



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

(1) In the Health, Welfare and Deprivation of Liberty Report: updated MCA/DoLS guidance, the anorexia Catch-22, and two important cases on deprivation of liberty;

(2) In the Property and Affairs Report: remote witnessing of wills, professional deputy remuneration and the OPG annual report;

(3) In the Practice and Procedure Report: CoP statistics, short notes on relevant procedural points and the UN principles on access to justice for persons with disabilities;

(4) In the Wider Context Report: the NICE quality standard on decision-making and capacity, litigation friends in different contexts, and a guest piece giving a perspective on living with a tracheostomy and a ventilator;

(5) In the Scotland Report: the human rights blind spot in thinking about discharge from hospital in the context of COVID-19.

You can find our past issues, our case summaries, and more on our dedicated sub-site [here](#), where you can also find updated versions of both our capacity and best interests guides. We have taken a deliberate decision not to cover all the host of COVID-19 related matters that might have a tangential impact upon mental capacity in the Report, not least because the picture continues to change relatively rapidly. Chambers has created a dedicated COVID-19 page with resources, seminars, and more, [here](#); Alex maintains a resources page for MCA and COVID-19 [here](#) and Neil has resources on his website [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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## HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

### Updated DHSC MCA/DoLS Emergency Guidance

The DHSC's MCA/DoLS [guidance](#) has been updated on 7 September, in particular to make clear that remote assessment is not now expected to be the sole way of proceeding. In material part, the guidance provides that:

*To carry out DoLS assessments and reviews, remote techniques can be considered, such as telephone or video calls where appropriate to do so, and the person's communication needs should be taken into consideration. Views should also be sought from those who are concerned for the person's welfare.*

*Face-to-face visits by professionals are an important part of the DoLS legal framework.*

*These visits should currently occur if needed, for example to meet the person's specific communication needs, urgency or if there are concerns about the person's human rights.*

*When deciding whether or not to visit in person, DoLS best interests assessors and mental health assessors should work closely with hospitals and care homes to decide if visiting in person is appropriate, and how to do this safely. Visiting professionals should understand and respect their local visiting policies. Visitors must follow important local infection control policies in the setting that they visit, which are based on national government guidance.*

*DoLS best interests assessors and mental health assessors should work collaboratively with hospital and care home staff. They should be mindful of their distinct, legal duties under DoLS.*

The [additional guidance](#) has also been updated to address the fact that in some cases testing and other necessary measures will be needed for the purposes of procedures like elective surgery.

*For example, a person may lack the relevant mental capacity to consent to testing and self-isolation, before or after an appointment or surgery as an NHS inpatient. In this case, the decision-makers with responsibility for the person before and/or after the procedure, including family, care home staff and other professionals will need to work collaboratively with NHS professionals and consider what is in*

*the person's best interests. They may conclude that it is in the person's best interests to follow infection control procedures mandated by the hospital, in order to ensure that the procedure goes ahead. Joint working and communication will be important in these cases, as the hospital will be dependent on these decision-makers, in care homes and other settings, to ensure that these decisions are taken and implemented at the right time.*

The additional guidance also reflects the expectation that, in line with assessors, RPRs should undertake face-to-face visits if needed, for example to meet the person's specific communication needs, urgency or if there are concerns about their human rights.

The updated guidance can be found alongside other relevant guidance on Alex's MCA/COVID-19 resources page [here](#).

### The anorexia Catch-22?

*Northamptonshire Healthcare NHS Foundation Trust v AB [2020] EWCOP 40 (Roberts J)*

*Mental capacity – best interests – medical treatment*

#### Summary

This case concerned a 28 year old woman, referred to as AB, who had suffered from anorexia nervosa since the age of 13. At the time of the application she was severely unwell, and her treating clinicians applied to the court for declarations that AB lacked capacity to make decisions '*about treatment relating to anorexia nervosa*' and that it was in her best interests not to receive any further active treatment, even though she was at imminent risk of death.

The only possible option for treatment was said to be forced feeding via a tube inserted into her stomach, with physical restraint and sedation required to prevent her from removing the tube. She would need to be hospitalised at least 6 months and sedated as often as twice a day. Neither AB nor her doctors thought this was in her best interests. The case therefore concerned the first question only, namely AB's capacity.

It was evident that AB understood that her life was at risk and what the risks and benefits of treatment were. She filed a written statement in which she discussed her illness and differentiated it from herself, saying that her decision to refuse treatment was '*a decision made by me as opposed to my illness*'. She said that she had suffered during previous hospital admissions and had been in a cyclical pattern of admission and discharge with no endpoint. She said she understood that she would die if she did not eat, and the physical risks of the possible treatment, but had realised that she would never defeat the illness and so had chosen her future path: '*the decision not to undergo further inpatient treatment is mine. The illness is a part of me, yes. It is a voice, yes. It is a bullying and powerful voice, yes. But the voice making this particular decision is mine. It is a voice made hoarse by screaming, and tearful by the prospect of being forcibly treated against my will – knowing all the while both that any such treatment may cause my death in any event, and that, even were it not to, the likelihood of it 'working' is minute. I do not believe that anyone*

*would agree to undergo further inpatient treatment knowing what it entails, and if told, as I have been, that the chances of 'success' – whatever that actually means – are so low."*

It was agreed that AB had capacity to conduct the proceedings, but not that she had capacity to decide to refuse treatment. The Trust said that AB lacked capacity on that issue because she could not '*weigh and use information in the limited sphere of decisions relating to her need to put on weight*'. Her beliefs about the need to reduce her calorific intake were '*overvalued ideas*' to which she attached such extreme levels of weight that she could not properly weigh in the balance other factors. In a previous assessment in 2019, she had said that having the eating disorder made her feel safe, numbed her emotions and gave her a sense of achievement, and that she feared she would not be able to cope with normal life. The medical view was that there was '*no prospect*' of recovery from anorexia for AB.

Having formulated the decision in question as being one concerning the need to put on weight, the court found that AB lacked capacity, as her fixed beliefs about eating and weight were more than just her subjective values, and were preventing her from carrying out an appropriate weighing or balancing exercise. Even though AB understood the options and the risks, her eating disorder '*infected "to such a significant extent the very nature of her decision making processes which are engaged in relation to food, calories and weight gain that any decisions flowing from those processes cannot be considered as legally capacitous decisions."* So, even though AB did not give the wish to avoid putting on weight as a reason to refuse treatment, her capacity was still lacking. She "*may objectively appreciate that she will only avoid death in the weeks or months ahead if she finds the ability to overcome this illogical fear but she appears powerless to reach any other decision which will preserve her life. In my judgment, the fact that she does not want to die and sees many reasons to continue living are, in themselves, the clearest manifestation of the extent to which her judgment is impaired in relation to this narrow field of decision making."*

As a postscript, a possible appeal on AB's behalf against the finding that she lacked capacity did not proceed on her behalf following her death.

### Comment

It was said on AB's behalf that the reasoning as to her lack of capacity meant that no-one with anorexia nervosa could ever be said to have capacity to make decisions about medical treatment for that condition or any related problem. The corruption of her view of reality caused by her eating disorder could not be disentangled from her decision-making, even by reframing the decision in question as one about whether to agree to in-patient admission or palliative care, rather than to put on weight, and so there was effectively a non-rebuttable presumption that people with severe anorexia lacked capacity to make treatment decisions. The submissions put on AB's behalf reflect the proposals set out in the article by Emma Cave and Jacinta Tan (2017). [Severe and Enduring Anorexia Nervosa in the Court of Protection in England and Wales](#) *International Journal of Mental Health and Capacity Law*, which sought to rescue some autonomy for people with anorexia nervosa. It is difficult to disagree with the authors of that article that the court's approach, repeated in a number of cases, does suggest that people with severe and enduring anorexia nervosa will not be able to demonstrate they have capacity in relation to

medical treatment or any other decision that touches on their illness.

The case is also of interest as being one of the situations Munby J (as he then was) thought vanishingly unlikely – where P has capacity to conduct proceedings but not to make the decisions in issue:

*Whilst it is not difficult to think of situations where someone has subject-matter capacity whilst lacking litigation capacity, and such cases may not be that rare, I suspect that cases where someone has litigation capacity whilst lacking subject-matter capacity are likely to be very much more infrequent, indeed pretty rare. Indeed, I would go so far as to say that only in unusual circumstances will it be possible to conclude that someone who lacks subject-matter capacity can nonetheless have litigation capacity.” (Sheffield City Council v E & Anor [2004] EWHC 2808 (Fam)).*

It is indeed difficult to see how AB could have capacity to give a solicitor instructions about a dispute about her capacity to make a specific decision, while simultaneously lacking capacity to make that decision, particularly when the basis for her incapacity was said to be an enduring and strongly held belief that infected all of her thinking.

### Control, the acid test, and the policy of caution

*A Local Authority v AB* [2020] EWCOP 39 (Sir Mark Hedley)

*Article 5 – deprivation of liberty*

#### Summary

There have been very few cases concerning the meaning of deprivation of liberty in the context of adults since the immediate flurry of post-*Cheshire West* activity and the decision of the Court of Appeal in *Ferreira* about the position in relation to hospitals. The decision of Sir Mark Hedley in this case, handed down in late August 2020 but appearing on Bailii more recently, is therefore noteworthy. It is also noteworthy because it concerns the interaction between the two limbs of the ‘acid test’ set down by Lady Hale in *Cheshire West* to determine whether a person is confined.

AB was a 36 year old woman. She had been detained under the Mental Health Act 1983 and was then discharged under a Guardianship Order under s.7 MHA 1983 to a supported living placement. Her circumstances were described at paragraph 10 thus:

*AB lives in a flat in supported accommodation where there is always support available at any time of the day and night. She is broadly at liberty to do as she pleases within her own flat. She is free to leave the accommodation but her leaving and returning will always be seen by a member of the supervisory staff simply because of the geography of the property. She is required to reside at that property and thus if she fails to return the police would ordinarily be notified. There is extensive support available to her but it is support for her to take up or not as she pleases. She has a long record of being unable to look after her own accommodation and accordingly staff will enter her flat for the purposes of inspecting, cleaning or repairing. Indeed they will often wait for her to leave in order to do that so as to cause the least possible distress to her. It follows that they have access to her property whenever*



*they think fit.*

It was common ground (although this is not addressed in any detail in the judgment) that AB lacked capacity to consent to the arrangements in question; they were also clearly imputable to the state. The sole question referred to Sir Mark Hedley by the District Judge with conduct of the case, was therefore whether they amounted to a confinement so that all three limbs of the test for identifying a deprivation of liberty were made out. In answering that question, the issue in dispute was very narrow. It was common ground that the Guardianship Order (which included a condition of residence at the placement) meant that she was not free to leave the placement – the dispute was therefore she was **also** subject to continuous supervision and control so as satisfy the ‘acid test,’ Lady Hale having made clear that in *Cheshire West* that “[i]t is possible to imagine certain situations in which a person is not free to leave but is not under such continuous supervision and control as to lead to the conclusion that he was deprived of his liberty.”

Sir Mark Hedley noted that he had been referred to two decisions of trial judges in the Family Division who have had to consider the question of deprivation of liberty (*Re RD (Deprivation or Restriction of Liberty)* [2018] EWFC 47 and *Re HC (a Minor Deprivation of Liberty)* [2018] EWHC 2961 (Fam)). However, whilst he considered these cases to be “helpful,” he also noted at paragraph 9 that:

*it is vital to bear in mind that they relate to young people who would in any event have been under the watchful eye and authority of concerned parents had they not been in public care. The case of an adult is very different, for part of the rights of an adult are to behave in ways which others might regard as foolish without those others having the right of interference. Thus what may only be a restriction of liberty in a young person may yet be a deprivation of liberty in an adult.*

The Official Solicitor contended that AB’s circumstances amounted to continuous supervision and control; the local authority resisted that submission, arguing that “[t]hat the voluntary nature of the support, the freedom to come and go as she pleases and her freedom of action once she has left the accommodation speak more powerfully of a lack of continuous control and supervision” (paragraph 11).

As Sir Mark identified at paragraph 12, what made the case difficult was that both approaches were “inherently reasonable. This is a case at the borderline and is, as the law of the European Court recognises, ‘one of degree or intensity, and not one of substance or nature.’ There is a judicial judgment required.”

Sir Mark was clear that the mere presence of a Guardianship Order with a condition of residence of itself would not amount to a deprivation of liberty, even if it must be recognised that it is a very significant restriction of liberty. There would have to be something more, which, after “very careful consideration” he found there to be in this case:

13. [...] *it seems to me that the question of supervision and control must be viewed in the context of the prescribed condition of residence. Thus whilst she may be free to leave the property as she chooses, she is always subject to state control requiring her return should she be otherwise unwilling to do so. The fact that she generally willingly returns does not of itself negate this point. Again whilst*

*the supervision of her coming and going is not intrusive, it is the fact that all her movements are known and noted. Moreover, while she is free to do as she pleases in the community, there will inevitably be some obligation to restrain or control those movements should they become seriously detrimental to her welfare. That control could lawfully be implemented without recourse to the Court.*

*14. When considering a deprivation of liberty it is not sufficient just to see what actually happens in practice but to consider what the true powers of control actually are. Again the power to enter someone's private residence is a major intrusion on liberty however much, as it is here, it is to the benefit of the protected person for it to happen.*

*15. When looking at all these matters it is essential to consider them in the round and to ask whether in all the circumstances that actually prevail, or might reasonably come about, the arrangements amount to a deprivation of liberty. In my view they do here. In reaching that conclusion I have drawn upon the policy set out by Baroness Hale and that has, I should acknowledge, been a critical factor in my conclusion. However much these arrangements may be to the benefit of AB, and undoubtedly they are, one has to reflect on how they would be observed by an ordinary member of the public who, I strongly suspect, would regard them as a real deprivation of liberty. The policy that everyone should be treated the same leads me to the conclusion that I have set out.*

It should perhaps also be noted that Sir Mark also made the observation (at paragraph 12) that "*supervision and control should be viewed as separate requirements in considering [the acid] test and the word 'continuous' applied to both.*"

## Comment

This decision is logically impeccable, following clearly as it does the logic of *Cheshire West* (which, itself did no more than repeat the test for confinement set out by the European Court of Human Rights in *HL v United Kingdom* at paragraph 91). It also sits clearly in the line of Strasbourg case-law such as *Ashingdane* and *Stanev*, both cases in which the ECtHR found that the person in question was deprived of their liberty even though they were subject to periods of time when they were on unescorted leave (of one form or another) from the place where they were required to reside. The case is therefore a helpful reminder that a leash can be long, but so long as it remains a leash, it should be characterised as such.

What this case does not answer – because it is not a question that has yet been tackled head-on by the courts – is whether and how it is legitimate to look to the concept of 'valid consent' to see whether it might give a different approach. Indeed, it is perhaps striking that because it was common ground that AB did not have capacity applying the MCA 2005 test to consent to the arrangements, there was no consideration all in the judgment of how AB might feel about them. Some might feel (and Alex certainly is one of those – see this [paper](#)) that we should listen more carefully to those who have determined to lack capacity, and to reach a determination of whether they are deprived of their liberty based upon whether the circumstances amount to an overbearing of their will. We should emphasise that we have insufficient evidence in this case to be able to venture an opinion either way in AB's case,



but there will definitely be other cases where we might have a clearer idea; this case also makes clear that attempts to 'rein in' *Cheshire West* in this context by arguing about the objective element are likely to face an uphill struggle.

## Ducks, hats and deprivation of liberty – the Upper Tribunal grapples with conditional discharge

*MC v Cygnet Behavioural Health Ltd and SSJ* [2020] UKUT 191 (AAC) Upper Tribunal (AAC) (UTJ Jacobs)

Article 5 – deprivation of liberty

### Summary

UTJ Jacobs has confirmed that the decision of the Supreme Court in *MM* [2018] UKSC 60 does not serve as a bar to the Mental Health Tribunal "coordinating" the discharge of a patient on conditional discharge with the provision of authority under the MCA to deprive her of her liberty. As UTJ Jacobs noted:

*2. Every judge of the Upper Tribunal, the High Court and the Court of Appeal who has expressed a view has said this approach is permissible. The Supreme Court has declined to deal with the issue. No judge at any of those levels has said that it is not permissible. So what's the problem?*

He identified that there were three problems: (1) that not all First Tier Tribunal judges agreed; (2) whether the reasoning in *MM* undermined the reasoning in previous cases on patients who lack capacity, and in particular the reasoning of Charles J in *Secretary of State for Justice v KC and C Partnership NHS Foundation Trust* [2015] UKUT 376 (AAC), to the effect that authority to implement conditions selected by the MHA decision-maker giving rise to a deprivation of liberty could be given under the MCA; and (3) whether a patient's ECHR rights prevent the First-tier Tribunal from coordinating with the capacity decision-maker.

UTJ Jacobs did not have to address the first problem, as by his decision, binding on the First Tier judges, he would achieve consistency. Before turning to the second problem, he addressed the question as an issue of principle, helpfully encapsulating it in this way:

*11. [...] There are two regimes, governed by the 1983 Act and the 2005 Act. They deal with different things, but they are related. The mental health regime is concerned with detention on the basis of a mental disorder, a need to protect the patient or the public, and the availability of treatment in hospital. The mental capacity regime is concerned with the best interests of a person who lacks capacity to make decisions. Those are separate matters but they can interrelate. The mental health regime will involve a deprivation of liberty, and the mental capacity regime may do so.*

*12. The difficulty arises at the point of transition as a patient moves from the mental health regime to the mental capacity regime. Suppose that a patient has a mental disorder that requires treatment*

*for their benefit and the protection of others which could be given without the need to detain the patient under the mental health regime but only if the patient was not free to leave the place where they were living without being accompanied and supervised. The First-tier Tribunal has power to discharge a patient conditionally, but has no power to impose a condition that would involve a deprivation of liberty. The mental health regime requires the tribunal to take account of the possibility of treatment and protection being provided outside that regime, but how is that to be organised in a way that is compatible with the limited powers of the different decision-makers operating the two regimes? That is what underlies this case.*

UTJ Jacobs then undertook a review of the authorities, and noted that the Supreme Court in *MM* expressly did not deal with the issue of a patient who lacked capacity to consent to a deprivation of liberty; indeed, he considered that “[t]he terms of paragraph 271 also show that it did not consider that its reasoning might have an impact on such a patient. Otherwise, paragraph 27 of its judgment would not have been worded as it was. But it left open the issue open for later cases to decide.” He therefore concluded that the Supreme Court’s reasoning did not undermine Charles J’s decision in *KC* which (UTJ Jacobs considered) was “concerned with achieving a coherent interpretation of the 1983 and 2005 legislation in a way that was appropriate across the range of circumstances in which it might apply and did not leave gaps” (paragraph 25). UTJ Jacobs considered Charles J’s reasoning to be persuasive; he was equally persuaded by the judgment of Lieven J in *SR and JTA* [2019] EWCOP 28, which addressed the position from the perspective of the Court of Protection. He considered that it was “imperative” that the First-Tier Tribunal:

28. [...] apply the 1983 Act in a way that allows a patient to be discharged if there are means by which the patient’s case can be appropriately dealt with under other legislation. The 2005 Act is such legislation. If a patient’s case is to be dealt with correctly under the 1983 Act and fairly and justly under the tribunal’s rules of procedure, the tribunal is under a duty to find a way that allows both Acts to be applied in a co-ordinated manner.

He then turned to considering how the necessary “mental capacity arrangements” could be made. If authorisation had already been obtained (either by way of a DoLS authorisation where such was appropriate) or by way of an order from the Court of Protection, the tribunal could potentially proceed to a conditional discharge without further ado. Otherwise, he noted, there were two possibilities which had been canvassed – there might be other and better ones, but if there were he could not think of them, although he made clear that he did not intend to limit the Tribunal to these approaches if there

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<sup>1</sup> “27. 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, are not issues which it would be appropriate for this court to decide at this stage in these proceedings. Assuming that both are possible, and therefore that there might be an incompatibility with article 14, read either with article 5 or with article 8, it would make no difference to the outcome of this case. The outcome of this case depends upon whether it is possible to read the words ‘discharge ... subject to conditions’ in section 42(2) (dealing with the Secretary of State’s powers) and ‘conditional discharge’ in section 73(2) (dealing with the FtT’s powers) as including the power to impose conditions which amount to a deprivation of liberty within the meaning of article 5.”

was a more appropriate one.

The two approaches are:

1. “the different hats approach”: i.e. the same judge sitting in the Court of Protection and in the First-tier Tribunal to ensure that all decisions could be made that would allow the patient to be conditionally discharged on appropriate conditions and with the benefit of a deprivation of liberty authorisation. This had been the suggestion of the Court of Appeal in *MM* (and also, although UTJ Jacobs did not mention this, the approach proposed by the Law Commission in its Mental Capacity and Deprivation of Liberty report, at 12.79), and UTJ Jacobs made clear that he considered that this was lawful and appropriate.
2. “the ducks in a row approach”: i.e., if the “same hats” approach would not work, to adjourn, to make a provisional decision or to defer discharge in order to allow the necessary authorisation to be arranged (discussed further in *DC v Nottinghamshire Healthcare NHS Trust and the Secretary of State for Justice* [2012] UKUT 92 (AAC))

UTJ Jacobs noted that the choice between the two regimes:

*32. [...] may come to little more than a matter of preference for the tribunal. It may, though, depend on how sure the tribunal is that the mental capacity decision will be put in place and how confident it is of the terms of any such decision (the terms of the care package, for example).*

In terms of the third problem, the patient’s ECHR rights, UTJ Jacobs had little hesitation in finding that it was, in fact, no such thing. Charles J had held that there was no breach of either Article 5 read in isolation or in combination with Article 14 by virtue of the existence of parallel proceedings (overseen by parallel courts). He accepted the argument advanced by the SSJ that the existence of s.17(3) MHA 1983 leave, which meant that capacitous patients could be transferred from hospital to another placement, meant that, in fact, there was no discrimination in favour of those lacking capacity. UTJ Jacobs could see “no violation of the patient’s rights in providing a procedural route that works within the limited mental health jurisdiction of the First-tier Tribunal and is in the patient’s best interests. Quite the reverse” (paragraph 34).

## Comment

This judgment is helpfully clear as to the position and as to the potential options open in these parallel cases. Some, though, may want to read it in light of the observations of Charles J, now Sir William Charles, as to the impact of the decision in *MM*. In a speech given to the Judicial College (now to be found in the June 2019 Report), Sir William expressed deep concern at the use of the use of a back door route to bring about the imposition of what are, in effect, conditions dictated by the mental health decision maker in circumstances which he saw as contrary to the approach of the Supreme Court in *MM*. Given the reliance placed by UTJ Jacobs upon Charles J’s decision in *KC*, it would have been of interest to see what UTJ Jacobs made of the fact that Charles J himself now considered – albeit

extra-judicially – that the reasoning in that case had been undermined by the Supreme Court’s decision in *MM*.

The reality, of course, and as highlighted in the Report of the [Independent Review of the MHA 1983](#) (at page 202) is that it is fundamentally problematic that it is necessary to have two parallel regimes. Parliament needs to be asked to consider whether it actually wants the MHA 1983 to be able to be used to authorise deprivation of liberty in the community (outside the scope of s.17(3) MHA 1983). If it does, then it should provide a regime which enables express consideration of this, and express recourse to one judge, sitting with one hat in one court. Until then, and whilst the approach of UTJ Jacobs in this case is undoubtedly helpful in terms of ensuring that – on the ground – individual patients are not stuck, the overriding impression remains that the ducks are wearing hats that do not fit.

### Short note: what role clinical ethics committees?<sup>2</sup>

In *Great Ormond Street Hospital for Children NHS Foundation Trust v MX & Ors* [2020] EWHC 1958 (Fam), a medical treatment case concerning a 9 year old child, Roberts J had some important observations to make about clinical ethics committees. The case concerned treatment escalation in relation to a 9 year old child, who was at that point on the Paediatric Intensive Care Unit at Great Ormond Street Hospital. The observations – which are of wider relevance – are contained in two helpfully self-contained paragraphs:

*21. Referral to Ethics Committee. During her latest admission to PICU X's case was referred to and discussed by the Applicant Trust Ethics Committee on 15<sup>th</sup> May 2020, where the consensus reached was that further invasive treatments, including renal replacement therapy, were not in X's best interests and that the focus should be on palliative care to maximise her comfort and quality of life prior to death. Although no external second opinions were sought this process, regrettably it did not involve the 1<sup>st</sup> and 2<sup>nd</sup> Respondents. I was told that there is no protocol or definitive guidance for the constitution and conduct of Ethics Committees, particularly as to the involvement of patients or their families in the meetings and decisions. Counsel for the child (through her guardian) drew my attention to the UK Clinical Ethics Network which on its website notes that "Current practice of most UK CECs does not usually involve patients or their families and carers in the committee's discussion but some committees have considered cases at the request of a patient's family or carer."<sup>11</sup> In addition I was referred to an article, Newson, Ainsley J. "The role of patients in clinical ethics support: a snapshot of practices and attitudes in the United Kingdom." *Clinical Ethics* 4.3 (2009): 139-145, which I have read.*

*22. I consider that a lack of involvement by patients and/or their families is itself an issue of medical ethics and I am most surprised that there is not guidance in place to ensure their involvement and/or participation. While it is a matter of common sense and good practice for medical professionals and members of a multidisciplinary treating team to have discussions sans the patient or their relatives to enable an uninhibited and frank exchange of professional views and information without the need for the empathic, sensitive and supportive language used when speaking to patients and/or their*

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<sup>2</sup> Note, Tor has not contributed to this, having been involved in the case.

*families, the absence of any prior consultation or participation, cannot be good practice and should generally be unacceptable. Even at hastily assembled meetings there should be notice taken of the views of the patient and/or close relatives which could take the form of some written notes or letter submitted on their behalf. There should be guidance on patient/family participation and a clear protocol of how and when they are informed as to the arrangements being put in place for an Ethics Committee to meet along with being informed as to the outcome.*

These comments have provoked different reactions amongst ethicists: for contrasting views, see the blog posts by [Daniel Sokol](#) and [Dominic Wilkinson/Michael Dunn](#). At a minimum, though, the observations by Roberts J are important in focusing attention on the question of what, precisely, the role of clinical ethics committees (or, as many are known, Clinical Ethics Advisory Groups) is in the type of complex decision-making that is ever-prevalent in the clinical setting in relation both to children and adults with impaired decision-making capacity.

### DoLS in Wales

A [joint report](#) between the Care Inspectorate Wales and Healthcare Inspectorate Wales – delayed by COVID-19 – has now been published, looking at the position in 2018-19.

The key findings are:

- The total volume of applications received by local authorities increased by 6% in 2018-19. However, for health boards, the number of applications has remained relatively stable for the last two years.
- Roughly three quarters of applications sent to health boards are for urgent authorisations. Similarly, three quarters of applications sent to health boards are approved.
- The majority of DoLS applications are for individuals who are aged 65 or older.
- The vast majority of the applications that were refused were on the grounds of mental capacity. The authoriser required further evidence that the person lacked the mental capacity to make the decision in question before the DoLS application was accepted.
- Most Standard applications were not completed in 28 days. Supervisory bodies are unable to assure themselves that people's human rights are not being breached by being deprived of their liberty unlawfully.
- Very few people were referred to Independent Mental Capacity Advocates (IMCAs) or referred to the Court of Protection.

Amplifying this last point, a total of 64 referrals to the Court of Protection were made in 2018-19 from Wales. This is a fall of 18%, from 72 applications in 2017-18 to 59 in 2018-19. This means less than 2% of all DoLS in Wales were referred to the Court of Protection.

## PROPERTY AND AFFAIRS

### Video witnessing of wills

Legislation has been laid before Parliament to come into effect on 28 September 2020 to allow on a temporary basis for witnessing of wills to take place by video. The Wills Act 1837 (Electronic Communications)(Amendment) (Coronavirus) Order 2020 provides for the Wills Act 1837 to be amended with effect between 31 January and 31 January 2020 so as to allow for video witnessing. The legislation does not apply to grants of probate issued before this instrument was made, nor does it affect anything done pursuant to a grant of probate being issued prior to the legislation coming into force. This is the case even where the will was made on or after 31 January 2020. As distinct from grants of probate, the legislation does apply to grants of letters of administration (issued when a person dies without having made a will), provided that the video-witnessed will in question was made on or after 31 January 2020. The Explanatory Memorandum also makes clear that:

*The Government considered many other options for reform of will making in the pandemic, but has chosen not to pursue certain reforms in view of the perceived risks of undue influence or fraud against a testator. As such, the legislation does not amend Section 9(a) of the Wills Act 1837, meaning that neither the remote signing on behalf of a testator, nor the use of electronic signatures or counterpart documents are permitted under these reforms.*

It should perhaps be noted that **no** such equivalent legislation has been passed in relation to Lasting Powers of Attorney: as the OPG guidance makes clear, the relevant steps have to be taken in person.

Rather oddly, the guidance relating to the legislation was introduced in advance. It is available here. An interesting feature of the guidance is that it notes that:

*If possible, the whole video-signing and witnessing process should be recorded and the recording retained. This may assist a court in the event of a will being challenged – both in terms of whether the will was made in a legally valid way, but also to try and detect any indications of undue influence, fraud or lack of capacity.*

Putting aside the (substantial) potential complexities of retaining recordings, the recognition that capturing the signing and witnessing process might enable detection of the wider and more subtle factors at play (including, in particular the interaction between witness and testator) is an interesting one. Translated to other settings – for instance the grant of a power of attorney or (even) the assessment of capacity – the recognition that the written word alone may not capture the true position is an important one.



## Professional deputies and solicitors' rates

*The Public Guardian v Andrew Riddle (Nos 1 and 2)* [2020] EWCOP 41 (Senior Judge Hilder)

*Deputies – financial and property affairs*

### Summary

Senior Judge Hilder has considered at considerable (necessary) length the ability of a professional deputy who is not a solicitor to charge fees at the solicitors' rate, as well as making more general observations as to their duties.

In *The Public Guardian v Andrew Riddle (No 1)* [2020] EWCOP 41,<sup>3</sup> she held (at paragraph 104) that it would be appropriate to exercise the court's discretion to extend the solicitors' costs provisions to a non-solicitor deputy where that deputy demonstrates that he/she/it is also subject to professional obligations comparable to those integral to being a solicitor, and where that non-solicitor deputy accepts being held to the same standards as a solicitor. On the facts of the (several) cases before her, she was not satisfied that Mr Riddle met these two tests. She acknowledged that Mr Riddle was not alone in calling for a review of the fixed rates under Practice Direction 19B, as the rates have not increased since 2010 and The Professional Deputies Forum argues that rates are now therefore 31% lower in real terms than they were in 2010. She noted that, as of March 2020, a subcommittee of the Civil Procedure Rules Committee, with the agreement of the Master of the Rolls, was engaged in a review of solicitors' guidelines rates in civil cases, which have also not been increased since 2010. She observed at paragraph 107 that:

*there is undoubtedly force in the argument that the rates of Practice Direction 19B should be similarly reviewed. However, in my judgment, that does not provide any basis for unilaterally behaving as if the rates are other than as they are. Until there is a review - which, as already set out in *The Friendly Trust's Bulk Application*, is beyond the remit of proceedings such as these - I cannot give any weight to this part of Mr. Riddle's argument. To do so would simply be to subvert the Practice Direction.*

Of wider relevance, Senior Judge Hilder observed at paragraph 120 that, so as to ensure 'absolute clarity' for the future,

*Going forwards, so that there is absolute clarity from the outset, any non-solicitor applicant for deputyship who operates on a basis which involves VAT liability should specifically seek in their deputyship application authority to pass onto the protected person any VAT in respect of deputyship fees at the public authority rate. Specific provision can then be made in the appointment order.*

She also confirmed (at paragraph 131) that:

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<sup>3</sup> Oddly, available via hyperlink from the body of the judgment available on Bailii, and only in PDF.

*If a deputy acting under the fixed fee regime at the public authority rate wishes to reclaim from the protected person the costs of an Independent Visitor in addition to the fees set out in paragraph 16 of PD 19B, specific authority is required. An Independent Visitor does not provide "specialist services that P would normally have been expected to pay if P had retained capacity," and so any charges incurred do not fall within the 'disbursements' permitted by paragraph 20 of the Practice Direction.*

At paragraph 134, Senior Judge Hilder reminded deputies that:

*It is obviously important that returns are made to the OPG in a timely fashion. The very purpose of supervision of deputies is to protect the interests of vulnerable persons, so a deputy's failure to meet its obligations to the supervising body inevitably triggers concern. A deputy cannot fail to meet their obligations and then complain that questions are asked about their management of a protected person's estate. The onus is on the deputy to demonstrate that he is acting properly, and not on the Public Guardian to enforce compliance. Inadequate staffing resources is not an acceptable reason for failing to comply with reporting obligations but rather itself a cause for legitimate concern. It is part of the obligations of a paid deputy not to take on more appointments than he has resources to manage properly.*

On the facts of the cases before her, Senior Judge Hilder made orders refusing Mr. Riddle's applications for authorisation to charge fees at the solicitors' rate, refusing his applications for relief from liability for past charges, and giving Mr Riddle a very short further period of time to make good his words and restore each estate to its rightful level.

The subsequent judgment ([2020] EWCOP 41) contained confirmation that Mr Riddle had been good to his word, and that the Public Guardian did not now seek revocation of his appointment in those cases; it also contained specific supervision arrangements for him. The judgment also confirmed that Senior Judge Hilder had refused Mr Riddle's application to charge fees at anything other than the public authority rate, emphasising at paragraph 14(a) that "[t]he Court's determination of fees authorisation must be determined in the best interests of the protected person, not the business interests of the potential deputy," and that Mr Riddle had not demonstrated that he offered services over and above those which a public authority might be expected to provide."

As to costs, in the second judgment, Senior Judge Hilder agreed with the Public Guardian that each party should bear their own costs, and rejected Mr Riddle's claim for the Public Guardian to pay any of his own costs. Of wider relevance is her observation at paragraph 23 that:

*The Public Guardian should not be constrained from bringing complex and multi-faceted cases to the attention of the court by a fear of costs risks. These proceedings were procedurally complicated to manage and administer as the number of cases under consideration grew in a piecemeal fashion, as set out in paragraphs 17 to 27 of the first judgment. That context is an important consideration when determining any allegation by Mr. Riddle that the conduct of the Office of the Public Guardian during these proceedings was not appropriate. Any order for costs against the Public Guardian must be clearly based on demonstrable significant failings. I am not satisfied that there were such failings in*

this matter.

## Comment

The length and fact-specificity of the two judgments are understandable given the complexity of the cases before the court, but the principles derived and extracted above are admirably simple and clear, as well as uncompromising both in relation to the powers of non-solicitor deputies to charge, and as to their obligations as regards the number of cases that they should take on.

## Assessing capacity with one (judicial) hand tied behind the back

*King v The Wright Roofing Company Ltd* [2020] EWHC 2129 (QB) High Court (Queen's Bench Division (Kerr J))

*Other proceedings – civil – mental capacity – assessing capacity – finance – litigation*

## Summary

In this personal injury case, Kerr J had to decide whether the claimant had capacity to conduct the proceedings, and whether he had capacity to manage his property and affairs.

The factual background is somewhat complex, but its very complexity is at the heart of the issue, and set up a position where the judge had a seemingly overwhelming number of obstacles to overcome to answer the questions before him.

The defendant had admitted liability (subject to contributory negligence) after the claimant, a roofer by trade, fell from a roof and suffered a severe head injury, and other serious injuries, falling from a roof in March 2016. The claimant had only partially recovered from the accident. He could not longer work, has lost his income and had been living off the interim payments and beyond them, running up debts including to his parents with whom he had been living since before the accident. He had taken five or six holidays in the Dominican Republic, funded by interim payments.

The claimant issued the claim in March 2019 as a protected party, with a litigation friend. In its defence, the defendant denied that he lacked capacity to litigate and manage his financial affairs. These issues therefore came before Kerr J as preliminary issues.

The claimant did not give evidence but, the court was told, regarded himself as having capacity to litigate and manage his finances. He mistrusted his solicitors and others involved in the claim on his side. He was weary of and exasperated with the litigation. He had approached the defendant's insurers, bypassing his solicitors, with a view to reaching a settlement directly with the insurers. He had also made cynical remarks indicating that he regarded the litigation process as a money spinner for the professionals involved. They were, he maintained, exploiting his claim and being paid out of his compensation money. He had also expressed a desire to buy a property and settle in the Dominican Republic, where he said he had friends.

The claimant's solicitors were receiving instructions from the litigation friend. With the approval of the court, they were withholding certain interim payments from the claimant, wishing to protect him from squandering them. The Court of Protection appointed two deputies in February 2020 to manage his finances. The claimant's litigation friend and solicitors asserted that he did not have capacity to litigate this claim or manage the compensation he receives from it, applying the tests in the MCA 2005. They were concerned that he would "under-settle" the claim, squander the fruits of it and become unable to pay for the care he needs and will need for the rest of his life.

A trial on contributory negligence and quantum was scheduled to take place in a window from January to April 2021, i.e. at least 6 and potentially 9 months away. An offer or offers of settlement under CPR Part 36 had been made and rejected, but the judge did not know when and in what amounts. As he observed (at paragraph 9): "[e]ven if I did, I would be in no position to assess whether they are, objectively good, bad or indifferent from the claimant's perspective."

The evidence was voluminous, including both lay and expert. The judge was concerned about the fact that he did not hear directly from the claimant, noting at paragraph 119 that:

*The claimant, however, was not called by either party so I did not, unfortunately, hear from him directly. I understand he was aware that the hearing was taking place and was not willing to provide a statement. I am not privy to any privileged discussions with him about whether it would be a good idea for him to give evidence. I can see why neither side might want to risk calling him but it concerns me that, while all the experts have met him, I have not.*

Kerr J found the case a "worrying" one (paragraph 123), for several reasons.

First, relations between the claimant and his representatives were poor and, at or near the point of breaking down. With his former case manager, they have already broken down. With his litigation friend, his former partner, his relations were now very difficult. Kerr J did not criticise her, but noted that she clearly did not command the claimant's confidence nor, in turn, did the solicitors who received her instructions. This in turn, meant that his Counsel was put in difficulty properly representing his interests in court before me. As Kerr J noted (at paragraph 125), "[s]he is right, indeed obliged, to argue for the position of the litigation friend, supported by the solicitors but not by her ultimate client." But, he asked, this meant:

*126. Who, then, truly represents the claimant's viewpoint before me? The only party supporting his position is, paradoxically, his opponent in the underlying litigation. The interest of the defendant in the underlying claim is directly opposed to that of the claimant. It is no criticism of the defendant to say that it has a financial interest in the claimant settling the claim "fast and low".*

Second, Kerr J was very concerned at the costs of the satellite litigation concerning the claimant's capacity:

127. *Could not a joint expert on capacity have been appointed? Were four experts and six reports really needed? The directions hearings were attended by two counsel, again at considerable expense. Who is going to pay the costs of all these reports, the deputies, the Court of Protection application and the fees of solicitors and counsel?*

128. *Would it be fair for these costs to come out of the claimant's compensation if the defendant is right that he has capacity to litigate and manage his own finances? This is, of course, a question for me if and when that outcome is reached, but it is concerning that the claimant is, apparently, supportive of an outcome that could lead to a costs order that eats into his damages.*

129. *Viewed in that light, the claimant's suspicions that the professionals may gain financially at his expense are not as fanciful as they might seem. Dr Toone's description of his suspicions as close to "pathological" ought to imply that they are groundless, but it is not certain that they are.*

130. *The litigation friend and advisers had no choice but to act in what they consider the claimant's best interests, but that includes doing so at proportionate cost. It is obviously concerning to the claimant that his representatives are spending money on opposing his views and it is right that the money spent could, in principle (though it may be unlikely), deplete the net amount of compensation he eventually receives.*

Third, the claimant's approach to the defendant's insurers, "*while unorthodox and obviously inappropriate, [did] not lack a certain logic*" (paragraph 131):

*If the claimant and the defendant are right, the litigation friend and solicitors may have allowed the action to become mired in unnecessary cost and delay. And it is not necessarily wrong to reason that a bird in hand may be worth two in the bush.*

A fourth difficulty was that:

132. [...] *The content of the claimant's discussions with Mr Anderson, of the defendant's insurers, is probably relevant to the capacity issues I have to decide; but the conversations surely took place behind the "without prejudice" curtain. The claimant's privilege cannot reasonably be waived by his representatives even if the defendant were willing to waive privilege on its side.*

Against the backdrop of those difficulties, and after a discussion which is striking for its thoroughness, and merits reading in its full for its clear agonising over the position, Kerr J concluded that:

162. [...] *the present circumstances including the claimant's absence from court make it difficult to judge his capacity. The breakdown of relations between him and his advisers and the strained relations with his litigation friend are inhibiting the court from deciding the issues on the basis of the best available evidence. Doing the best I can, I am just persuaded that absence of capacity on both counts is at present proved on the balance of probabilities.*

Kerr J then turned to case management. He laid down a marker, inter alia, that it was a "*serious question of case management*" as to whether he could or should require the claimant to attend and give evidence,

or at least require his solicitors to convey to, the court's request to do so. He noted that it was an "open question" whether the court had the power to call a witness called by neither party.

He also noted that there was still time to change the litigation friend, either by consent or by order of the court. As he noted:

*172. Difficulties in managing cases such as this fairly and effectively may arise where it is the defendant's admitted tort that has, or may have, changed the victim's personality in such a way that he acquires a propensity to under-settle the claim. The law appears to permit the wrongdoer to take advantage of this by agreeing to settle the claim at less than its true value, in its own interest.*

*173. This is subject to the doctrine of undue influence and fiduciary duties that may be owed to vulnerable persons (cf. *Masterman-Lister v. Brutton & Co (Nos 1 and 2)* [2003] 1 WLR 1511, CA, per Chadwick LJ at [78]). But rather than have to resort to such doctrines, it is better for the claimant's interests to be protected by effective representation by persons in whom, even if lacking capacity, he has confidence.*

## Comment

This is a fact-specific decision but Kerr J's judgment alighted upon a number of important points of difficulty that are unlikely to be limited to this case alone, including as to the delicate position occupied by a litigation friend in circumstances where (as so often) the absence of capacity does not mean the absence of strong feelings on the part of the protected party. And he chose his words with care, no doubt, when identifying that the claimant might be said to have a point that the litigation appeared to have gained a life of its own which on its face did not appear to be of direct benefit to him.

Finally, and although it did not feature heavily in the discussion, the case is of some interest for highlighting the evidence of a neuropsychologist, Dr Carter-Allison, who carried out a clinic based cognitive assessment as part of the claimant's rehabilitation programme. She reported on 12 August. This included a "multiple errands task" carried out in Bexleyheath town centre by Dr Carter-Allison and a specialist occupational therapist. This test, as Dr Carter-Allison explained in her report, "evaluates the effect of executive function deficits on everyday functioning through a number of real-world tasks" such as shopping and writing down information. Such observational evidence is vital in the assessment of the situation where a person is said to lack capacity because of executive dysfunction, and this reminds us that in such a situation, a final determination can only be reached by combining assessment by interview and assessment by observation (see also here our [guidance note](#) on capacity assessment).

## OPG Annual report and accounts 2019/2020

This has just been [published](#). It contains a useful survey of performance over the year and sets out aims for the next 5.



Highlights include:

For the future:

*In the OPG business plan for 2019/2020 we had two key areas of work – OPG 2025 and the OPG business as usual (BAU). We have done a considerable amount of work in both areas – with some of the highlights given below.*

*Within the OPG 2025 programme we have taken forward work on:*

- research to understand what our users and potential users need from an LPA*
- 'Use an LPA', which allows our users to use an electronic version of an LPA – currently at private beta stage*
- our case management system, to the point where supervision cases can now be undertaken on the new system, as well as the registration of LPAs*

*Within the BAU sphere we have:*

- continued to work to achieve our targets and put resources into those areas where performance has not been to target*
- published our revised Welsh Language Scheme following approval by the Welsh Language Commissioner*
- continued to look at how we can get people into the OPG from a wide range of backgrounds – more detail of our work on social mobility can be found on page 26*
- produced a learning and development strategy and programme for the OPG and launched this within the agency*
- launched the processes for the supervision of Court Appointed Guardians for missing persons.*

Some interesting statistics:

*As at 31 March 2020 we were supervising 60,793 deputyship orders, an increase of 1,385 from the end of 2018/19 (59,408)*

*The number of applications to register LPAs and EPAs received in 2019/20 was 917,550 an increase of 81,600 on 2018/19 (835,950).*

*We ended the year with over 4.7 million current PoAs on the register*

*Average actual clearance time for power of attorney applications 40 days. Target: 40 days*

*Customer satisfaction survey % with PoA services (very or fairly satisfied) 89%. Target: 80%*

*Customer satisfaction survey % with deputyship services (very or fairly satisfied) 77%. Target: 80%*

*Customer satisfaction survey % with digital services (very or fairly satisfied) 95%. Target: 80%*

*% of safeguarding risk assessments carried out within 2 days 98%. Target: 95%*

*"Average time to conclude investigations 74 days. Target: 70 days"*

Significant achievements:

*Launched OPG's first ever marketing campaign in Islington and Leeds, receiving over 5,000 visits to our 'your voice, your decision' campaign site in the first six months.*

*Carried out research to explore the potential for a fully digital LPA service.*

*Built and tested the 'use an LPA' digital service to help attorneys use their LPA more easily.*

*Started research to look at the impact LPAs have had on our society and how we could further develop services to meet the needs of our customers.*

*Successfully migrated our data onto our LPA case management system, shutting down old systems and reducing costs.*

The "Use an LPA" project referred to in the report is now live, as we reported in the July issue, and [FAQs](#) about it can now be found in the OPG website.

## PRACTICE AND PROCEDURE

### Official Solicitor change of address

With effect from 24 August, the Official Solicitor and Public Trustee has moved. The address / DX details are now:

The Official Solicitor & Public Trustee Office  
Post Point 0.53  
102 Petty France  
London  
SW1H 9AJ  
(DX 152380 Westminster 8)

As staff will continue to work remotely, the Office asks that where you are able to send post / documents electronically that you continue to do so.

### E-applications pilot expanded

The pilot scheme established to allow electronic submission of straightforward property and affairs deputyship applications to the Court of Protection has been expanded to cover a further additional 10 professional users. Professional users (who must be on the PBA scheme) who want to be on the waiting list for any further expansion should contact Ross Hamilton ([ross.hamilton@justice.gov.uk](mailto:ross.hamilton@justice.gov.uk)).

### CoP statistics January – March 2020

Arriving like a voice from a far distant pre-COVID-19 past, the CoP statistics for the first three months of 2020 are now [available](#).

Highlights include:

- There were 805 applications relating to deprivation of liberty (DoL) made in the most recent quarter, down by 39% on the number made in the same quarter in 2019.<sup>4</sup> However, there was an increase of 41% in the orders made for deprivation of liberty over the same period, from 746 to 1,054. For the first time in this time series, the number of DoL orders made was higher than the number of applications made. Whilst several orders can stem from the same application, it is worth noting that the Court of Protection deployed more resource to the deprivation of liberty orders during 2019-2020;
- There were 8,267 applications made under the MCA 2005 in January to March 2020, down by 6%.

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<sup>4</sup> Unfortunately, and in an error that we understand will be corrected in the next iteration of the statistics, the breakdown that is usually provided of what these applications were for (i.e. 21A challenges, 'Re X' applications or otherwise) is not updated so it relates to the last quarter of 2019, rather than the first quarter of 2020.

Of those, 47% related to applications for appointment of a property and affairs deputy. In comparison, there were 13,829 orders made under the MCA 2005, up by 17% on the same quarter in 2019 (the highest quarterly volume seen since the start of the series). Of those, 36% related to orders by an existing deputy or registered attorney;

- In total there were 239,647 Powers of Attorney received in January to March 2020 up 5% from the same quarter in 2019. Lasting Power of Attorney (LPAs) made up 99% of POAs received in January to March 2020, with Enduring Powers of Attorney (EPAs) making up the other 1%. The sharp increase in LPAs seen during 2015 and 2016 was largely due to increased publicity and the new online forms introduced in July 2015 making it simpler and faster to apply. There were 2,239 EPAs in January to March 2020, down 20% on the equivalent quarter in 2019.

### Mediation and the Court of Protection

The interesting – and important - final report of the mediation and the Court of Protection roundtable held in June 2020 by Jaime Lindsey of the University of Essex has now been [published](#). It makes stimulating reading, not least as it does not shy away from the challenges, as well as the promise, of mediation.

### Short note: time running for appeals

In *McDonald v Rose & Ors* [2019] EWCA Civ 4, the Court of Appeal helpfully reminded practitioners of the rules that apply where a party wishes to seek permission to appeal from the lower court (which is good practice, but not mandatory). Although given by reference to the CPR, they are equally applicable to the position under the COPR. The rules are comprehensively summarised at paragraphs 21 and 22 and serve as a helpful guide through the sometimes complex positions that can arise given all the different ways in which decisions can now be handed down.

### Short Note: maintaining Zoom security

In a judgment reflecting the current world, the Divisional Court in *Gubarev & Anor v Orbis Business Intelligence Ltd & Anor* [2020] EWHC 2167 (QB) had to consider the position where a solicitor had shared the Zoom hearing link given to them to other persons without the permission of the court. As the court noted:

*50. During this pandemic, there have been temporary changes to the way in which parties and their representatives and others, including the media and the general public, have been permitted to obtain access to proceedings. Nonetheless, whether a court hearing is a remote hearing or a hybrid hearing, that is one that is partially face to face and partially remote, or a conventional face to face hearing, it must be conducted in a way that is as close as possible to the pre-pandemic norm.*

*51. In normal circumstances a judge can see and hear everything that is going on in court. The judge can see who is present, and whether a witness who is giving live evidence has been present in court*

*observing and listening to the evidence of other witnesses. The judge can see whether someone is attempting to influence, coach or intimidate a witness whilst they are giving evidence. The judge can immediately see, as Warby J did in the course of this hearing, that a person sitting in court who is not a journalist appears to be tweeting on their mobile phone without first obtaining permission. That a judge can see and hear everything that happens in court enables the judge to maintain order, discipline and control over what is done in court, and thus to maintain the dignity and the integrity of the proceedings as a whole. This control extends to the recording of images and sounds of what goes on in court and what is then used outside court.*

*52. Once live streaming or any other form of live transmission takes place, however, the Court's ability to maintain control is substantially diminished, in particular where information is disseminated outside the jurisdiction, as happened in this case. The opportunity for misuse (via social media for example) is correspondingly enhanced, with the risk that public trust and confidence in the judiciary and in the justice system will be undermined. In these circumstances, it is critical that those who have the conduct of proceedings should understand the legal framework within which those proceedings are conducted, and that the Court is able to trust legal representatives to take the necessary steps to ensure that the orders made by the Courts are obeyed.*

It is not surprising that, to put it mildly, the Divisional Court was underwhelmed by what had taken place on the specific facts of the case.

### Short note: access to documents filed in proceedings

In the [September 2019](#) report we covered the question of disclosure of documents from proceedings to the police and the wider question of access to documents. For completeness, the Supreme Court case of *Cape Intermediate Holdings Ltd v Dring (for and on behalf of Asbestos Victims Support Groups Forum UK [2019] UKSC 38* has now returned to the High Court, which has given further consideration ([\[2020\] EWHC 1873 \(QB\)](#)) to the question of how to apply the principles set down in that case to the question of whether access should be granted. As Picken J held (at paragraph 81):

*the Court should engage in the balancing exercise described by Lady Hale (as well as Lord Reed and Lord Toulson) and, in so doing, accord appropriate weight to the various different factors. The fact that a third party is seeking documents for collateral purposes which have only a limited connection with advancing the open justice principle will not, therefore, operate as a bar to the ordering of production but will be a factor which will weigh less heavily in the appropriate balancing exercise than if the position were otherwise and the documents sought would more significantly advance the open justice principle.*

### Access to justice in the context of disability

The three UN bodies that deal with disability rights have teamed up to issue the first-ever [guidelines](#) to help countries implement existing obligations to ensure effective access to justice for people with disabilities. The Special Rapporteur on the Rights of persons with Disabilities, the Committee on the Rights of Persons with Disabilities and the Special Envoy of the Secretary-General on Disability and

Accessibility have jointly published (on 28 August 2020) a set of 10 [Principles and Guidelines on Access to Justice for Persons with Disabilities](#).

As the introduction makes clear:

*While access to justice is fundamental for the enjoyment and fulfilment of all human rights, many barriers prevent persons with disabilities from accessing justice on an equal basis with others. Such barriers include restrictions on the exercise of legal capacity; lack of physical access to justice facilities, such as courts and police stations; lack of accessible transportation to and from these facilities; obstacles in accessing legal assistance and representation; lack of information in accessible formats; paternalistic or negative attitudes questioning the abilities of persons with disabilities to participate during all phases of the administration of justice; and lack of training for professionals working in the field of justice. In the justice system, persons with disabilities are often considered to be unworthy of, unable to benefit from or even likely to be harmed by due process protection provided to all other citizens. Even fundamental rights, such as the right to remain silent and the presumption of innocence, may be denied either directly in law or policy or indirectly in custom and practice. The risks are extreme – e.g. false confessions, erroneous verdicts and unlawful deprivation of liberty.*

The principles are as follows:

#### **Principle 1**

All persons with disabilities have legal capacity and, therefore, no one shall be denied access to justice on the basis of disability.

#### **Principle 2**

Facilities and services must be universally accessible to ensure equal access to justice without discrimination of persons with disabilities.

#### **Principle 3**

Persons with disabilities, including children with disabilities, have the right to appropriate procedural accommodations.

#### **Principle 4**

Persons with disabilities have the right to access legal notices and information in a timely and accessible manner on an equal basis with others.

#### **Principle 5**

Persons with disabilities are entitled to all substantive and procedural safeguards recognized in international law on an equal basis with others, and States must provide the necessary accommodations to guarantee due process.



## Principle 6

Persons with disabilities have the right to free or affordable legal assistance.

## Principle 7

Persons with disabilities have the right to participate in the administration of justice on an equal basis with others.

## Principle 8

Persons with disabilities have the rights to report complaints and initiate legal proceedings concerning human rights violations and crimes, have their complaints investigated and be afforded effective remedies.

## Principle 9

Effective and robust monitoring mechanisms play a critical role in supporting access to justice for persons with disabilities.

## Principle 10

All those working in the justice system must be provided with awareness-raising and training programmes addressing the rights of persons with disabilities, in particular in the context of access to justice.

The guidelines amplify each of the principles, and set out an important road-map towards making justice equally accessible to all.

The introduction makes clear that:

*The Principles and Guidelines are not intended to describe in detail a particular system of justice. Rather, drawing on the consensus of contemporary thought and on actual experience, they seek to set out what is generally accepted as good practice in guaranteeing, without discrimination, equal and fair access to justice, in accordance with article 13 and other relevant provisions of the Convention. In implementing the Principles and Guidelines, States should be cognizant of and address multiple and intersectional discrimination in access to justice. Consistent with their obligations under the Convention, it is also critically important that States closely consult with and actively involve persons with disabilities and their representative organizations.*

Without for one minute detracting from the hugely important challenge being laid down here to how things have traditionally been done in a whole host of systems simply because they always have been done that way, it should be noted that the guidelines accompanying the principles are infused with the hardline interpretation of Article 12 CRPD (the right to legal capacity) that has marked much of Committee on the Rights of Persons with Disabilities' approach to date. Compliance with Principle 1

therefore requires states to:

[...]

(c) Ensure that constructs such as “cognitive incapacity” and “mental incapacity”, as determined, for instance, by functional or mental status assessments, are not used to restrict a person’s right to legal capacity;

*(d) Repeal or amend all laws, regulations, policies, guidelines and practices that directly or indirectly restrict the legal capacity of persons with disabilities, including those that allow for substituted decision-making and those that require that a person be “of sound mind” to take any action, thereby excluding persons with disabilities from equal access to justice;*

[and]

*(e) Repeal or amend all laws, regulations, policies, guidelines and practices that establish and apply doctrines of “unfitness to stand trial” and “incapacity to plead”, which prevent persons with disabilities from participating in legal processes based on questions about or determinations of their capacity;*

Put another way, the guidelines might be thought to take the Committee straight back into the deeply problematic territory which we thought that they had now sought to avoid through their endorsement of the Australian Law Reform Commission’s proposal as a model for law reform compliant with Article 12.

However, this unhelpful complication aside, these principles, if taken seriously, would bring about a major, and crucial, transformation in ensuring both access to justice for disabled people, and, in turn, for their ability to use that access to secure their substantive rights.

## THE WIDER CONTEXT

### Living with a tracheostomy and ventilator

*[We are very grateful to Ginny Butcher, disability activist and law graduate, who we invited to share her experiences of living with a tracheostomy and ventilator, a perspective which we think may be of use for those who may be involved in decision-making in relation to such interventions where the individual in question has impaired decision-making capacity]*

Living with a neuromuscular condition is my area of expertise. I have a rare form of Muscular Dystrophy called Nemaline Myopathy. This causes a weaken of the musculoskeletal system; as a result, I am a full-time electric wheelchair user, I require two trained carers to be with me at all times, and I have a permanent ventilated tracheostomy. This is a plastic tube which sits in my trachea to create an artificial airway, it is connected to a ventilator.

As a young child I had a severe scoliosis of the spine. At age 11, my scoliosis was so severe that my lungs were being gradually crushed. To survive, I had to have titanium spinal rods fused to the full length of my spine, and have a ventilated tracheostomy inserted.

I have now lived with this tracheostomy for half of my life. I would like to present you with a brief, first-hand account of what it is like to live with invasive ventilation and everything that comes with it.

Please keep in mind that I can only speak from my personal perspective; that of a young woman, from a privileged background, with a non-disabled and supportive immediate family, with full cognitive function, and with limited physical ability. I am fully *compos mentis* and can therefore control, manage, and choose my own care. I cannot speak to other circumstances.

Being attached to a ventilator for 24 hours a day is a funny thing. The sensation of being ventilated (air pushed into your lungs at a set rate and pressure) is just something that one gets used to. It may be strange at first, but ultimately it is not distressing or uncomfortable. My ventilator is small and sits neatly on the back of my wheelchair, so I can move around freely. It is somewhat noisy, so one must get used to the sound at night-time, as must any roommates.

Most people with a tracheostomy change their tube maybe once a fortnight. For a plethora of reasons, I change my tube daily. My first ever tube change was very difficult; the stoma was raw and bloody, and stitches had to be pulled out. Tube changes were painful for perhaps a number of months after the operation. But now, after so long, this process is as simple and as dull as clipping one's toenails. It takes my two carers about ten minutes to do (this includes washing my neck and other hygiene add-ons) and is completely painless. I lie there and make conversation while they work.

My tracheostomy tube can block up with secretions, so there are two main medical procedures which I can undergo in order to solve this issue.

Firstly, suctioning. I feed a catheter down into my tube and suck out any secretions. I have a suction around 10 times a day, and I also use the Yankauer sucker for my nose and mouth. I am able to control all of my suctioning as I have use of my hands and arms (to an extent), and can therefore control how deep the catheter goes. Tracheal suctioning for me is completely painless, and it is such a part of my daily life that I hardly think about it. However, if I make a mistake and push the catheter in too deep, it can touch my lung tissue. This stings a little and may cause a small amount of bleeding, but there are no long-term effects.

Secondly, a cough assist. My carers connect my tracheostomy tube to a machine and it forces a high volume of air into my lungs and sucks it out again. This moves any secretions up my lungs so that I can suction them out. I use this machine daily, it takes only 10 minutes and actually makes me feel lovely afterwards as my lungs are hopefully clear and expanded. The sensation of using the machine is strange, perhaps a little uncomfortable, as my lungs are being stretched and vacuumed, but it is short lived.

There are some stresses which come with this form of invasive ventilation. The ventilator pipe can pop off at any moment, so I must have a carer nearby at all times in order to re-attach it. I can experience drowning if any water enters my tracheostomy tube, so my carers are careful when bathing me and I try not to enter any water fights. I must be extremely hot on charging ventilator batteries and carrying spares wherever I go. Ventilator batteries are not my only piece of baggage; I take four bags of equipment whenever I leave the house. This is bothersome, but it can mostly be left in the car, so it is manageable.

I would say, overall, the tracheostomy and ventilator have greatly improved my life. Prior to my operation I was ventilated via a face mask. This meant that I struggled with eating (I was forced to have a gastrostomy inserted) and speaking. With the tracheostomy, I can eat and talk 'normally'. Having completed a LLB, LLM, and LPC, this has come in very handy. There was a concern that I would be unable to talk after having the tracheostomy inserted, but I am lucky in the sense that I retained my ability to verbalise.

This form of invasive ventilation definitely comes with an array of burdens and struggles. But I know for me, I have learnt over time how to manage and accept these things. I absolutely have days where I feel uncomfortable, breathless, tired, or even self-conscious, but not to an extreme level. I live a full and energetic life; I have been rock climbing, abseiling, canoeing, and zip wiring all with my ventilator strapped to my body. I have flown a plane and completed a half marathon and acted in a professional play.

My tracheostomy and I have a complicated relationship, but we live in precarious harmony. Personally, I would much rather be alive and living with a tracheostomy and ventilator, than be dead.

## Learning disability and contraception – survey

Jodie Rawles is part of a team, based at the University of Cambridge, conducting research around the contraception decisions of people with learning (also known as intellectual) disabilities. Research tells us that lots of people with learning disabilities use contraception, but very little is known about how these decisions are made.

To find out more, the team have produced an anonymous, online survey for people who are, or have been, involved in the lives of adults with learning disabilities. The survey takes approximately 15 – 45 minutes to complete. They would really like to hear from you if you have been involved in the lives of people with learning disabilities in some way, whether that be as a family member, support worker, legal professional, or in some other capacity.

You are eligible to take part if:

- You are above the age of 16
- You have been involved in the lives of adults (aged 16+) with learning disabilities within the last five years
- The time that you have spent with adults with learning disabilities has been in England or Wales

While the survey questions are focused on contraception decisions, you do not need to have been involved in the contraception decisions of adults with learning disabilities before to take part.

To find out more or take part, please see [here](#).

## NICE Quality Standard: Decision-Making and Mental Capacity

In August 2020, NICE published [QS194](#), a quality standard covering decision making in people aged 16 and over, using health and social care services who may lack capacity to make their own decisions (now or in the future). It aims to support implementation of the aims and principles of the Mental Capacity Act 2005 and relevant Codes of Practice. It is not a substitute for these. As NICE rather ruefully notes, it was *“developed before the coronavirus pandemic and is intended to support quality improvement as services return to normal. Please tell us if there are any particular issues relating to COVID-19 affecting its use that should be highlighted.”*

The quality standard is based around four ‘quality statements’:

- [Statement 1](#) People aged 16 and over who may lack capacity to make decisions are supported with decision making in a way that reflects their individual circumstances and meets their particular needs.
- [Statement 2](#) People aged 16 and over at risk of losing capacity to make decisions, and those with fluctuating capacity, are given the opportunity to discuss advance care planning at each health

and social care review.

- [Statement 3](#) People aged 16 and over who are assessed as lacking capacity to make a particular decision at the time that decision needs to be made, have a clear record of the reasons why they lack capacity and the practicable steps taken to support them.
- [Statement 4](#) People aged 16 and over who lack capacity to make a particular decision at the time that decision needs to be made have their wishes, feelings, values and beliefs accounted for in best interests decisions.

Against each quality statement are a set of quality measures which are designed to enable measurement of whether the statements are being met, as well as an indication of what the statement means for different audiences, including the relevant individuals themselves.

### Hospital discharges and Continuing Health Care

On 21 August 2020 the NHS COVID-19 [guidance](#) on hospital discharge was comprehensively updated. This document makes clear that the usual obligations under the MCA 2005 continue to apply. As such, if there is reason to believe that an individual lacks capacity to make decisions about ongoing care and treatment then a capacity assessment should be carried out followed by, where relevant, the making of a best interests decision (see p.13).

The guidance also indicates that testing is required prior to discharge to a care home:

*DHSC/PHE policy is that people being discharged from hospital to care homes are tested for COVID-19 in a timely manner ahead of being discharged (as set out in the Coronavirus: adult social care action plan), regardless of whether they were residents of the care home previously or not. Where a test result is still awaited, the person will be discharged if the care home states that it is able to safely isolate the patient as outlined in Admission and Care of Residents in a Care Home guidance. If this is not possible then alternative accommodation and care for the remainder of the Hospital Discharge Service Policy and Operating Model required isolation period needs to be provided by the local authority, funded by the discharge funding. (p.7 para 3.13)*

From 1 September 2020, CHC assessments and Care Act 2014 assessments will recommence in England (the NHS having paid for care packages from 19 March to 31 August 2020 for patients discharged from hospital or who would otherwise have been admitted to hospital). Specific [guidance](#) on the reintroduction of CHC was published on 21 August 2020.

In summary, NHS funding will be provided (in addition to existing local authority and CCG funding) to help cover the cost of post-discharge recovery and support services for up to a maximum of six weeks following discharge from hospital. During that period, an assessment of the individual's longer-term needs (including a CHC assessment and an assessment under the Care Act 2014 if relevant) should be undertaken. The expectation is that these assessment processes will be completed within the six week period, and CCGs will not be able to rely on the additional NHS discharge support funding at the



end of this time.

## Who Pays?

Updated “Who Pays?” guidance has been published on NHS England’s website, and came into effect from 1 September 2020. The guidance sets out the framework for establishing which NHS body in England is responsible for paying a provider of healthcare services for an individual’s NHS care and treatment. It is to be used as the basis for resolving any relevant funding disagreement in relation to historic or ongoing cases.

The core principle remains unchanged that the commissioner responsible for payment will be the CCG of which the patient’s GP practice is a member, although the guidance does outline some exceptions to this (see section D, paragraphs 12-19).

The main changes concern stays in hospital (paragraph 13), discharge from hospital and continuing care (paragraph 14) and s.117 aftercare under the MHA 1983 (paragraph 18). There are also new, compulsory arrangements for dispute resolution (Appendix 1 and Appendix 4). It remains the case that uncertainty about which commissioner is responsible for funding should not lead to the refusal or delay in providing treatment.

## Article 2 in the community

Those following the Melissa Lee inquest will be aware that it concerns the death of a 26 year old woman, with a complex history of mental health problems and substance abuse, who is understood to have died from a drug overdose in 2016. At the time of her death, Ms Lee was an outpatient whose mental health difficulties were being treated through a care plan which provided for care and treatment in the community.

In 2017 the coroner decided that the inquest did not engage Article 2 ECHR because there was no arguable case that the state had breached the operational duty under Article 2 or the systemic duty under Article 2 in the context of a mental health service user receiving services in the community. Ms Lee’s mother successfully challenged this decision by way of judicial review ([2019] EWHC 3227 (Admin)), with the court finding that the reasons given for the finding that the Article 2 operational duty was not engaged were inadequate. As such, this matter was remitted back to the coroner for fresh consideration; the coroner’s decision in this regard (given in December 2019) has recently become available via the Mental Health Law Online website. In short, the coroner has found that the Article 2 operational duty was not engaged and also that it was not arguably breached on the facts of Ms Lee’s case.

In deciding whether the Article 2 operational duty was engaged the coroner applied the three “indicia” identified by the Supreme Court in *Rabone v Pennine Care NHS Trust* [2012] 2 AC 72 said to assist in assessing whether the Article 2 duty applied in a new situation not previously considered by the courts: (i) assumption of responsibility and exercise of control; (ii) the vulnerability of the person concerned;

and (iii) the nature and degree of the risk involved. The key aspects of the coroner's reasoning in this regard were as follows:

*The first of the three "indicia" is assumption of responsibility. Melissa was a young woman who at the relevant time apparently had mental capacity to make decisions as to her own care. She was living independently in the community, in her own home. She was receiving social care assistance and clinical care for personality disorder in the community. The Trust had produced a care plan in conjunction with Melissa herself, and the objective of that plan was to promote her personal autonomy. Its guiding principles and provisions were intended to underpin her care and support her in living independently, rather than to place her under supervision. Accordingly, and as explained by Dr Mitchell, the plan sought to avoid unjustified hospital admissions in the best clinical interests of the patient.*

*In my view, the situation in Melissa's case did not involve assumption of the level of responsibility by the state which has been found in the cases where the Article 2 duty is owed. The state did not exercise close supervision or control, as in the cases involving detention or a situation closely comparable to that of detention. It did not take responsibility for overseeing Melissa's daily life. It did not assume responsibility by creating a danger for her, as has been the case in some of the authorities.*

[...]

*The second of the three "indicia" is vulnerability. It is true that, in one sense, Melissa was more vulnerable than most people in the community, in that she had mental health problems which presented an established propensity for self-harm (with the risk of serious harm). However, she did not demonstrate the kind of helpless or acute vulnerability which Lord Dyson instances at para. 23 of the Rabone case (there, a child known to be at risk of abuse). Melissa had mental capacity at the relevant times, and was involved in the care plans which were made for her. She exercised self-will and had the means and ability to request help. To the extent that she was vulnerable, it was an inherent vulnerability to her own condition.*

[...]

*The third of the three "indicia" is the nature and degree of risk. Again, it is true that Melissa presented a particular kind of risk. However, it was a long-term, chronic risk of self-harming which fluctuated and at over a long period entailed the possibility of inadvertent, serious harm. This nature and degree of risk can be seen from her previous episodes of self-harm and from the sequence of events in the months and weeks leading up to her death which I have summarised above. Although there were signs of dangerous behaviour in the period leading up to Melissa's death, the records indicate that similar signs could have been identified at many times in the past. In Rabone at para. 24, when referring to this feature, Lord Dyson suggested that the question was whether or not the risk was "ordinary" for individuals of the kind in question (his example being that of soldiers in a combat zone). The risk of self-harm and suicide in Melissa's case was chronic and was sadly consistent with her condition. The best available guidance, and the advice of clinicians, supported her living independently despite that chronic risk.*

The coroner went on to find that even if the Article 2 operational duty was engaged, there was no arguable breach. In particular, it was said that there was no point at which clinicians ought to have appreciated that Ms Lee presented a real and immediate risk of death in circumstances where there was a history of self-harming behaviour that was part of Ms Lee's chronic clinical presentation, and where Ms Lee was under a regime of care whereby she was only to be admitted to hospital where that was necessary to deal with immediate management of a crisis and for clear and specific therapeutic purposes.

As such, while every individual case will turn on its facts, this particular case demonstrates the difficulties in attempting to extend the Article 2 operational duty to mental health service users being treated in the community, as opposed to those who are being detained or whose hospitalisation amounts to a high degree of control being exercised by agents of the State.

### Article 2 – systemic vs individual failures in the context of DNACPR

The Divisional Court has recently handed down judgment in *R (Iroko) v HM Senior Coroner for Inner South London* [2020] EWHC 1753 (Admin), a challenge to the relevant coroner's ruling that there was no requirement to hold an Article 2 compliant inquest in that particular case. In circumstances where the Hospital Trust had made a "do not resuscitate" ("DNR") decision<sup>5</sup> without having consulted with the deceased's family, the Claimant argued that Article 2 required an examination of whether there were systemic failings underlying Trust's failure in this regard.

The challenge was dismissed, with the court finding that there was no systemic failure which would trigger the need for an Article 2 compliant inquest. That was because the Trust's DNR Policy was clear that, in taking a DNR decision, clinicians were required to consult with family members. In so far as the clinicians here failed to comply with the DNR Policy, that was an individual error in the face of systemic requirements (see paragraph [40]).

### Short Note: the EAT and litigation capacity

*Stott v Leotec* [2020] UKEAT 0263\_19\_2002 is an interesting case which considers when the court should properly consider that a party before it lacks capacity to conduct proceedings.

The Appellant in the case brought a claim for unfair dismissal having been sacked from his job as a sequence picker for twice having breached rules preventing him from leaving his "work cell" during a shift. The Appellant was agreed to be disabled by reason of mental impairment, namely anxiety. His claim for unfair dismissal was not successful however, the Employment Tribunal determining that it was neither substantively nor procedurally unfair.

He appealed to the Employment Appeal Tribunal, representing himself and settling his own notice of appeal and skeleton argument. At the Preliminary Hearing, however, he advised the court that he had

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<sup>5</sup> In fact, it was not a Do Not Attempt Resuscitation decision, but a Do Not Attempt CPR decision.

problems with both mobility and Autistic Spectrum Disorder. At the hearing before the EAT, he was represented by an Employment Law Appeal Advice Scheme (“ELAAS”) representative: a barrister acting in a pro bono capacity on his behalf<sup>6</sup>.

At the commencement of the EAT hearing, the Claimant’s ELAAS representative addressed the Court, taking on the role of friend of the Court (“amicus curiae” as formerly known) rather than on the Claimant’s behalf, to raise concerns she had regarding his litigation capacity. She noted that he had previously been determined to lack litigation capacity in unconnected possession and committal proceedings and was in position of a certificate as to capacity from a psychiatrist. With reference to the *Assessment of Mental Capacity: A Practical Guide for Doctors and Lawyers* – edited by Alex – the ELAAS representative submitted that if the court were to proceed with the appeal without considering further the question of the Appellant’s capacity, it would be acting unlawfully.

Naomi Ellenbogen QC, sitting as a Deputy High Court Judge, acknowledged that she had not been referred to any authority directly concerning the EAT’s power to appoint a litigation friend. Nonetheless, she determined that following the judgment in *Jhuti v Royal Mail Group Ltd* [2018] ICR 1077, once invited to investigate a party’s mental capacity, the ETA should only accede to such an approach where there is clear evidence to support it (para 8.i). Noting the lack of any clear Rules or Guidance to be followed in the EAT in such circumstances, she recorded the Court’s hope that “urgent consideration” would now be given to implementation of powers regarding proceedings involving protected parties. She adjourned the appeal in order that up to date evidence as to the Appellant’s litigation capacity could be sourced.

As Naomi Ellenbogen QC remarks in her judgment, it is significant and concerning that some 2.5 years after the “urgent” need for rules regarding the treatment by tribunals of those lacking capacity had been identified by the Court of Appeal in *AM (Afghanistan)* [2017] EWCA Civ 1123 no obvious progress has been made in this area. It is equally troubling that, but for the pro bono representation with which the Appellant was fortunate enough to have been provided, the matter might never have been raised.

### Short note: litigation friends and liability for costs

*Glover v Barker, Con fiance & Barker* [2020] EWCA Civ 1112 concerns the vexed subject of when litigation friends in civil proceedings should be liable for costs.

It is a fiendishly long and complex judgment arising out of the fiendishly long and complex litigation regarding negligent tax advice given to the Claimant, Mr Barker, regarding the creation of an employee benefit trust (“EBT”). The EBT created a sub-trust of which it was intended that Mr Barker’s five children from three different relationships would become beneficiaries. Due to the negligent advice, however, it was necessary for Mr Barker to seek to wind up the sub-trust. He launched proceedings in order to do so; a compromise was agreed which provided for £1 million to be settled on discretionary trusts for

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<sup>6</sup> Katherine Apps of 39 Essex Chambers, who has not contributed to this note.

the benefit of one of Mr Barker's children, Euan, and the principal beneficiaries of the sub-trust. The compromise was reached on the basis that Euan was acting as representative for all of Mr Barker's Principal Beneficiaries. In fact however, two of his minor children – his eldest children, twins, and their mother, were unaware of the settlement, or indeed the claim.

A claim was then made on behalf of the twins with their mother acting as litigation friend, seeking to set aside the order authorising the compromise. It was not successful and a costs award was made against the company said to be the children's assignee. The costs were not paid and the company representing the twins was wound up.

In further litigation brought by the twins by their litigation friend and mother that followed, the court held that, had it been asked to approve the order compromising the original proceedings, it would have had "no hesitation" in approving the settlement; further, that even if it had been aware that the twins were not aware of the proceedings and that their brother was not representing them, the settlement would, in all probability, still have been approved. The parties sought the costs of the application as against the children's litigation friend. The judge refused to make a costs order against the twins directly but did order their mother and litigation friend to pay the costs of all the other parties.

This costs order was the subject of the Court of Appeal judgment. The judge at first instance had determined that "*[w]hen considering whether to make an order for costs against a litigation friend, who has acted for an unsuccessful child party, the court should apply the general approach that, as regards costs, the litigation friend is expected to be liable for such costs as the relevant party (if they had been an adult) would normally be required to pay. The governing rule is that the court has regard to all the circumstances of the case and it is open to the litigation friend to point to any circumstance as to their involvement in the litigation which might justify making a different order for costs from that which would normally be made against an adult party.*"

Allowing the litigation friend's appeal, Newey LJ giving a judgment, with which LJJ Patten and Moylan agreed, held that while it remained the case that liability for costs should typically be imposed on a claimant's litigation friend, this was with the important caveat that, "*when deciding whether to make such an order, the Court is exercising a discretion and entitled to have regard to the particular circumstances of the case*" (paragraph 62). Holding further that there was not a "*general principle to the effect that a defendant's litigation friend should be liable for such costs as the child or protected party would normally be required to pay*", Newey LJ set down this helpful precis of the law at paragraph 64:

*i) ....where a litigation friend has not previously given an undertaking to pay the costs at issue, the power to make an order for costs against a litigation friend derives exclusively from section 51 of the 1981 Act;*

*ii) When deciding whether an order should be made against a litigation friend under section 51, the "ultimate question" is "whether in all the circumstances it is just to make the order";*

*iii) It will typically be just to order a claimant's litigation friend to pay costs if such an order would have been made against the claimant himself had he not been a child or protected party, but it remains the case that the Court is exercising a discretion and entitled have regard to the particular circumstances;*

*iv) There is no presumption that a defendant's litigation friend should bear costs which the defendant would have been ordered to pay if not a child or protected party. That the litigation friend controlled the defence of a claim which succeeded will not of itself generally make it just to make an adverse costs order against the litigation friend. Factors that might, depending on the specific facts, be thought to justify such an order include bad faith, improper or unreasonable behaviour and prospect of personal benefit. If a director causes his company to litigate "solely or substantially for his own benefit" (to quote Lord Brown in *Dymocks*), that may point towards a costs order against him. The fact that a litigation friend stands to gain a substantial personal benefit must also, I think, be capable of weighing in favour of a costs order against him.*

Following this analysis, the Court of Appeal allowed the litigation friend's appeal and set aside the costs order made at first instance.

While this judgment is useful for the encyclopaedic review of the law it sets out on the subject, its main takeaway, as is increasingly the case it seems in the Court of Appeal, is that the award of costs is a matter for the discretion of the court to be determined by the facts of the particular case.

### The 'frozen' attorney

Whilst we await – we hope – further guidance on the position in relation in the next iteration of the MCA Code of Practice/from the OPG, Alex has given some thoughts on his website as to the – not uncommon – situation where an attorney is empowered to make a decision but cannot bring themselves to make it.

#### 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 the special issue of the International Journal of Law and Psychiatry drawing on the work of the Mental Health and Justice Project. Amongst other articles, it includes an article co-written by Alex on Taking capacity seriously? Ten years of mental capacity disputes before England's Court of Protection.



### BOOK REVIEW

[A Practical Guide to the Law of Medical Treatment Decisions](#) (Ben Troke, Law Brief Publishing, 2020, c£39.99)

Ben Troke, a solicitor and partner at Hill Dickinson, expresses the hope in the introduction in this new book that in it, he can “*set out a practical overview that might be helpful not only to lawyers in the field, but also to clinicians and to any individuals who have an interest in how crucial medical treatment decisions will be made for ourselves and our families.*” He succeeds triumphantly in his goal, in a book which is accessible, accurate, timely (including discussion of COVID-19), personal (in the right way), and even in places surprisingly funny. In a (relatively) short compass, he manages to cover a huge amount of ground, covering both the position in England & Wales both in respect of children and in respect of adults; importantly, he also never loses sight of the fact that – more here than anywhere else – the law and ethics are in constant conversation.

Many who buy this book may well be doing to get an overview of the key issues, and I suspect that many of those who do so will indeed be clinicians as Ben anticipates. They will gain a huge amount from it, and, in many cases, it will provide them all that they need to be able to think through matters from themselves (and/or – which is just as important – stop and ask themselves whether now is the time to go and consult a lawyer). However, even for the real enthusiasts who already have on their bookshelves works such as the monumental [Principles of Medical Law](#) or the slimmer, but still very dense (in the right way) [Medical Treatment: Decisions and the Law](#), the book will make a stimulating read.

*Alex Ruck Keene*

[Full disclosure, I had sight of this book, and made comments upon it, in draft form, and was also provided with a copy by the publishers.]

## SCOTLAND

### Decision on Judicial Review jurisdiction overturned

In the [February 2020](#) Report we covered a decision by the Outer House in *Terri McCue as guardian of Andrew McCue* holding that the court had no jurisdiction to hear an application seeking judicial review of a refusal by Glasgow City Council to take into account, in calculating charges to be made in accordance with the Council's Charging Policy, the full amount of the "disability-related expenditure" of Andrew McCue. Lady Wolffe held that the jurisdiction of the court was excluded because the petitioner had an available alternative remedy in the form of a complaint or application to the Ombudsman for all of the grounds of challenge contained within the Petition.

That aspect of Lady Wolffe's decision has now been overturned on appeal. The Judgment of the Inner House, delivered by Lady Dorrian, the Lord Justice Clerk, was issued on 21<sup>st</sup> August 2020 and is available [here](#). The court held that this question turned upon the interpretation of section 7(8)(c) of the Scottish Public Services Ombudsman Act 2002, under which the Ombudsman must not investigate any matter in respect of which the person aggrieved has or had a remedy by way of proceedings in any court of law. The court held that this wide reference covered proceedings by way of judicial review. Where proceedings for judicial review had been presented, and there remains the possibility of a successful remedy thereby, the jurisdiction of the Ombudsman is ousted, at least insofar as it relates to any complaint which asks the Ombudsman to address the same matter as addressed in the judicial review. Where the complainer elects not to pursue judicial review, the Ombudsman has a discretion to decide whether to accept the complaint. This however does not mean that the court may never decide to dismiss a petition for judicial review on the basis that it is a matter more appropriate for the Ombudsman. The court may do so, either at the permission stage or later, if it becomes clear that the matter is not one amenable to the supervisory jurisdiction. But the jurisdiction of the court was not thereby excluded.

However, in this case the applicant had failed to demonstrate that the issues raised by her were amenable to judicial review, so her appeal failed on those grounds, notwithstanding that she was successful on the question of jurisdiction.

*Adrian D Ward*

### Equalities and Human Rights Committee and related matters

On 1<sup>st</sup> September 2020 the Scottish Government's Interim Director-General, Health and Social Care, wrote to the convener of the Scottish Parliament's Equalities and Human Rights Committee. The letter is available [here](#). Annex A to the letter is headed "Lessons learned from reducing delayed discharges and hospital admissions". One positive aspect is a strongly-worded assertion that reform of the Adults with Incapacity (Scotland) Act 2000 is required by 2021. That must be right. The widespread "blind spot" in Scotland in relation to issues of deprivation of liberty, contrary to Article 5 of the European

Convention on Human Rights, was addressed as long ago as 2014 by Scottish Law Commission, but the pace of urgently required law reform has slowed more and more ever since, and while we have welcomed the measured approach of the Scott Review, into which AWI reform has been incorporated, that is a consequence of the decision to sideline AWI reform while mental health law aspects of the Scott Review's remit catch up.

The blind spot is evident in Annex A. Circumstances which appear to amount to deprivations of liberty without due process leap out from the pages, but the topic of deprivation of liberty and how it should be addressed does not feature once. "Successes" in reducing the incidence of delayed discharge appear to treat human beings as statistics, without reference to basic human rights. Annex A states that: *"When people were discharged from hospitals into long stay care home beds, this was because they had been assessed as needing a care home place and went with their agreement and that of their families. As much as possible this was directly to their first choice of home. A few areas reported moving some people to interim care home beds in advance of a bed in their choice of care home becoming available, but noted that this could result in other problems, so over time they did this less. More commonly people were only being moved once, when their care home of choice became available."* If such a patient had adequate capacity to consent to the move competently, the agreement of families is quite irrelevant. If families were deciding the matter without lawful authority, that was clearly wrongful. If, as appears to be implied, people lacking capability to agree competently were being moved to a care home rather than returned to their own home without due process compliant with Article 5, that was a violation of Article 5; all the more so if they were moved to somewhere other than their own choice of placement.

The report states that: "Powers of attorney and anticipatory care plans/DNACPR: Individuals admitted to hospital with existing cognitive impairment and difficulties with decision making were identified early by health and social work staff, who then engaged with individuals and families to promote power of attorney and anticipatory care plans." That raises serious concerns as to what authority existed for decision-making upon admission to hospital. Starting the process of granting a power of attorney or making an anticipatory care plan will not help at that point in time; the references to cognitive impairment and difficulties with decision-making point towards lack of adequate capacity to do either; and – yet again – the reference to involvement of families is seriously problematical, suggesting either unauthorised decision-making or a failure to recognise lack of capacity and to guard against the risk of undue influence. There is no reference to utilization of section 47 of the 2000 Act, or of any other lawful procedure to authorise treatment.

This all arises against the background of evidence provided by the Law Society of Scotland to the Equalities and Human Rights Committee of known cases where DNACPR notices have been permanently applied to the records of patients for no reason other than that facilities to treat them were not available when they first presented to hospital; and cases where notices had been attached to the records of all the residents of particular care homes that they should not be admitted to hospital in any circumstances.

We understand that it has been admitted in the context of current proceedings before the Court of Session by *Equality and Human Rights Commission against Glasgow Council and others* that transfers of patients from hospital to a particular facility were unlawful deprivations of liberty.

It is perhaps unfortunate that failures in provision unrelated to the pandemic seem to be either ignored altogether or impliedly blamed upon the pandemic. For example, there is no reference to the long-term failure on the part of local authorities to recruit, train and retain adequate numbers of mental health officers, so that breach of the explicit statutory obligation upon local authorities to produce MHO reports within 21 days of intimation of intention to seek a guardianship order with welfare powers is almost universal, with the statutory time limit regularly exceeded by many months; all prior to the pandemic.

The "blind spot" in relation to Article 5 was clearly demonstrated in the case of *Borders Council v AB* which we described in the [December 2019](#) report. It was plainly obvious that implementation of the order sought in that case would amount to a deprivation of liberty, yet the mental health officer suggested that it would not, until the sheriff put him right. Moreover, to ensure lawful compliance with Article 5, the sheriff imposed a strict six-month time limit on the guardianship order, yet it is understood that in that and other similar cases the "stop the clock" provisions mean that deprivation of liberty has continued unlawfully beyond time limits explicitly set by sheriffs.

Some countries have notified temporary derogation from Article 5 by reason of the pandemic. The United Kingdom has not done so. Article 5 contains explicit rights to redress. One trusts that Scottish Government and relevant local authorities are budgeting for this; though it would be far better if they were to recognise the fundamental human rights of people involved in their decision-making, including their focus upon arithmetical "success" in reducing delayed discharges.

*Adrian D Ward*

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## Conferences

Members of the Court of Protection team are regularly presenting at webinars arranged both by Chambers and by others.

Alex is also doing a regular series of 'shedinars,' including capacity fundamentals and 'in conversation with' those who can bring light to bear upon capacity in practice. They can be found on his [website](#).

### **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 October. Please email us with any judgments or other news items which you think should be included. If you do not wish to receive this Report in the future please contact: [marketing@39essex.com](mailto:marketing@39essex.com).

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