approved ethical governance.

If you wish to find out more about this project email Professor Emma Bond ([e.bond@uos.ac.uk](mailto:e.bond@uos.ac.uk)) or Professor Andy Phippen ([andy.phippen@plymouth.ac.uk](mailto:andy.phippen@plymouth.ac.uk)).

#### **Further guidance about secure accommodation**

The President of the Family Division, Sir Andrew MacFarlane, has given further guidance on the appropriate legal route for authorising the deprivation of liberty of children via secure accommodation. This was considered necessary in light of some confusion that has arisen following the Court of Appeal's decision in *Re B* [2019] EWCA Civ 2025.

The key point is that *Re B* does not require the court to use s.25 of the Children Act 1989 as the route for determining applications for a deprivation of liberty in a unit which has not been approved by the Secretary of State as "secure accommodation". Rather, such applications should continue to be considered under the inherent jurisdiction.

The guidance is available [here](#).

#### **Short Note: family life, discrimination and rights**

In *Cinta v Romania* ([Application no. 3891/19](#)), a decision of the European Court of Human Rights dated 18 February 2020, the court found a breach of Article 8 ECHR, as well as Article 14, and awarded 10,000 euros in damages. This was in circumstances where the Romanian courts had approved significant restrictions on contact between a father with paranoid schizophrenia and his four year old daughter (Y).

The applicant and his wife (X) were in the process of getting divorced, with X arguing that the applicant's mental health problems meant that he posed a risk to Y such that contact had to be restricted. The authorities, and then the courts, accepted X's argument despite a lack of clear evidence about the way in which the applicant's condition meant that he was unable to care for Y or otherwise endangered Y. This was in the context of evidence from the hospital treating the applicant that he had been compliant with his medication and had not suffered any psychiatric episode in the last two years.

In these circumstances the court found that there no "objective element" (para 48) in the domestic decisions to substantiate X's allegations that the applicant's mental disorder posed a threat for Y, and was troubled by the absence of independent expert evidence. This resulted in the finding that Article 8 had been breached, the court observing that the margin of appreciation is substantially narrower where the interference with human rights concerns "someone belonging to a particularly vulnerable group in society that has suffered considerable discrimination in the past, such as the mentally disabled" (paragraph 41)

In finding a violation of Article 14 ECHR the court relied on similar factors as well, expressly, as the CRPD:

*76. The international standards and recommendations [...] encourage respect for equality, dignity and equality opportunities for persons with mental disabilities. Of particular relevance for the*

*facts of the present case, mentally-ill persons must receive appropriate assistance from the State in the performance of their child-rearing responsibilities, and children must not be separated from their parents without a proper judicial review of the matter of the competent authorities.*

### Short Note: disability and the contractual balance

In *TUV v Chief of the New Zealand Defence Force* [2020] NZCA 12, the New Zealand Court of Appeal made some interesting observations about the common law approach to contractual capacity (which is the same in New Zealand as in England & Wales, but not to that in Scotland, which follows the civil law here). The orthodox approach to capacity provides that a contract is voidable (not void, as it is in Scotland and in civil law countries) if:

- (a) that party lacked the mental capacity to enter into the transaction; and
- (b) the other party knew or ought to have known of that lack of capacity.<sup>1</sup>

The facts of TUV arose in a factual matrix irrelevant for these purposes, but the following observations are of wider relevance:

*The balance struck by the orthodox approach to capacity*

*[57] The law of contract seeks to strike a balance between respect for the autonomy of contracting parties and protection of the vulnerable, including*

<sup>1</sup> In New Zealand, the test is set down in the decision in *O'Connor v Hart*; in England & Wales, by *Imperial Loan Co*

*Ltd v Stone* [1892] 1 QB 599; see also *Dunhill v Burgin* [2014] UKSC 1.

*those who are vulnerable as a result of mental illness.*

*[58] If a party lacks capacity, and the other party knows this, there can be no justification for enforcing a contract between them if the incapacitated party (or their representative) wishes to set it aside. Similarly, if the other party is on notice that an individual may lack capacity, they should not be permitted to turn a blind eye to those circumstances and take the benefit of a contract that exploits that incapacity. Rather, if they refrain from making inquiries, they take the risk that the contract will be set aside because the other party lacked capacity to enter into it.*

*[59] But on the orthodox approach, a contracting party dealing with an individual who is not a minor can proceed on the basis that that individual has contractual capacity unless they know the individual lacks capacity, or are aware of circumstances that would put a reasonable person on inquiry about the individual's capacity. They can enter into contracts with that individual without needing to actively inquire into questions of capacity, absent such notice, and do not face the risk of subsequent invalidation of the contract on the basis of a lack of capacity. That approach is consistent with the objective approach to contract formation that underpins the common law of contract. It promotes certainty. It also reduces barriers to contracting for individuals, because other people who deal with them can assume capacity and do not need to make inquiries or take other active steps to ascertain their capacity.*

*[60] If capacity could not be assumed, then in some (potentially quite broad)*

*circumstances the risk of a contract being voidable for incapacity would incentivise businesses and other people entering into significant transactions with individuals to seek comfort on that issue: for example, by requiring a certificate in relation to capacity from the individual's lawyer or a doctor. That would increase the cost and practical difficulty of contracting for many individuals – not just those who do in fact lack capacity. The cost and inconvenience of steps of this kind could prevent entry into contracts that those individuals wish to enter into and would benefit from. In other cases, the contract would be entered into despite the cost and inconvenience of such steps, but that additional cost would be borne by the parties – including the individuals who were required to take steps to establish their capacity to enter into the contract. The purpose of the second limb of the test in *O'Connor v Hart* is to avoid creating barriers to contracting and costs of contracting of this kind.*

*[61] Nor, it should be noted, is this a test that has been developed solely – or even primarily – in a commercial context. *O'Connor v Hart* itself was a case about an elderly farmer selling a family farm. All cases about mental capacity by definition concern dealings by individuals. Many of these are family transactions rather than truly commercial transactions.*

#### RESEARCH CORNER

We highlight here recent research articles of interest to practitioners. If you want your article highlighted in a future edition, do please let us know – the only criterion is that it must

be open access, both because many readers will not have access to material hidden behind paywalls, and on principle.

This month, we highlight two outputs from the Wellcome-funded Mental Health and Justice Project. The first is an article by Dr Oliver Lewis and Professor Geneva Richardson on “The right to live independently and be included in the community” appearing in the International Journal of Law and Psychiatry, which offers a commentary on article 19 of the UNCRPD, drawing on its drafting history, on the interpretation provided by the responsible UN body and on the efforts by that body to monitor and encourage compliance. It emphasizes the extent of the transformation required to realize the full ambition of the article and the need for cooperation across UN treaty bodies.

The second, also on Article 19 CRPD, and appearing in the same journal, is by Emma Wynne Bannister and Sridhar Venkatapuram, and is entitled “Grounding the right to live in the community (CRPD Article 19) in the capabilities approach to social justice.”

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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](http://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), 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 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](#).

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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. 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 5<sup>th</sup> edition of the *Assessment of Mental Capacity: A Practical Guide for Doctors and Lawyers* (BMA/Law Society 2019). 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](#).

**Simon Edwards: [simon.edwards@39essex.com](mailto: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](#).

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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; 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.

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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 [here](#).

## Conferences

### Approaching complex capacity assessments

Alex will be co-leading a day-long masterclass for Maudsley Learning in association with the [Mental Health & Justice](#) project on 15 May 2020, in London. For more details, and to book, see [here](#).

### 2020 World Congress in Argentina

Adrian will be speaking at the 6<sup>th</sup> World Congress to be held at Buenos Aires University, Argentina, from 29<sup>th</sup> September to 2<sup>nd</sup> October 2020, under the full title “Adult Support and Care” and the sub-title “From Adult Guardianship to Personal Autonomy.” For more details, see [here](#).

### Other conferences and events of interest

#### Mental Diversity Law Conference

The call for papers is now open for the Third UK and Ireland Mental Diversity Law Conference, to be held at the University of Nottingham on 23 and 24 June. For more details, 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.

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Our next edition will be out in April. 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](mailto:marketing@39essex.com).

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