



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

(1) In the Health, Welfare and Deprivation of Liberty Report: updated DHSC MCA/DoLS COVID-19 guidance, an important LPS update, and the judicial eye of Sauron descends on new areas to consider (ir)relevant information;

(2) In the Property and Affairs Report: a complex case about when the settlement of an inheritance;

(3) In the Practice and Procedure Report: for how long does a Court of Protection judgment remain binding, and helpful guidance for experts reporting upon capacity;

(4) In the Wider Context Report: challenging reports about the disproportionate effect of COVID-19 upon those with learning disability, young people with learning disability and autism under detention, and capacity and public hearings before the Mental Health Tribunal;

(5) In the Scotland Report: discharge from hospital without proper consideration of ECHR rights.

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. 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 a page [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.

Editors

Alex Ruck Keene
Victoria Butler-Cole QC
Neil Allen
Annabel Lee
Nicola Kohn
Katie Scott
Rachel Sullivan
Stephanie David
Simon Edwards (P&A)

Scottish Contributors

Adrian Ward
Jill Stavert

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

Contents

HEALTH, WELFARE AND DEPRIVATION OF LIBERTY	2
Updated DHSC MCA/DoLS Emergency Guidance.....	2
LPS update – goodbye care home managers (and hello some ideas about draft regulations) 3	
More for the files on (ir)relevant information for important decisions.....	5
Severe depression and medical treatment.....	8
Short Note: the court and dental clearance.....	10
DoLS statistics for England.....	11
Advocacy: a call to arms.....	11
PROPERTY AND AFFAIRS.....	12
Trusts and benefits.....	12
PRACTICE AND PROCEDURE.....	14
For how long does a Court of Protection judgment remain binding?	18
The inherent jurisdiction, deprivation of liberty and out of hours applications.....	22
The habitual residence checklist (and an observation about necessity)	26
Court of Protection Users Group meeting	30
THE WIDER CONTEXT	31
Why have so many people with learning disability died of COVID-19?.....	31
Detention of young people with autism and/or learning disability: Government commitments?	31
'Out of sight – who cares?: Restraint, segregation and seclusion review'.....	33

Short note: an (odd?) inconsistency of judicial concern about deprivation of liberty	35
Capacity and public hearings before the Mental Health Tribunal	36
Report and webinar – learning from SARs.....	37
Mental Health Law Online – forum (and website update)	38
Short note: when is it right to be held to the consequences of your own actions?.....	38
Short note: suicide and the burden of proof	39
BMA assisted dying survey.....	41
INTERNATIONAL DEVELOPMENTS	42
Human Rights Indicators on the CRPD	42
World Psychiatric Association “call to action”. 42	
Research corner	43
SCOTLAND	45
What does the rule of law count for?	45

HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

Updated DHSC MCA/DoLS Emergency Guidance

The [latest iteration](#) of the guidance (11 November) now updates the main and additional guidance to take account of the new (English) lockdown regulations as of 5 November. In respect of DoLS assessments, it reads as follows:

To carry out DoLS assessments and reviews, remote techniques should 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, for example for DoLS assessments, are an important part of the DoLS legal framework. These visits can occur if needed, for example to meet the person's specific communication needs, in urgent cases or if there are concerns about the person's human rights.

National restrictions begin in England from 5 November 2020. Further information about the new restrictions can be found [here](#).

During and after the national restrictions in England, visits by professionals can occur if needed. Decisions around visiting are operational decisions and ultimately for the providers and managers of individual care homes and hospitals to make. DoLS professionals 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, including for individual hospitals and care homes. The government's policy for family and friends visits to care homes has recently been updated and contains practical advice about how to facilitate safe visits, which will also be useful for DoLS professionals.

Similarly, professionals in Wales are required to comply with any additional setting guidance or location specific guidance for Wales when considering professional DoLS visits.

Similar guidance is given in relation to IMCAs

and RPRs (helpfully expressly referring to unpaid RPRs) in the [additional guidance](#).

LPS update – goodbye care home managers (and hello some ideas about draft regulations)

In the minutes of the LPS Steering Group meeting held on 13 October 2020, published as part of the new LPS documentation [page](#), it was revealed that the Government has decided that it would **not** bring these provisions into force in April 2022. The minutes of the LPS Steering Group meeting on 13 October 2020 explain the position:

DHSC officials acknowledged that the role of the care home manager in the MC(A)A2019 has always been contentious. They explained that the Government has heard representations from across the sector, both for and against this role, and considered its potential very carefully. The Government has decided not to implement this aspect of the MC(A)A in England, for now. The relevant provisions in the Act will therefore not be commenced in April 2022.

The care home manager role was originally designed so that people who know the person and understand their wishes and feelings, could lead the LPS process, with the added benefit of reducing the burden on local authorities and CCGs. These aims are still valid, but the Government has decided that now is not the right time to introduce the role. Instead, the Government will focus on introducing all other aspects of the LPS; and working productively with stakeholders to ensure that implementation in 2022 is a success.

Staff who care for the person every day and therefore know them best will, alongside the person's family and friends, still play a vital role throughout the assessment process and during the consultation stages of the LPS process, in particular by helping decisions makers to establish the person's wishes and feelings. The Government will keep the case for the role under review as it prepares for LPS, and as the system is implemented. The Government's thinking on this issue will also be informed by responses to the public consultation on LPS, planned for 2021.

Our view is that this is an eminently sensible decision (and not just because the care home manager proposal had not appeared in the underlying Law Commission proposal). It caused deep unease amongst many – including many care home managers who felt that they were put in an impossibly conflicted position. It also looked like, in many cases, simply being unworkable because of the need to provide so many restrictions upon whom the care managers could call upon that it would have ended up being more complicated and more expensive than simply having the responsible body coordinate the assessment process.

The minutes of the meeting set out DHSC's position as to what five of the six anticipated sets of regulations will cover:

- The Independent Mental Capacity Advocate (IMCA) role under LPS will be set out in regulations. These regulations will amend existing IMCA regulations set out under the MCA. IMCAs will, for example, have the power to prepare a report in relation to the arrangements or proposed arrangements for the Responsible Body.
- Eligibility criteria and statutory training needed to be an Approved Mental Capacity Professional (AMCP) under LPS will be set out in a distinct set of regulations. Required training will include a conversion course for Best Interests Assessors (BIAs) under the Deprivation of Liberty Safeguards (DoLS) to become AMCPs under LPS. The regulations will explain which bodies will deliver the required training for the AMCP role. Practising Social workers, nurses; Speech and Language Therapists, psychologists and occupational therapists will be eligible for the AMCP role. These regulations will also include a definition of a prescribed connection to a care home. Individuals who meet that definition will not be able to act as an AMCP in certain cases.
- A set of transitional regulations will set out the legal framework for LPS and DoLS to run alongside each other for the first year of implementation. This will ensure that people who are subject to a DoLS authorisation or a Court Order, that runs into the first year of LPS implementation, are still able to access the necessary safeguards until their authorisation or Order ends.
- A set of assessments regulations will set out who is able to carry out assessments and determinations under LPS.
- A set of consequential regulations will amend other pieces of legislation that will need updating as a result of the MC(A)A2019.
- The policy decisions needed to inform drafting of the sixth set of regulations governing monitoring and reporting of LPS

in England would work are still being made. The policy decisions needed to inform drafting of the sixth set of regulations governing monitoring and reporting of LPS in England would work are still being made. The draft regulations will from part of the public consultation in Spring 2021 and the Government will take into account the outcome of that consultation before it takes final decisions about the design of LPS.

The next major milestone is likely to be the publication of the revised Impact Assessment in Autumn 2020. This assessment will cover the policy at the time of the primary legislation and will not take account of policy detail set out in the draft regulations (these will be covered by future impact assessments).

Alex's [LPS resources page](#) has been updated to take account of these developments, as has his [guide](#) to LPS.

More for the files on (ir)relevant information for important decisions

A Local Authority v GP (Capacity - Care, Support and Education) [2020] EWCOP 56 (HHJ Christopher Dodd)

Mental capacity – care – education

Summary

In this case, HHJ Dodd helpfully turned the eye of Sauron onto three areas of capacity that have not previously been the subject of judicial consideration. The court had to consider whether a young man, aged 19, had capacity to make a decision to accept or refuse care and support, and also to make decisions in relation to education. HHJ Dodd broke down each aspect in turn.

Refusal of assessment of care and support needs pursuant to s.11 Care Act 2014

HHJ Dodd identified this was the correct formulation of the decision in issue for purposes of s.15(1)(a) MCA 2005. Drawing upon the agreed position of the Applicant local authority and the Official Solicitor on behalf of GP, HHJ Dodd held that the information relevant to the decision will include:

- a. *A local authority has a statutory duty to meet a person's eligible care needs, which may be to prevent or delay the development of needs for care and support or reducing needs that already exist.*
- b. *The assessor may speak to other adults or professionals involved in GP's care and that GP may refuse to consent to this.*
- c. *The local authority will assess how GP's wellbeing can be promoted and whether meeting these needs will help GP achieve his desired outcomes.*

HHJ Dodd disagreed that relevant information included that "[t]he importance of GP participating as fully as possible in decisions related to the assessment of his needs and how those needs can be met," holding (at paragraph 22) that:

In my view, this is a value judgment rather than information relevant to GP's decision to refuse a Care Act assessment and is in any event too nebulous to amount to "the reasonably foreseeable consequences of deciding one way or another".

To make decisions as to his care and support

HHJ Dodd noted that guidance on what

information is relevant to this decision was formulated by Theis J in *LBX v K, L and M* [2013] EWHC 3230 (Fam) and approved by the Court of Appeal in *B v A Local Authority* [2019] EWCA Civ 913, namely: (a) with what areas GP needs support; (b) what sort of support GP needs; (c) who will provide such support; (d) what would happen without support, or if support was refused; and (e) that carers may not always treat GP properly, and the possibility and mechanics of making a complaint if GP is not happy.

The Applicant suggested, in addition, that in GP's case the relevant information would include:

- a. *why having a support worker is important to GP to access the community;*
- b. *the importance of structure and routine in GP's day;*
- c. *the importance of regular access to the local community to build and maintain his confidence in daily life and independence and to avoid a deterioration in his anxiety;*
- d. *the importance of developing relationships with others outside of his close family to build and maintain his confidence in daily life and independence and to avoid a deterioration in his anxiety, to avoid a dependency upon his close family members and to develop his own interests and opportunities for a social life with peers;*
- e. *the opportunities that may be available to engage in training, education, volunteering or employment.*

However, HHJ Dodd observed that:

26. *With one exception, these*

additional factors strike me as comprising (or at least incorporating) not facts but somewhat nebulous value judgments. The desire to ensure that GP takes full advantage of the services potentially available to him is laudable but has resulted, in my view, in the tail of welfare beginning to wag the dog of capacity.

27. *The exception is: "e. the opportunities that may be available to engage in training, education, volunteering or employment." This is certainly information, but it is not a salient feature of a decision about care and support.*

To request an EHC needs assessment under section 36(1) of the Children and Families Act 2014

HHJ Dodd observed that this formulation of the question was better than that advanced by the applicant ("to request or refuse an assessment of his education and health care needs for an education, health and care plan (EHC plan) pursuant to s.36 (1) of the Children and Families Act 2014"), because, as he held at paragraph 28, this had "*the attraction of greater simplicity and the omission of the reference to GP deciding to refuse an EHC assessment: as I understand it, if the obligation to carry out such an assessment is triggered under s.36, GP would not be entitled to decide that it should not be carried out.*"

HHJ Dodd endorsed the agreed position as to the following information being relevant:

- a. *An EHC plan is a document that says what support a child or young person who has special educational needs should have;*
- b. *Other people will be consulted during the assessment process including*

parents, teachers and other professionals;

- c. If assessed as requiring an EHC the young person has enforceable right to the education set out within their plan.*
- d. An EHC plan is only available up to the age of 25 years.*

HHJ Dodd did not agree with two further pieces of information suggested to be relevant by the applicant local authority:

- a. "If assessed as requiring an EHC plan, social care and health needs may be included on the plan and this may be advantageous to GP in having his needs met." HHJ Dodd held that this added nothing to (a) above;
- b. "The local authority would agree to 'lapse' GP's EHC plan this year, and he may reconsider next year but it may be difficult to seek an EHC plan after that." HHJ Dodd found that the possibility (of uncertain extent) that "it may be difficult to seek an EHC plan" is too nebulous to amount to relevant information.

To make decisions as to his education

HHJ Dodd agreed with this formulation rather than that advanced by the applicant (i.e. "to make decisions about his education and health care needs pursuant to the Children and Families Act 2014").

On this issue, there was not agreement between the appellant and the Official Solicitor as to the relevant information; HHJ Dodd did not resolve the disagreement, but indicated that, in the event that the parties could not agree, the formulation of the relevant information advanced by the

Official Solicitor, namely:

- a. The type of provision.*
- b. The type of qualifications, if any, on offer.*
- c. The cohort of pupils and whether P would match the profile of other pupils at the provision.*
- d. That P has additional rights up to the age of 25 because of his special educational needs.*

The independent expert, Dr Rippon, had said in evidence:

I think education is broader than just qualifications. I think education also has an important component in supporting a YP's social and emotional needs. YP who are having education via remote working are missing a key component of what school is. It is about supporting their development as an individual and it supports their emotional wellbeing in addition to just being somewhere you gain qualifications.

HHJ Dodd indicated that in this regard he had found helpful:

37. [...] the following passage from the decision of Macur J (as she then was) in In LBL v RYJ and VJ [2010] EWHC 2665 (at paragraph 58)

"In Dr Rickard's view it is unnecessary for his determination of RYJ's capacity that she should understand all the details within the Statement of Special Educational Needs. It is unnecessary that she should be able to give weight to every consideration that

would otherwise be utilised in formulating a decision objectively in her 'best interests'. I agree his interpretation of the test in section 3 which is to the effect that the person under review must comprehend and weigh the salient details relevant to the decision to be made. To hold otherwise would place greater demands upon RYJ than others of her chronological age/commensurate maturity and unchallenged capacity."

38. *Whilst I do not doubt the accuracy of Dr Rippon's observation that "education is broader than just qualifications" (indeed, it is almost a cliché), I fear that to require GP to understand and weigh the nature and extent of the social and personal development opportunities which might be available to him would be to do precisely what Macur J decided against, namely placing greater demands upon him than others of his chronological age/commensurate maturity and unchallenged capacity.*

On the facts of the case, HHJ Dodd found that GP did not have capacity in any of the relevant domains.

Comment

This is a very useful addition to the canon of cases which give guidance as the categories of information which is likely to be relevant (or irrelevant) to particular decisions – although such cases should always be read subject to the injunction in *B v A Local Authority* that the guidance must always be tailored to the specific

situation of the individual in question.

As a further point, it was extremely helpful that this judgment gave an indication in its title as to what it was about; this practice, common in family proceedings, could usefully be more widely adopted in Court of Protection cases as we otherwise drown in an ever greater deeper alphabet soup.

Severe depression and medical treatment

University Hospitals of Leicester NHS Trust v TC & Ors [2020] EWCOP 53 (Cobb J)

Capacity – best interests – medical treatment

Summary

In this case, Cobb J was required to consider an urgent application for a best interests decision with respect to carrying out chemoradiotherapy and an endoscopic resection and/or tracheostomy (as well as authorising any deprivation of liberty).

TC was a 69-year old with advanced cancer of the larynx, which was only diagnosed on 7 September 2020 and had become increasingly life-threatening. She suffered from longstanding anxiety for which she took anti-depressant medication. The deterioration in her health meant that she required hospital admission on 6 October 2020.

Following her diagnosis on 7 September 2020, she was offered two treatment options – surgery or chemotherapy ("CRT"). The surgery would involve a total laryngectomy (removal of TC's voicebox) and bilateral neck dissections (surgical removal of lymph nodes in both sides of her neck). Depending upon the histology following surgery, she might still require

radiotherapy. At that stage on 7 September 2020, and following discussions, TC made a capacitous decision to undergo a course of CRT.

On 9 September 2020, TC presented as confused and her anxiety levels were noted to be higher, which was not unusual given the diagnosis. Her presentation, however, deteriorated; and her behaviour became increasingly erratic. On 16 September 2020, she met with the consultant oncologist; and discussed the proposed treatment again. She signed the consent form for CRT. She attended a planning appointment on 22 September 2020 and no concerns were raised. She was able to discuss the treatment and side effects. After that appointment, however, there was a gradual decline in TC's physical and mental health. She was unable to discuss the proposed treatment and she behaved irrationally. She refused to eat and drink and became too weak to get out of bed.

TC was assessed as lacking capacity to make decisions regarding the proposed treatment as a result of her depression and chronic anxiety on 7 October 2020. The capacity evidence before the court concluded that the impairment of TC's mind was such that she was unable to make a decision to proceeding with a treatment option, namely the CRT. She was also unlikely to regain capacity in the short term, and particularly within the relevant timescales, given the urgency of the treatment – the progression of her condition meant that, if nothing were to be done, she would die within the next few weeks.

The Official Solicitor obtained and presented a second opinion to the court on TC's mental capacity. That opinion concluded:

TC has demonstrated that she is able to

understand and retain information in regard to her diagnosis and the treatment interventions available. She is also able to communicate her decision. However, as a result of her depressive illness, she is experiencing symptoms of hopelessness and does not consider that she has a future. As is typical in severe depression she is experiencing catastrophic thinking. As a result, she is unable to weigh up the information she has been given in order to make a capacitous decision. It is therefore my view that TC lacks capacity to make decisions about her medical treatment. (emphasis added)

On the basis of the evidence before him, Cobb J was satisfied that TC lacked capacity to make a decision about this medical treatment.

Regarding the treatment options, the surgery and CRT offered a 60% chance of being curative (meaning that TC had a 60% chance of overall survival for 5 years after treatment; thereafter a patient's odds of longer term survival are significantly improved).

The options had, however, been rendered more complicated because the tumour had grown significantly. Preparatory work was therefore required that would debulk the tumour (either through a micro-debrider, last treatment, or treatment that vaporises the tumour). If one of these procedures failed, then a tracheostomy would be required. It was acknowledged by all the treating doctors and the family that TC would not want this, but it was necessary to ensure the integrity of the airway before CRT is commenced.

The expert evidence indicated that the long-term cure rate was in the region of 60-70%. He also laid out the survival rate if all treatment were

refused, as well as the risks and complications associated with the procedures.

In terms of TC's views, she had signed a written consent form to the treatment on 16 September 2020 (when she was capacitous), but she subsequently refused the treatment. Her family supported the treatment.

In considering best interests, Mr Justice Cobb started with the presumption that it was TC's best interests to stay alive (*Aintree v James* [2013] UKSC 67); and observed that without the proposed treatment TC would die, and soon. He was entirely satisfied that the proposed treatment was in her best interests; and that it was the least restrictive and/or interventionist. He observed that the treatment proposed was the closest to what he found TC's wishes to be, even though it is not exactly what she consented to when she was capacitous. He was satisfied that it was in TC's best interests to secure her airway before beginning the CRT.

Comment

The case shows the importance of promptly obtaining expert evidence (with the court's permission) in cases such as this, even when the application is urgent. The expert evidence on capacity, in particular, was able to explain to the court's satisfaction how TC had gone from being able capaciously to decide upon her medical treatment to now being in a position where she lacked that capacity – i.e. how, as a result of the catastrophic thinking (associated with her severe depression) she was unable to weigh up the information relevant to the decision in question.

Short Note: the court and dental clearance

Livewell Southwest Community Interest Company v MD [2020] EWCOP 57 is another case on full-dental clearance following very shortly after the *United Lincolnshire Hospitals NHS Trust v Q* [2020] EWCOP 27 case.

The *Livewell* case concerned MD, a morbidly obese 24 year old man with learning disabilities, paranoid schizophrenia and ADHD and a possible diagnosis of autism. Rather surprisingly, given his significant mental impairments, the judgement records that MD is voluntarily accommodated in a residential home for men with mental health problems.

In a hearing before Mostyn J it was detailed how, by virtue of his sweet tooth and resistance to dental hygiene, MD's teeth had reached a state where they were considered to pose a risk of infection, sepsis and even death if untreated. Due to MD's resistance to intervention and his significant size, the applicant sought orders that would authorise both sedation in the community, soft handcuffing if necessary, and transfer to hospital. This was all in the context of MD having expressly indicated an unwillingness to have any teeth removed – albeit that the evidence pointed to this being due to concerns regarding the pain that might involve, rather than aesthetic ones.

Mostyn J had no difficulty making declarations as to MD's lack of capacity to conduct proceedings and make decisions regarding his dental treatment, having been provided with a full psychiatric report.

As to best interests, he determined that it was in MD's best interests to undergo treatment

commenced covertly (ie without warning MD he was going to be taken to hospital) and with the use of chemical and physical restraint not least because he concluded, “if MD were to have a brief window of capacity, I am sure that he would consent to intervention as a necessary measure to avoid pain” (para 17).

Interestingly, the care plan proposed for MD’s treatment included the enlisting of third party care givers, previously unknown to him, in order to maintain the relationship of trust with his current team. Mostyn J also determined, having considered the proportionality of the same, to make a declaration in favour of full rather than partial treatment on the basis that, given the evidence of MD’s inability to comply with elementary dental hygiene, any residual teeth would inevitably decay and result in an identical application and procedure in future (see para 22).

DoLS statistics for England

The DoLS statistics for England for 1 April 2019 to 31 March 2020 were published on 12 November 2020. They are likely to be the last set published before DoLS starts to be wound down in April 2022 which show how DoLS was (or was not) working in non-pandemic conditions.

In headline terms:

- There were 263,940 applications for DoLS received during 2019-20, relating to 216,980 people. The number of applications has increased by an average of 13.9% each year since 2014-15.
- The number of applications completed in 2019-20 was 243,300. The number of

completed applications has also increased each year, by an average of 31.2% each year since 2014-15.

- The reported number of cases that were not completed as at year end was 129,780. This is the first year since reporting began in 2015-16 that the number of cases not completed at year end has fallen, by 1.2%, from 131,350 at the end of 2018-19.
- The proportion of completed applications in 2019-20 that were not granted was 51.0%. The main reason was given as change in circumstances, at 62.0% of all not granted cases.
- The proportion of standard applications completed within the statutory timeframe of 21 days was 23.6% in 2019-20. The average length of time for all completed applications was 142 days (down from 147 days).

Advocacy: a call to arms

A report published in October, Valuing voices: Protecting rights through the pandemic and beyond report, highlights that disabled people and care home residents have seen their human rights breached, and access to independent advocacy and health and social care reduced, during the coronavirus pandemic. It also sets out a call to arms to ensure that the same result does not occur as we go through second (and further) waves).

The report, supported by NDTi, is the result of a survey of nearly 450 advocates. Advocacy organisations across the UK, including VoiceAbility and n-compass, worked in partnership to run the survey and launch the report.

PROPERTY AND AFFAIRS

Trusts and benefits

Re LMS (Settlement of Property into a Trust)
[2020] EWCOP 52 (District Judge Beckley)

Best interests – property and affairs

Summary

In this case, the court was asked to approve a settlement of an inheritance of which P was beneficiary. The application was made by P's attorney under an LPA and opposed by the Official Solicitor acting as P's litigation friend.

P suffered from a significant degree of autism and had a learning disability. She had sufficient capacity to appoint her mother her attorney under an LPA but was assessed as lacking capacity to agree to the settlement of her 30% share of her late grandfather's estate coming into possession when she attained 25 (she was 21 at the time the case was before the court).

P was in receipt of means tested benefits and the local authority paid her residential care fees, again subject to means testing. When her inheritance came into possession, she would those benefits until the capital dropped below the capital limits.

Thus, P's mother proposed a settlement of P's inheritance into a disabled person's trust where the capital would not be taken into account in means testing.

The OS opposed that, saying that the settlement would not have that effect because P would be deemed to have deprived herself of the capital for the purpose of securing the benefits in

question and, therefore, the capital would continue to be taken into account.

The OS further said that the settlement would not otherwise be in P's best interests and the court at paragraph 39 agreed, saying:

Firstly, and most importantly, LMS made a capacitous decision that her property and affairs should be managed by her attorneys under the LPA. The proposed deed is contrary to LMS's wishes as expressed through her execution of the LPA. Secondly, the trustees of the proposed trust would not be bound to apply the principles of the 2005 Act to their decisions. Thirdly, the regime of supervision by the Public Guardian of LPA attorneys does not apply to trustees (I do not intend to suggest in any way that the proposed trustees are likely to act other than in LMS's best interests). Fourthly, the proposed deed would mean LMS's capital being managed under the trust and her income under the LPA which does not seem to be the most efficient method of management of her property and affairs.

Thus, the court had to consider whether the settlement would be caught by the anti-deprivation provisions. The court held that any decision that the court made on P's behalf would be attributed to her (see paragraph 50).

Principally, the court had to consider the purpose of the settlement applying the following principles at paragraph 17:

The principles applicable to determining whether a disposal of capital is a deliberate act for the purposes of means-tested benefits were considered by Mr Howell QC then a Social Security

Commissioner in R(H)1/06 at paragraphs 20 to 23:

“significant operative purpose” of the settlement no matter what the COP says.

“20. I direct the new tribunal that as quite correctly assumed by the previous chairman and not disputed on this appeal, the correct test to be applied in determining whether the claimant is shown to have deprived himself of capital for the purpose of securing entitlement to housing benefit is the well-established one applied on similar wording in the main social security legislation, namely whether the securing of such entitlement is shown to have been a “significant operative purpose” of the claimant’s relevant actions in disposing of his capital.”

The court was persuaded that securing the entitlement to means tested benefits was not a “significant operative purpose” of the settlement because it would better represent P’s grandfather’s wishes, namely to benefit P (see paragraph 46). The court applied similar reasoning to that which persuaded the court in a similar fashion in the Northern Ireland case of *In the matter of the will trusts of Sarah McCullagh* [2018] NICH 15.

Thus, the court decided to approve the settlement.

Comment

The relevant local authority and benefits agency are not bound by this decision and are free to contest the conclusion as to the operative purposes behind the settlement. It must be arguable that if the **only** reason that the settlement is in P’s best interests is that it secures her benefits, then that reason is a

PRACTICE AND PROCEDURE

Reporting upon capacity for the court (and more broadly) – what (not) to do

AMDC v AG & Anor [2020] EWCOP 58 (Poole J)

Mental capacity – assessing capacity

This decision serves as an important reminder of how demanding the process of assessing and reporting upon capacity is – or should be. The case concerned a 68 year old woman, AG, whose capacity was asserted by the local authority applicant to be lacking in respect of a broad number of welfare-related domains, as well as the management of her property. However, on the second day of the final hearing of the application, following the conclusion of the oral evidence of the jointly instructed expert, the local authority informed the court that it did not consider that it could rely upon this evidence – the sole evidence before the court – to prove that AG lacked capacity in the material respects.

All the parties agreed that, although further delay in determining capacity was very regrettable, it was necessary for instructions to be given to a fresh expert to report to the court. As Poole J identified, this was not a case in which the application could simply be dismissed for lack of evidence. Importantly, he founded himself upon the following observations by Baker J, as he then was, in *Cheshire West and Cheshire Council v P* [2011] EWCOP 1330 (at paragraph 52):

The processes of the Court of Protection are essentially inquisitorial rather than adversarial. In other words, the ambit of the litigation is determined, not by the parties, but by the court, because the function of the court is not to determine

in a disinterested way a dispute brought to it by the parties, but rather, to engage in a process of assessing whether an adult is lacking in capacity, and if so, making decisions about his welfare that are in his best interests.

Poole J was satisfied that, notwithstanding the concerns about the expert opinion evidence, the evidence as a whole established that there was reason to believe that AG lacked capacity to make the decisions under consideration and that it was in her best interests to make interim orders and directions. Poole J therefore authorised the continued deprivation of AG's liberty with her residence and care being in accordance with a safeguarding plan dated 20 May 2020. A resumed hearing was fixed in January 2021 with directions for the receipt of evidence from a new expert psychiatrist. These interim orders deprived AG of her liberty and interfered with her Article 8 rights. Amongst other restrictions, the ongoing regime which the court had authorised to continue until the final determination of this case effectively prevented AG from engaging in sexual intercourse, from leaving ECH and from choosing her care arrangements. Because of the impact of an adjournment on AG, and to assist the newly instructed expert, Poole J was invited to and agreed to give an interim judgment.

The expert, Dr Quinn, had given evidence on many previous occasions. However, in this case, Poole J noted that “[h]is evidence left the parties, the court, and even Dr Quinn himself, with some ‘disquiet’.” Poole J made clear that he was not questioning Dr Quinn's professionalism, expertise or conduct, but rather that he shared the concerns raised with him in questioning at

the hearing relating to his reports, including (as set out at paragraph 24), the following:

- (a) *Paragraph 4.16 of the Code of Practice states, "It is important not to assess someone's understanding before they have been given relevant information about a decision. Every effort must be made to provide information in a way that is most appropriate to help the person understand". The expert's reports did not provide sufficient evidence either that AG had been given the relevant information in relation to each decision, or of the discussions the expert had had with P about the relevant information.*
- (b) *It is not a criticism of an expert that at different times they have reached different conclusions about a person's capacity. Capacity can change and new evidence may come to light. However, in this case significantly different conclusions had been reached at different times without clear explanations of why the conclusions had changed or how the evidence as a whole fitted together. Further, the change in opinion between the June report and the August letter had followed the receipt of a single further statement and without any further face to face assessment.*
- (c) *The expert's final conclusion had been reached on a broad-brush basis rather than by reference to each decision under consideration.*

- (d) *A lack of information to show how AG had been assisted to engage when the expert had "hit a brick wall" in his attempts to have a discussion with her at his final interview. The lack of information left doubt as to whether AG was incapable of understanding the purpose of the interview, whether she had been given adequate support to engage, or whether she had simply chosen not to talk to the expert.*
- (e) *A lack of a cogent explanation for why the presumption of capacity had been displaced in relation to the decisions under consideration. Conclusions were stated but not clearly explained.*

Poole J then indicated that it might be helpful to provide some indications of how experts' reports on capacity in a case such as this could best assist the court. In doing so, he emphasised that he did not wish to be prescriptive about the form and content of reports – the Court of Protection Rules r15 and the Practice Direction 15A should of course be followed by all experts and those instructing them. He also refrained from commenting upon the way an expert should interview or assess P – those are matters for the expert's professional judgment. As he noted at paragraph 26, "[t]he inquiry into capacity will vary considerably from case to case, and experts must always be sensitive to what is required for the individual assessment in which they are engaged." Poole J was also "mindful of the very recently [5 November 2020] published final report of the President's Working Group on Medical Experts in the Family Courts, in which Mr Justice Williams and his working group highlight the pressures on expert witnesses that surely apply also to those giving evidence in the Court of

Protection – the rates of remuneration, the lack of support and training, the court processes and perceived criticism by lawyers, judiciary and the press.” It was therefore “with due care therefore that I provide the following comments which are intended merely to assist experts when writing reports in cases such as the present one. The Working Group recommends constructive feedback to encourage good practice.”

Poole J started by reminding himself that expert evidence under COPR r.15 was by no means the only way in which capacity assessments are provided to the court. He noted, in particular, that some s.49 reports are written by psychiatrists who might, in other cases, provide an expert report under r.15. Importantly, he reminded himself at paragraph 27 that “[a]n assessment of capacity is no less important when carried out under s. 49 or by a social worker or Best Interests Assessor.” The guidance that he then set out he indicated “might be of assistance to all assessors, but it is specifically directed to r15 expert witnesses because that is the form of evidence under consideration in this case.”

28. When providing written reports to the court on P’s capacity, it will benefit the court if the expert bears in mind the following:

(a) An expert report on capacity is not a clinical assessment but should seek to assist the court to determine certain identified issues. The expert should therefore pay close regard to (i) the terms of the Mental Capacity Act and Code of Practice, and (ii) the letter of instruction.

(b) The letter of instruction should, as it did in this case, identify the decisions

under consideration, the relevant information for each decision, the need to consider the diagnostic and functional elements of capacity, and the causal relationship between any impairment and the inability to decide. It will assist the court if the expert structures their report accordingly. If an expert witness is unsure what decisions they are being asked to consider, what the relevant information is in respect to those decisions, or any other matter relevant to the making of their report, they should ask for clarification.

(c) It is important that the parties and the court can see from their reports that the expert has understood and applied the presumption of capacity and the other fundamental principles set out at section 1 of the MCA 2005.

(d) In cases where the expert assesses capacity in relation to more than one decision,

i) broad-brush conclusions are unlikely to be as helpful as specific conclusions as to the capacity to make each decision;

(ii) experts should ensure that their opinions in relation to each decision are consistent and coherent.

(e) An expert report should not only state the expert’s opinions, but also explain the basis of each opinion. The court is unlikely to give weight to an opinion unless it knows on what evidence it was based, and what reasoning led to it being formed.

- (f) *If an expert changes their opinion on capacity following re-assessment or otherwise, they ought to provide a full explanation of why their conclusion has changed.*
- (g) *The interview with P need not be fully transcribed in the body of the report (although it might be provided in an appendix), but if the expert relies on a particular exchange or something said by P during interview, then at least an account of what was said should be included.*
- (h) *If on assessment P does not engage with the expert, then the expert is not required mechanically to ask P about each and every piece of relevant information if to do so would be obviously futile or even aggravating. However, the report should record what attempts were made to assist P to engage and what alternative strategies were used. If an expert hits a “brick wall” with P then they might want to liaise with others to formulate alternative strategies to engage P. The expert might consider what further bespoke education or support can be given to P to promote P’s capacity or P’s engagement in the decisions which may have to be taken on their behalf. Failure to take steps to assist P to engage and to support her in her decision-making would be contrary to the fundamental principles of the Mental Capacity Act 2005 ss 1(3) and 3(2).*

As Poole J noted in concluding at paragraph 29, “[t]he newly instructed expert in this case may or may not reach the same conclusions as Dr Quinn, but it will be important that the parties and the court can see from their report that the fundamental

principles of the MCA 2005 have been followed, that proper steps have been taken to support AG’s decision-making and participation in the assessment, and that the conclusions reached are adequately explained.”

Comment

Poole J has only very recently been appointed to the High Court bench, and then to sit as a nominated judge of the Court of Protection, but he has – with respect – come sprinting out of the starting blocks. The guidance given in this judgment is crisp, clear and immensely helpful, not just for those completing expert reports for the purposes of the Court of Protection, but for anyone completing a capacity determination. The comments amplify the equally helpful observations of the (Australian) judge, Mr Justice Bell, in *PBU and NJE v Mental Health Tribunal* (relating to medical treatment, but equally applicable to other contexts) that

The fundamental principles of self-determination, freedom from non-consensual medical treatment and personal inviolability, and the equally fundamental principles behind the right to health, are most respected by capacity assessments that are criteria-focussed, evidence-based, person-centred and non-judgmental. Such assessments engage with the demand (or plea) of the person to be understood for who they are, free of pre-judgment and stereotype, in the context of a decision about their own body and private life.

Particularly welcome, for our part, are three points in particular:

1. The distinction that Poole J draws between “assessment” – the process of thinking

about P – and “report” – the record of the conclusions of that thinking process. In our [capacity guide](#) we talk about “determination” rather than “report,” but we equally seek to draw a distinction between the two concepts. Using the term “assessment” to cover both the process of thinking and the process of recording the conclusions of that thinking is dangerous for two reasons: (1) many “capacity assessment” forms are predicated on the basis that they are simply records of why P does not have capacity, as opposed, which is pre-loading the position; and (2) it can lead people to forget that assessment is a process which needs to be continued for as long as is required until it is possible to reach a conclusion;

2. The reminder of the fact that experts, as much as those involved in the day to day care, treatment or affairs of P, are bound to take practicable steps to support them before reaching the conclusion that they lack capacity in any material domain; and
3. The reminder that capacity assessments, including those prepared for the court, are not the sole domain of psychiatrists, as this is an ongoing, and unhelpful, myth.

The judgment also provides a useful immediate confirmation that the findings of the very detailed (and frankly somewhat depressing) report of the Working Group on Medical Experts in the Family Courts are equally applicable in relation to experts appearing before the Court of Protection.

For how long does a Court of Protection judgment remain binding?

An NHS Trust v AF & Anor [2020] EWCOP 55 (Poole J)

Practice and Procedure (Court of Protection) – other

Summary

Poole J has answered an important question that has – oddly – not been definitely determined previously: when does a decision of the Court of Protection stop being binding? The question is important, given that the court has to make decisions about capacity and best interests on the facts as they are at the point of its decision, but we know that it is entirely possible for those facts to change.

The case is the follow up to the decision of Mostyn J in March 2020 (*A CCG v AF* [2020] EWCOP 16), in which it had been held that it was in the best interests of AF, a man in his mid-seventies who had a severe stroke in May 2016, to continue receive Clinically Assisted Nutrition and Hydration (‘CANH’) via a PEG. That decision was not appealed by his daughter, who had argued strongly that he would not have wished to continue to be fed.

At that point, the PEG tube had been in place since 2016 and they usually last for two to four years before requiring replacement. Therefore, in March 2020 it could have been expected that re-insertion would soon be required. However, the court in March 2020 was not made aware of that expectation and therefore the order made did not expressly cover the need for reinsertion of the PEG tube.

After the judgment of Mostyn J, AF continued to live at his care home receiving CANH via his PEG without incident until on 28 August 2020 the PEG tube became blocked. After an overnight admission to hospital the blockage resolved and he was discharged back to the care home. On 9 October 2020 the PEG tube fell out. It is likely that the bumper which helped to keep the tube in place, failed due to wear and tear. AF was taken to the Emergency Department of the Applicant Trust's hospital and was admitted under the care of the gastroenterology team. A feeding tube was inserted, not for the purpose of administering hydration and nutrition, but to maintain the patency of the PEG tract. AF was able to consume food orally and sometimes does so, but with no gastrostomy in place he was not receiving sufficient nutrition to sustain life. By order of Williams J on 16 October 2020, the feeding tube was removed and a balloon gastrostomy ('BG') inserted. AF was discharged back to the care home on 20 October 2020. A BG will typically last for about three months before having to be replaced.

AF was then admitted to hospital again on 28 October when very unwell with pneumonia. The evidence before the court was, however, that he was a good condition nutritionally and was physiologically robust such that when he recovered from his pneumonia, it was likely that he would be fully restored to his pre-pneumonia condition. The consultant gastroenterologist's evidence was that she would expect, other things being equal, that with continued CANH he could live for a few more years yet.

Poole J was asked to declare that it was lawful (when AF was medically sufficiently fit) to undergo insertion of a PEG.

AF's daughter argued that was that it was not in AF's best interests to have the PEG re-inserted or to continue to have CANH. She went further, contending that it was not in AF's interests to receive any active treatment, including antibiotics, or blood tests for the purpose of monitoring and investigation, and that it was in his best interests to be placed back on an end of life pathway as had briefly been overnight on 28th and 29th October 2020. She told that the court she thought that the BG should now be removed.

Poole J outlined the decision that Mostyn J had reached, and the evidence that had been before him in March 2020. At paragraph 19, he noted that:

The judgment was not appealed. The question now arises as to the extent to which, if at all, my evaluation of AF's best interests should be circumscribed by the findings made by Mostyn J seven months ago.

The three parties before him (the Trust, the Official Solicitor, and AF's daughter) proposed slightly different formulations of the approach that should be adopted. At paragraph 22, Poole J set out that:

both principle and good practice point to the same approach to this application in which the court is being asked to make a best interests evaluation only a few months after another court has made a determination of best interests in respect of a similar decision, concerning the same P, and after a full hearing.

(a) There is no strict rule of issue estoppel binding on the court.

(b) Nevertheless, the court should give effect loyally to a previous judicial finding or decision that is relevant to the determinations it has to make, and should avoid re-opening earlier findings that cannot be undermined by subsequent changes in circumstances. An example would be a finding that P lacked capacity at a particular point in time. Such findings, if not successfully appealed, should generally only be re-opened if new evidence emerges that might reasonably have led the earlier court to reach a different conclusion.

(c) Where there has been no material change of circumstances subsequent to a previous judgment, no new evidence that calls for a re-opening of the earlier findings, and the earlier evaluation of best interests clearly covers the decision that the new court is being asked to consider, appropriate case management might involve the court summarily determining the new application.

(d) Determinations of capacity and best interests are sensitive to specific decisions and circumstances, therefore the court will exercise appropriate restraint before making any summary determination.

(e) If the decision or circumstances that the new court is being asked to consider are not clearly covered by the earlier judgment, or there has been a material change of circumstances or new evidence that calls into question the previous findings, the court should manage the case in a way that is

proportionate having regard to the earlier judicial findings and decisions.

(f) *In dealing with the new application proportionately, the court's focus will be on what has changed since the previous ruling, and any new evidence. It should usually avoid re-hearing evidence that has already been given and scrutinised in the earlier proceedings.*

Applying that approach to the facts of the case, all parties "pragmatically agreed that the failure of the PEG on 9 October 2020 was a material change in circumstances that had not been expressly contemplated by the court in March 2020, and that therefore the decision to re-insert the PEG was a new decision for the Court to consider. Similarly, there was no argument against approaching AF's recent hospital admission for pneumonia as a change in circumstances that required a best interests evaluation, in particular given SJ's position that treatment for it should cease" (para 23). Poole J observed that "[i]t might have been contended, but was not, that it was implicit in Mostyn J's determination that re-insertion of the PEG was in AF's best interests because it was necessary to ensure the continuation of CANH. The focus of the evidence before me was therefore on developments since Mostyn J's judgment."

That having been said, Poole J held that:

24. Nevertheless, Mostyn J's conclusions are highly material to my evaluation of best interests in relation to these new decisions. Indeed, it would be wrong in my judgment to re-open his findings that (i) AF had lacked capacity in 2016 when he made statements indicating that he wanted to die; (ii) as of March 2020 AF derived "pleasure and satisfaction" from

his life; and (iii) AF's statements before his stroke, that he would not want to be kept alive as a "body in a bed", were not applicable to his condition in March 2020. Those findings cannot be altered by subsequent events and there is no new evidence to demonstrate they could now be challenged. I also give significant weight to Mostyn J's very firm conclusion that at the time of his judgment it was in AF's best interests to receive continuing CANH through his PEG.

Having considered the further evidence as to developments since March 2020, Poole J was "quite satisfied" (paragraph 28) that it was in AF's best interests to undergo re-insertion of the PEG.

Importantly, and no doubt reflecting on what had happened since March 2020, Poole J concluded at paragraph 30 by observing that:

The court cannot predict every treatment decision that may have to be made over the remainder of AF's life. However, all parties agree that there ought to be an ongoing care plan, in accordance with guidance from the BMA at section 2.7 of its document, "CANH and adults who lack the capacity to consent – guidance for decision-making in England and Wales." The Trust has agreed to write to the GP and CCG to inform them of this judgment and to ask them to use their best endeavours to ensure advance care planning now takes place, the CCG will be asked to put advance care planning on the agenda for the forthcoming best interests meeting that has been

convened to determine whether AF should change GPs.

Comment

Strong views have been expressed both about the original decision of Mostyn J (including the process of the hearing itself, one of the very first to be held remotely during the pandemic) and about the merits of the judgment reached by Poole J. We do not comment upon those views here, although we do note that the judgment of Poole J makes very clear the potential consequences for a person who does not agree with the outcome of a decision but does not seek to appeal it.

For present purposes, we focus upon the approach taken to Poole J to how to answer the question of what to do where the Court of Protection has previously considered an issue. Now that the Court of Protection has been 'in business' in its current form for 13 years, there are a substantial number of cases where decisions made both as to capacity¹ and best interests on the evidence available at the time simply do not now fit. It had never been entirely clear what was to happen in such circumstances, and this decision very helpfully resolves this ambiguity.

Although strictly only relating to the position where the court, itself, is being asked to revisit an earlier decision, the logic of this judgment applies equally outside the courtroom. If anyone does not agree with the decision when it is made, they should appeal. Otherwise, and in the same

¹ [1] Note, this is not the same as the situation where the court is aware at the time that the case is before it that the person's capacity to make the relevant decision(s) may fluctuate and expressly sets out

contingency planning. This position has now helpfully been considered and resolved in GSTT & SLAM v R [2020] EWCOP 4.

fashion as applies in the mental health setting,² then unless there has been a material change of circumstances or new material that could not have been known to the court at the point when it had made its decision (whether as to capacity or best interests), those concerned should loyally follow the decision. In legal terms, their belief as to the individual's capacity and best interests will only be "reasonable" (and hence enable them to be protected from liability by s.5 MCA 2005) if it is what the court has decided. If there has been such a change of circumstances or new material, they may conclude that they may now reasonably be able to come to a different conclusion about either the person's capacity or best interests. However, especially if the conclusions of the court were reached after it had had to resolve a dispute about capacity or best interests, it would always be sensible to consider obtaining legal advice as to whether they can simply proceed on the basis that the facts have now changed, or whether it is necessary to go back to court to ask for the original decision(s) to be revisited.

Entirely separately, the judgment is also of considerable importance in reminding us of the importance of ensuring that there is **ongoing** consideration of whether CANH is in the best interests of the person, rather than simply making a decision at point A in time and assuming that this will remain fixed for all time. It is helpful, therefore, in terms of emphasising that guidance as to how this can

and should be done has been given by the BMA and RCP (with the endorsement of the GMC).

The inherent jurisdiction, deprivation of liberty and out of hours applications

Mazhar v Birmingham Community Healthcare Foundation NHS Trust & Ors [2020] EWCA Civ 1377 (Court of Appeal (Hickinbottom, Newey and Baker LJJ))

Article 5 – Deprivation of liberty

Summary

In, the Court of Appeal almost, but not quite, answered the question of whether it is lawful to use the inherent jurisdiction to deprive an adult of their liberty. They also gave very helpful interim guidance as to what needs to be done in any application under the inherent jurisdiction in relation to a vulnerable adult.

The case has a very long and tangled procedural history which is – for these purposes – irrelevant. It stems from a without notice application made to Mostyn J as urgent applications judge for an order under the inherent jurisdiction enabling Mr Mazhar to be removed from his home and taken to hospital to provide urgent medical treatment. That application was granted, the order made, and Mr Mazhar removed. There was never any suggestion put to Mostyn J – or indeed subsequently – that Mr Mazhar had a mental disorder, or lacked decision-making capacity in the relevant domains. The key question for the Court of the Appeal was whether Mostyn J could make such an order: Mr Mazhar ultimately pursuing solely a declaration that he was wrong to do so (as opposed to

² See *R(Von Brandenburg) v East London and The City Mental Health NHS Trust* [2003] UKHL 58, [2004] 2 AC 280.

damages, a claim which could have caused some procedural complications).

Can the inherent jurisdiction be used to deprive a vulnerable adult of their liberty?

Baker LJ, giving the sole reasoned judgment of the court, noted that the question of whether an order could be made under the inherent jurisdiction depriving a vulnerable adult of their liberty had never arisen for consideration before the Court of Appeal. However – and frustratingly for those who had been awaiting a definitive pronouncement – he considered that, because of the way in which matters now stood procedurally, it was neither necessary nor appropriate to determine the question. He did, though, make the following observations at paragraph 52:

52. [...] The preponderance of authority at first instance supports the existence of this jurisdiction, but there is some authority to the contrary. There is also uncertainty as to whether it is permissible in urgent situations to depart from the Winterwerp criteria, in particular the requirement for medical evidence. The qualification in Winterwerp itself ("except in emergency cases") suggests that some limited departure may be permissible, although more recent decisions of the European Court have not repeated that qualification. But it could be said that the pragmatic approach of this court in G v E about the difficulties faced by judges dealing with a busy court list applies also, for different reasons, to judges sitting out of hours.

Out of hours inherent jurisdiction applications

Baker LJ made a number of preliminary observations about the difficulty of judges sitting out of hours, including that:

- A judge is not infrequently required to make a decision on an important issue in less than optimal circumstances with incomplete evidence. Unable to wait until more information is available, he or she will have to do the best they can on the limited material in front of them. Sometimes, this will be no more than the scantiest information. This means that it is essential that any party seeking to invoke the court's jurisdiction in these circumstances spells out as far as possible in the evidence or written submissions the reasons for applying without notice, the jurisdiction they are seeking to invoke, the test to be satisfied in order to exercise the jurisdiction, and the basis on which it is said the test is satisfied in the case in question.
- The judge's instinct may well be to err on the side of caution and take the course that seems the least risky to the individual's physical well-being. This is an example of the "protection imperative" – the need to protect the vulnerable child or adult which may draw the professional and the judge to the outcome that is more protective. This tendency may arise whenever a court is exercising a jurisdiction that is substantially protective in nature. As Munby J noted in Re MM [2007] EWHC 2003 (Fam), the court must adopt a pragmatic, common sense and robust approach to the identification, evaluation and

management of perceived risk. However, this is not easy where it has to be carried out at speed, and particular care is needed where the application is made without notice. Baker LJ drew attention to the observations of Charles J in *B v A (Wasted Costs Order)* [2012] EWHC 3127 (Fam) (at paragraph 11):

... there is a natural temptation for applicants to seek, and for courts to grant, relief to protect the vulnerable But this temptation, and the strong public interest in granting such relief, does not provide an excuse for failures to apply the correct approach in law to such applications. Indeed, if anything, the strong public interest in providing such relief and its impact on the subjects of the relief and their families mean that the correct approach in law should be followed and so the sound reasons for it, based on fairness, should be observed.

- There is often a chain of professional trust relied on in such circumstance. Inevitably, however, the scope for human error in such a chain will raise, and each person is liable to the feelings described as the "protective imperative" above.
- It is often impractical to deliver a judgment in these circumstances when sitting out of hours, but practitioners who submit draft orders, and judges who approve them, should record in the order at least a summary of the reasons for the decision, for the benefit of any party not present and any subsequent court conducting the next hearing or

considering the matter at a later stage in the proceedings.

In the instant case, Baker LJ found that:

71. [...] the Trust's application for, and the granting of, the order for which there was no proper evidence and without giving Mr Mazhar the opportunity to be heard amounts to a clear breach of his article 6 rights and was a flagrant denial of justice. However, notwithstanding my criticisms of how the application was made and granted, I am unpersuaded that this court should go further and declare that the errors in this case amounted to "a gross and obvious irregularity". In the absence of a judgment, or a clear account of the reasons for the judge's decision recorded on the face of the order, such a declaration would not be appropriate, particularly having regard to the difficulties faced by judges hearing cases out of hours to which I have already referred. Justice will be served by the decision of this court to allow the appeal and the observations I have already made.

Lessons learned

Baker LJ proposed to draw the judgment to the attention of the President of the Family Division to allow him the opportunity to consider, after appropriate thought and consultation whether fresh guidance should be given to practitioners and judges about applications of this sort. For the time being, however, he identified at paragraph 74 the following clear lessons to be learnt:

(1) Save in exceptional circumstances and for clear reasons, orders under the inherent jurisdiction in respect of

vulnerable adults should not be made without notice to the individual.

(2) A party who applies for an order under the inherent jurisdiction in respect of vulnerable adults without notice to another party must provide the court with their reasons for taking that course.

(3) Where an order under the inherent jurisdiction in respect of vulnerable adults is made without notice, that fact should be recorded in the order, together with a recital summarising the reasons.

(4) A party who seeks to invoke the inherent jurisdiction with regard to vulnerable adults must provide the court with their reasons for taking that course and identify the circumstances which it is contended empower the court to make the order.

(5) Where the court is being asked to exercise the inherent jurisdiction with regard to vulnerable adults, that fact should be recorded in the order along with a recital of the reasons for invoking jurisdiction.

(6) An order made under the inherent jurisdiction in respect of vulnerable adults should include a recital of the basis on which the court has found, or has reason to believe, the circumstances are such as to empower the court to make the order.

(7) Finally, and drawing on my own experience of these cases, if an order is made out of hours in this way, it is essential that the matter should return to court at the earliest opportunity. In this case, the order properly included a direction that "the matter shall be listed for urgent hearing on the first available

date after 25 April 2016". In the event, however, it did not return to court until four weeks later. It has not been necessary to enquire, or reach any conclusion, as to why such a lengthy delay occurred. I would suggest, however, that it will usually be better for the order to list the matter for a fixed return date, say 2 pm on the next working day, either before the judge making the order or the urgent applications judge. Had that occurred in this case, the consequences of the errors made on 22 April 2016 might to some extent have been ameliorated.

Comment

It is unfortunate that the Court of Appeal could not resolve definitively whether the inherent jurisdiction can lawfully be used to deprive an adult of their liberty, although the fact that Baker LJ expressly noted that question was whether it could be used "provided the provisions of Article 5 are met" means, it is suggested, that it is clear that it cannot properly be used unless there is evidence (commensurate with the urgency of the situation) that they are of "unsound mind," in the awkward language of Article 5(1)(e). Pending the giving of such further guidance as the President of the Family Division considers necessary in due course, the "lessons learned" section of the judgment is very helpful in terms of framing practice in relation to these difficult applications – especially in urgent situations. It may also be of assistance to readers to look at the 39 Essex Chambers [inherent jurisdiction](#) guidance note and also our guidance note as to [without notice hearings](#) (this latter relates to hearings before the Court of Protection, but is equally applicable to applications under the inherent jurisdiction).

The habitual residence checklist (and an observation about necessity)

The Health Service Executive of Ireland v IM [2020] EWCOP 51 (Knowles J)

International jurisdiction of the Court of Protection – other

Knowles J has given a helpful summary of the approach to determining whether an adult with impaired decision-making capacity remains habitually resident within England and Wales.

The person in question, IM, was 92. She had been resident in Kent for over 55 years before moving to Ireland in September 2018, a little over 2 years prior to the matter coming to court. If, as the applicant (the Irish statutory body responsible for her) contended, she remained habitually resident in England and Wales, then issues as to her health and welfare were matters for the Court of Protection. Conversely if, as both IM's litigation friend and Kent County Council, the respondents, argued, then such matters would fall within the jurisdiction of the Irish High Court.

The legal framework was summarised by Knowles J in terms that merit reproduction in full as a convenient summary of the statutory position and case-law:

28. "Habitual residence" is defined in neither the MCA nor the Convention. In *An English Local Authority v SW and Others* [2014] EWCOP 43, Moylan J (as he then was) held that the meaning to be given to habitual residence in the context of the Convention and the MCA should be the same as in other family law instruments such as the 1996 Hague Child Protection Convention and Council

Regulation EC 2201/2003 (Brussels IIA) though he also acknowledged that different factors will be relevant and will bear differential weight (see [64]-[65]).

29. Thus, habitual residence is to be determined in accordance with the guidance given by the Supreme Court and the Court of Justice of the European Union in a number of recent cases. The following principles are key:

- a) *Habitual residence is a question of fact and not a legal concept such as domicile (A v A (Children: Habitual Residence) [2014] AC 1 at [54]);*
- b) *The test adopted by the ECJ is the "place which reflects some degree of integration by the child in a social and family environment". The child's physical presence should not be temporary or intermittent (Proceedings brought by A (Case C-523/07) [2010] Fam 42 at [38]);*
- c) *Consideration needs to be given to conditions and reasons for the child's stay in the state in question (Mercredi v Chaffe (Case C-497/10PPU) [2012] Fam 22 at [48]);*
- d) *The essentially factual and individual nature of the enquiry should not be glossed with legal concepts which would produce a different result from that which the factual enquiry would produce (see A v A above at [54]);*
- e) *Both objective and subjective factors need to be considered. Rather than consider a person's wishes or intentions, it is better to think in terms of the reasons why a person is in a particular place and his*

or her perception of the situation while there - their state of mind (Re LC (Children) [2014] AC 1038 at [60]);

- f) It is the stability of the residence that is important, not whether it is of a permanent character (Re R (Children) [2016] AC 76 at [16]); and
- g) Habitual residence is to be assessed by reference to all the circumstances as they exist at the time of assessment (ET v MM [2019] EWHC 935 (Fam) at [13]).

30. In Re LC (Children) (see above), Baroness Hale stressed the need to look at the circumstances which led to the move in question:

"The quality of a child's stay in a new environment, in which he has only recently arrived, cannot be assessed without reference to the past. Some habitual residences may be harder to lose than others and others may be harder to gain. If a person leaves his home country with the intention of emigrating and having made all the necessary plans to do so, he may lose one habitual residence immediately and acquire a new one very quickly. If a person leaves his home country for a temporary purpose or in ambiguous circumstances, he may not lose his habitual residence there for some time, if at all, and correspondingly he will not acquire a new habitual residence until then and later. Of course there are many permutations in between, where a person may lose one habitual residence without gaining another".

31. In An English Local Authority v SW (see above), Moylan J made the following additional points:

- a) The overarching test for habitual residence should be the same whether one is considering adults or children, although different factors may or will have differing degrees of relevance [66].
- b) The expression "degree of integration" is an overarching summary or question rather than the sole, or even necessarily the primary factor in the determination of habitual residence. The court's focus should not be narrowed to this issue alone as a question of fact [68] and [72].
- c) Integration, as an issue of fact, can be an emotive and loaded word. It is not difficult to think of examples of an adult who is not integrated at all in a family environment and only tenuously integrated in a social environment but who is undoubtedly habitually resident in the country where they are living. Integration as an issue of fact can also raise difficulties when a court is determining the habitual residence of a person who lacks capacity [70].
- d) The court "should not lose sight of the wood for the trees" [71].

32. Where an incapacitous adult has been moved from one jurisdiction to another, the question of the authority that the person effecting the move had to make it is also important. In Re MN (Recognition and Enforcement of Foreign Protective Measures) [2010] EWHC 1926 (Fam), Hedley J held that a move which was

wrongful should not effect a change in the habitual residence of the incapacitated adults and should leave the courts of the country from which that person was taken free to take protective measures [22]. In determining whether a decision is wrongful, the court must look not only at the terms of the authority conferred upon the person taking the decision, but also at their motives for taking that decision.

33. *The fact that the person effecting the move has formed a subjective view that it is in P's best interests may not suffice to prevent the move from being wrongful. Pursuant to s.4(9) and s.5(1)(b) of the MCA, a person making a decision on behalf of an incapacitous adult must "reasonably believe" the decision to be in their best interests. Thus, in Re QD (Jurisdiction: Habitual Residence) (No 1) [2019] EWCOP 56, Cobb J held that a decision by P's children to move him from Spain to England was wrongful and that they could not rely upon the doctrine of necessity [29]. The judge indicated that, whilst they may have believed that they were acting in P's best interests, this was not a reasonable belief on their part.*

Applying that framework to the facts before her, and noting, whilst she had had to try to resolve factual inconsistencies without hearing evidence, but that this was "not unusual in what is intended to be a summary process to resolve doubt as to this court's jurisdiction to make decisions for IM" (paragraph 7), Knowles J found that IM was now habitually resident in Ireland. She identified that she assumed that IM had had capacity to make the decision to move unless it was established that she did not and whilst there was some evidence that her capacity fluctuated, there was a larger body of evidence suggesting

that she had had that capacity. She also found that the decision to move was not one taken "with unreasonable pressure" from an individual, VS, with whom she had an undoubtedly complex relationship. As she noted at paragraph 42:

[...] He provided her with care and support as her medical records attested and she was wholly reliant upon him. I have no doubt that IM's decision to move to Ireland was made with the knowledge that she needed VS to care for her and did not want to live in England without him. That relationship of dependency between an elderly vulnerable person and their carer is entirely common and understandable. Though it is difficult to see objectively why IM would wish to move from Kent where she was long established and had potent family connections, the need to be with VS is likely to have displaced these and other considerations when IM agreed to move. For IM, the most important consideration would have been that she would continue to live with VS, who would look after her as he had already done for many years.

43. *No one involved with IM at the time was sufficiently concerned before the move to assist her in seeking advice support from statutory agencies. The move to Ireland was not achieved by stealth or made in an overly hasty manner. VS made no attempt to conceal the proposed move and IM discussed it freely with her GP and with FS over time. Her misgivings about moving expressed to the GP in August 2018 were understandable but do not, of themselves, suggest that IM had not voluntarily decided to move. Though that decision might have been unwise given that IM was leaving behind all she was familiar with, it was not without*

emotional and practical justification as far as IM was concerned.

Whilst VS had handled IM's money in a way that aroused concern, Knowles J was "not persuaded that the desire to enrich himself at IM's expense was the sole justification for the move to Ireland" (paragraph 44). Finally, Knowles J found that IM was both settled in Ireland and seemingly content to stay there.

Knowles J was invited to decide whether to consider to exercise the inherent jurisdiction to make decisions about her welfare given her British citizenship, on the basis that "[g]iven that her property was in this jurisdiction, Mr Rees QC [on behalf of the HSE] submitted that England and Wales remained the most appropriate forum in which to take decisions about IM." However, the HSE acknowledged that, if she declined to exercise the inherent jurisdiction with respect to IM, the HSE envisaged bringing proceedings in the Irish High Court to determine IM's best interests as to residence. If she were to remain resident in Ireland, the Irish High Court would be asked to approve steps to obtain the transfer of her property from England to the General Solicitor for Minors and Wards of Court in Ireland. On that basis, and

48. Having reflected on the HSE's submission, I decline to exercise the inherent jurisdiction with respect to IM. To apply the inherent jurisdiction in this case as a means of making orders with respect to IM would constitute a subversion of the comprehensive regime available in the MCA for those who lack capacity to make decisions about welfare, property and other matters as IM clearly does. Further, it would improperly reserve to this court decisions about IM's

welfare when there is a robust and appropriate jurisdictional framework in Ireland for taking such decisions about a person who is habitually resident there.

Finally, the court addressed the fact that the OPG had applied to withdraw the proceedings relating to IM at a time when it knew that the issue of IM's habitual residence was a matter unresolved by the court and did so without drawing that issue to the court's attention. The court then acceded to that application without apparently recognising that the issue was unresolved. Although she declined to give formal guidance to avoid such a situation arising again, Knowles J observed that:

51 [...] it seems self-evident to me that care should be taken in concluding proceedings on paper where there are unresolved issues which might potentially have implications for the court's jurisdiction and, most importantly, the welfare of a vulnerable and incapacitous person. Further, it seems to me that parties to proceedings should properly draw the court's attention to those unresolved issues when making applications which might bring the proceedings to a conclusion. Had the OPG done so, the hearing on 25 November 2019 might well have gone ahead.

Comment

The issue of when the habitual residence of an adult with impaired decision-making capacity may change is an important one, and not just in relation to overtly 'foreign' cases such as IM's. For these purposes, Scotland and Northern Ireland are just as foreign; the framework outlined by Knowles J is therefore equally helpful

as a checklist for considering intra-UK moves as it is for considering the position where a person has moved outside the UK.

The only note of caution that we would enter against both this judgment (and that of Cobb J *Re QD (Jurisdiction: Habitual Residence) (No 1)* [2019] EWCOP 56 is that it is not immediately obvious why the doctrine of necessity would be relevant. As Sir Robert Nelson held in *ZH v Commissioner of the Police for the Metropolis* [2012] EWHC 604 (Admin), “where the provisions of the Mental Capacity Act apply, the common law defence of necessity has no application. The Mental Capacity Act requires not only the best interests test but also specific regard to whether there might be a less restrictive way of dealing with the matter before the act is done, and, an obligation, where practicable and appropriate to consult them, to take into account the views of the carers. It cannot have been the intention of Parliament that the defence of necessity could override the provisions of the Mental Capacity Act which is specifically designed to provide specific and express pre-conditions for those dealing with people who lack capacity” (paragraph 44). Sir Robert Nelson also made clear in the same case (at paragraph 40) that a person can be acting by reference to the MCA (and be ‘covered,’ insofar as necessary by the defence in s.5 MCA 2005) whether or not they have specific knowledge of the Act at the time, so long as they reasonably believe at the material time are the facts which determine the applicability of the Mental Capacity Act. The decision in ZH was upheld by the Court of Appeal without considering these observations further, but it is suggested that they are a correct statement of the law. This being so, it is suggested that the correct analysis in deciding whether or not a move was wrongful was

whether those concerned in bringing it about could have brought themselves within the scope of s.5 MCA 2005 at the time.

Court of Protection Users Group meeting

The minutes of the most recent meeting, held on 8 October 2020, are now [available](#). They cover such matters as:

- Disposal times for applications (by judges and ACOs)
- Backlogs
- The electronic applications pilot
- The upfront notification pilot
- Remote hearings, at present and going forward
- *Re X* applications, and the expectation of a ‘winter onslaught’ of such applications 548 applications having been received in August 2020 compared to 245 in February 2020
- ALRs – 31 having been appointed in 2020, with 10 having self-nominated
- Digital developments
- Transfer of urgent hearings to regional hubs

THE WIDER CONTEXT

Why have so many people with learning disability died of COVID-19?

The Department of Health and Social Care, with the support of the Chief Medical Officer for England, commissioned Public Health England (PHE) to review the available data on the deaths of people with learning disabilities in England during the coronavirus (COVID-19) pandemic. In the [report](#), PHE concluded (having examined data on deaths from Covid from three different sources) that adults with learning disabilities were over-represented by at least 3.1 times among the numbers of people dying. Further findings include:

- COVID-19 deaths among people with learning disabilities were spread more widely across the adult age groups than in the general population. The age bands with the largest number of deaths was 55 to 64 years for people with learning disabilities, but over 75 for the general population.
- COVID-19 increased the number of deaths for people with learning disabilities by a greater margin than for the general population, across all adult age groups, but by a greater margin in younger age groups.
- The rate of COVID-19 deaths for adults with learning disabilities in residential care was higher than the rates of COVID-19 deaths of adults with learning disabilities generally. This difference is likely in part to reflect the greater age and disability in people in residential care.
- PHE data on the number of outbreaks in care homes indicates that care homes

looking after people with learning disabilities were less likely than other care homes to have had COVID-19 outbreaks. This is likely to be related to the fact they have fewer bed spaces.

Detention of young people with autism and/or learning disability: Government commitments?

The Government has responded to two JCHR reports, the first on detention of young people with autism published in 2019 called '[The detention of young people with learning disabilities and/or autism](#)' and the second published in June 2020 called '[Human Rights and the Government's response to COVID-19: The detention of young people who are autistic and/or have learning disabilities](#)'. The Government's response entitled 'The Government Response to the Joint Committee on Human Rights reports on the Detention of Young People with Learning Disabilities and/or Autism and the implications of the Government's COVID-19 response' can be found [here](#).

In its first report, published in November 2019, the JCHR had concluded that young people's human rights were being abused; that they were detained unlawfully contrary to their right to liberty, subjected to solitary confinement, more prone to self-harm and abuse and deprived of their right to respect for private and family life. The report made a number of recommendations which are summarised at the start of the Government's response:

- The establishment of a Number 10 unit to urgently drive forward reform, minimise the number of people with learning disabilities

and/or autism who are detained and to safeguard their human rights;

- A review to be carried out by the Number 10 unit of the framework for provision of services for those with learning disabilities with new legal duties introduced for Local Authorities and Clinical Commissioning Groups regarding the care of people with learning disabilities and/or autism;
- Stronger legal entitlements to support for individuals;
- Care and Treatment Reviews and Care, Education and Treatment Reviews to be put on a statutory footing;
- Narrowing of the criteria for detention under the MHA to avoid inappropriate detention;
- Families of those with learning disabilities and/or autism to be recognised as human rights defenders, and other than in exceptional circumstances, be fully, involved in all relevant discussions and decisions; and
- Substantive reform of the CQC's approach and processes.

The JCHR also published a report in June 2020 'Human Rights and the Government's response to COVID-19: The detention of young people who are autistic and/or have learning disabilities'. This report made 8 recommendations:

- NHS England must write immediately to all hospitals, stating that they must allow families to visit their loved ones unless there are clear reasons specific to the individual's circumstances why it would not be safe to do so;

- Figures on the use of restrictive practices, including physical and medical restraint and any form of segregation, must be published weekly, provided to the Secretary of State for Health and Social Care and reported to Parliament;
- The CQC should carry out all their inspections unannounced;
- The CQC must prioritise in-person inspections at institutions with a history of abuse/malpractice, and those which have been rated inadequate/requires improvement;
- The CQC should set up a telephone hotline to enable all patients, families, and staff to report concerns or complaints during this period;
- The CQC must report on reasons for geographical variation in practice with resultant harmful consequences;
- Rapidly progressing the discharge of young people to safe homes in the community must be a top priority for the Government. The recommendations from the Committee's 2019 report must be implemented in full; and
- Comprehensive and accessible data about the number of those who are autistic and/or learning disabled who have contracted and died of COVID-19 must be made available and include a focus on those in detention.

Of particular interest in the Government's response are the following:

- The Government's decision to consult through the MHA White Paper on new duties

to make sure Local Authority and Clinical Commissioning Group (CCG) commissioners ensure an adequate supply of community services for people with a learning disability and autistic people.

- To consult on creating a related duty that would ensure every local area understands and monitors the risk of crisis at an individual-level for people with a learning disability and autistic people in the local population.
- With respect to the recommendation (which endorses the recommendations made by the independent MHA review), that there should be reform of the MHA, the response is the somewhat vague “*we plan to publish a White Paper in due course.*”
- The Mental Health Units (Use of Force) Act statutory guidance, which is currently under development will set out guidance on reporting restrictive practices to NHS England, as well as best practice on notifying families of every incident of a restrictive practice being employed.
- In response to the recommendation that young people should not be placed too far from home, the report states that the NHS Long Term Plan commits to ensuring that every local area will have a seven-day specialist multidisciplinary service and crisis care by 2023/24. The aim of this is to “*enable more people to receive personalised care in the community, closer to home, and to reduce preventable admissions to specialist inpatient settings.*”
- With respect to the recommendation about families visiting loved ones during the

pandemic in hospital, the report sets out some of the guidance that has been disseminated and states:

*On 22 September 2020, NHS England and NHS Improvement wrote to NHS and independent sector providers of mental health, learning disability and autism inpatient care stating **that they must allow families to visit unless a risk assessment has been carried out that indicates it would be unsafe to do so.** NHS England and NHS Improvement would expect patient and family members to be informed where visits cannot happen and with clear reasons given for this. (emphasis in original)*

‘Out of sight – who cares?: Restraint, segregation and seclusion review’

The CQC’s [report](#) published on 27 October 2020 is required reading for anyone supporting those with autism or learning disability. Sadly, it is the latest in a long line of reports demanding change. Inspectors visited many hospital wards, care homes, and children’s residential and secure homes. The CQC also gathered information remotely from 452 questionnaires and sampled care plans and other records. Inspectors met 66 people in segregation, let down by the health and care system, two-thirds of whom were autistic. Diagnostic delays and inadequate support led in some cases to violent or suicidal distress, where in a crisis hospital was the only option left.

The majority of the 43 hospital wards visited were not therapeutic environments. Some people were admitted without, and remained without, a needs assessment resulting in no

clear care and treatment plan. The quality of those plans that were available varied. A common theme was a failure to understand the underlying causes of distress and focusing instead on behaviours that had to be managed.

Some staff did not feel listened to. Some staff felt untrained to understand people's needs. Wards were described as noisy and chaotic, entirely contrary to the sensory environment required for those with autism. When distress was caused, behaviour was either restrained, secluded, or segregated.

Finding suitable community care was a challenge due to complex commissioning arrangements and poor communication between providers and commissioners. In some cases, community care packages fell through due to issues with funding or providers feeling unable to meet the person's needs. Such delays and failed placements risked a deterioration in the person's behaviour as they became stuck in the system, transferring into more secure restrictive environments. The use of physical (including prone), chemical, rapid tranquillising, and mechanical restraint varied across services. The CQC noted that there is no national oversight on the use of restraint and restrictive practices, such as seclusion and long-term segregation.

Some care homes and supported living services had staff that did not always recognise when patients were being secluded. The conditions of many seclusion rooms in hospital were found to be unacceptable and did not help people to get better, with no access to natural light or fresh air and only some had access to bathrooms or toilets. Most rooms were bare, without personal

belongings or access to a TV or music. Blanket restrictions seemed commonplace.

Some people in long-term segregation were in good quality environments with a homely feel. However, for many the physical environment did not meet their needs or help them to get better. Little or no access to outdoor space, unclean accommodation and no access to personal belongings because of blanket restrictions. There was an absence of care plans aiming to reintegrate those segregated back to the main ward as a step towards moving into the community.

Inspectors saw how frightening it could be for people to be restrained but providers did not always recognise it, or the long-term impact it might have. People described how the more they were restricted in hospital the harder they found it to recover, with few staff trained in trauma-informed care and therefore few opportunities for people to talk through their distress.

There were some examples of good practice, mostly in the community. In some hospitals people were being cared for in innovative ways with smaller units and higher staff ratios. But overall the CQC found people got better care in the community than in hospital. It also saw some great examples of care planning at the secure children's homes they visited, such as screening assessments on admission for autism. For each child placed there was a clear aim for the time they were at the home; the goals were clear, and the success of the service was measured against those goals.

The conclusion section ends with a call to arms:

There have been too many missed opportunities to improve the lives of

autistic people and people with a learning disability and/or mental health condition, whose behaviour others find challenging. Immediate action is needed to put an end to the abuses in human rights that we have seen throughout this review. This action must be owned and led from the top by government, delivered by local systems working together, and involve people and their families to ensure the needs of the individual are met.

Recommendations were made in four key areas:

- People with a learning disability and or autistic people who may also have a mental health condition should be supported to live in their communities. This means prompt diagnosis, local support services and effective crisis intervention.
- People who are being cared for in hospital in the meantime must receive high-quality, person-centred, specialised care in small units. This means the right staff who are trained to support their needs supporting them along a journey to leave hospital.
- There must be renewed attempts to reduce restrictive practice by all health and social care providers, commissioners and others. We have seen too many examples of inappropriate restrictions that could have been avoided. We know in absolute emergencies this may be necessary, but we want to be clear – it should not be seen as a way to care for someone.
- There must be increased oversight and accountability for people with a learning disability, and or autistic people who may also have a mental health problem. There

must be a single point of accountability to oversee progress in this policy area.

The CQC will publish a report on progress made on the recommendations in Winter 2021/22.

Short note: an (odd?) inconsistency of judicial concern about deprivation of liberty

In *Re Z (A Child: Deprivation of Liberty: Transition Plan)* [2020] EWHC 3038 (Fam), Knowles J considered the situation of a 14 year old boy with autism and PDA traits who needed to be moved from their home to a residential school. The local authority sought permission to authorise Z's deprivation of liberty during the transfer under the inherent jurisdiction. There was no dispute that the move, the transfer arrangements and the new placement were in Z's best interests, although Z himself had a very troubled history with school placements and was said to have become verbally aggressive and physically violent when he was told of the plan. The parties agreed that Z's placement at the school did not require court authorisation – apparently on the basis that his parents could consent to any deprivation of liberty, and the use of 'reasonable force' to manage his behaviour in school would fall under s.93 Education and Inspections Act 1996.

The court was therefore only asked to look at the transfer plan, which included the presence of the police and the use of medication and physical restraint as a last resort if Z would not go to the school otherwise: *"it was eventually envisaged that staff would physically hold him and lead him to the car."*

The court held that the local authority should have permission under s.100 CA 1989 to apply to invoke the inherent jurisdiction, and authorised the plan.

In the event, Z went to the school without restraint being required, so the arrangements considered and authorised by the court were not required.

The judgment might be thought to raise more questions than it answers. Why could Z's parents not consent to any deprivation of liberty occasioned by the transfer plan – current caselaw confirms that parents can consent to what would otherwise be a deprivation of liberty on behalf of a child aged under 16. The court formed the view that the transfer plan fell outside the bounds of parental consent even for a child under 16 because it envisaged the use of restraint, and so independent oversight was required. No contrary argument appears to have been advanced before the court.

Is the implication that any use of force that might amount to a deprivation of liberty must be authorised by a court? Apparently not, as the court was satisfied that Z's care at the residential school – a 52 week placement where physical restraint was envisaged – did not require court approval. The court proceeded on the basis that there were statutory provisions concerning the use of restraint in educational settings, and this provided an adequate legal framework. In fact, the use of excessive and unlawful restraint and seclusion in special schools is a very real problem, and the statutory frameworks alluded to in this judgment do not in themselves provide any recourse to the courts for a child or concerned parent or advocate, nor any independent monitoring. While a claim for

judicial review or under the Equality Act or Human Rights Act could be brought after problems have been identified, there is no automatic oversight of such placements beyond standard local authority reviews of children placed pursuant to s.20 CA 1989. One is left with the puzzling conclusion that a short period of physical restraint to get a child from A to B requires the approval of a High Court Judge, while a child's admission to a permanent residential placement where restraint could be used on a daily basis, does not.

Capacity and public hearings before the Mental Health Tribunal

AR v West London NHS Trust and the Secretary of State for Justice [2020] UKUT 273 (AAC) (Upper Tribunal ACC (UTJ Jacobs))

Mental Health Act 1983 – interface with MCA

Summary

AR had been detained under ss.37/41 MHA 1983 since 1993. The tribunal refused his application for the hearing to be in public. The issues were (a) AR's capacity; and (b) the relevance of incapacity to the application for a public hearing in light of the decision in *AH v West London Mental Health Trust* [2010] UKUT 264 (AAC); [2011] UKUT 74 (AAC).

The Upper Tribunal decided that the tribunal erred in law in two respects:

1. The 'matter' for MCA 2005 purposes was *not* to decide to apply for a public hearing. Instead the matter was the patient's ability to conduct proceedings;
2. That the patient does not have capacity to conduct the proceedings does not mean the

hearing cannot be held in public. The starting point is Article 6 ECHR which confers a qualified right to a public hearing and the best interests of the patient should be considered as part of the application.

So a patient does not need to have litigation capacity to apply for a public hearing. UTJ Jacobs then gave some guidance at paragraph 20 as to the salient features of a public hearing which were not intended to be comprehensive:

- The tribunal's powers of disposal are the same, regardless of whether or not the hearing is held in public. Those powers will vary according to the nature of the case. Having the hearing in public will not affect the decision that the tribunal makes within the scope of its jurisdiction under the Mental Health Act 1983. It does not acquire power at a public hearing to deal with any issue that is outside its jurisdiction.
- The tribunal's procedural powers are also the same regardless of the form of the hearing. They include the power to exclude people from all or part of the hearing. The nature of the hearing will not affect the way that the hearing is conducted, the evidence that is relevant, what the patient is allowed to say, or the outcome of the case.
- Members of the public, including the press, are allowed to observe and may wish to do so, although they may not. They not allowed to take any part in the proceedings.
- A public hearing is no guarantee of publicity, even if members of the public do observe. The tribunal's power to limit disclosure remain the same as for a private hearing.

- A hearing may adversely affect the patient's health, for example as a result of receiving adverse publicity or realising that no one is interested in the case.
- Although the patient may want publicity, this may have a detrimental effect on others, such as his family or any victim.

Accordingly, the case was remitted to a different tribunal.

Comment

This decision avoids the decisional salami-slicing of litigation capacity, which might otherwise lead to an impractical approach when conducting proceedings, whilst equally ensuring that the voice of the person is not lost when considering issues arising in the course of proceedings. It reflects the increasing role of the MCA 2005 to issues arising under the MHA 1983 and the fleshing out of the tribunal rules.

Report and webinar – learning from SARs

The first national analysis of learning from Safeguarding Adults Reviews (SARs) in England was carried out during 2020, its purpose being to identify priorities for sector-led improvement in adult safeguarding. The report is being launched at a webinar on 14 December, where the authors will present key findings from the study, to which 98% of Safeguarding Adults Boards in England contributed material. The resulting analysis of 231 SARs across all types of abuse and neglect provides a significant body of evidence on which to base recommended priorities for sector-led improvement.

The webinar is free to attend: for details and to reserve a place, see [here](#).

Mental Health Law Online – forum (and website update)

The invaluable Mental Health Law Online [website](#) has now launched an open-access [forum](#) (to accompany the existing email discussion list to which access must be requested). For those who have not already explored the depths of the website, which has an amazing range of resources, you will be able to do so at even greater speed than you might have been able to before as it has had an update behind the scene.

Short note: when is it right to be held to the consequences of your own actions?

In *Henderson v Dorset Healthcare University NHS Foundation Trust* [2020] UKSC 43, the Supreme Court considered whether Ms Henderson could recover damages for loss of liberty and loss of amenity, consequent upon her detention; and damages for having developed a depressive illness and having lost her share in her mother's estate. The court concluded that she could not; and reaffirmed the proper approach to the common law illegality defence across civil law generally as distilled by the earlier decision of the court in *Patel v Mirza* [2017] AC 467.

Ms Henderson had a history of schizophrenia with paranoia; and during a psychotic episode she killed her mother. At the time, she was under the care of the community mental health team managed and operated by the defendant trust. The trust admitted breach of duty but contended that since the damages claimed were a consequence of the sentence imposed on her by the criminal court, they were irrecoverable on illegality or public policy grounds.

At first instance, Jay J determined that the facts were identical to *Gray v Thames Trains Ltd* [2009] AC 1339, which was also a case of manslaughter with diminished responsibility (and the first instance decision of *Clunis v Camden and Islington Health Authority* [1998] QB 978). The appeal raised the question of whether *Gray* can be distinguished (because it only concerned claimants with significant personal responsibility) and, if not, whether it should be departed from in light of the decision in *Patel*. In that case, the Supreme Court had provided that a court should consider a trio considerations when faced with an illegality defence: (i) whether the underlying purpose of the prohibition which had been transgressed would be enhanced by denial of the claim ("Stage A"), (ii) whether there existed any other relevant public policy on which the denial of the claim might have an impact ("Stage B") and (iii) whether denial of the claim would be a proportionate response to the illegality ("Stage C").

The Supreme Court determined that *Gray* was compatible with the trial of consideration identified in *Patel*:

1. Stage A – The policy reasons in support of denial of the claim were: the need for consistency as between the civil and criminal law to maintain the integrity of the legal system; the need to maintain public confidence in the law (heightened by the proper allocation of NHS resources); and the public interest in deterring and condemning unlawful killing.
2. Stage B – The court did not consider that there were any countervailing policies that outweighed the policy reasons identified as Stage A.

3. Stage C – The denial of the claim was a proportionate response to the illegality (taking into account (i) the seriousness of the conduct; (ii) the centrality of the conduct to the transaction; (iii) whether the conduct was intentional; and (iv) whether there was a marked disparity in the parties' respective wrongdoing).

Thus, all heads of loss in relation to the killing and detention were irrecoverable.

At a procedural level, the case shows that careful consideration needs to be given to ensuring that any illegality defence is properly pleaded in light of *Patel* as reaffirmed in *Henderson*. In particular, ensuring that, on the facts of the particular case, public policy means that the claimant should not recover; and it is proportionate to deny the claimant recovery.

More broadly, the case raises again the question of whether and how people should be considered to be responsible for their own actions in in the civil as well as the criminal sphere, especially where they have an argument that (at least part of) the reason for their actions is a failure on the part of others. In assessing how they feel about the judgment, readers might also care to skim the decision in *Campbell v Advantage Insurance Co Ltd* [2020] EWHC 2210 (QB) examining whether it could be said in retrospect that a passenger who was drunk and under the influence of drugs had capacity to decide to get into a car and not fasten his seatbelt before it was driven off by a friend in a similar condition with the inevitable consequences of death and serious injury.

Short note: suicide and the burden of proof

In *R (Maughan) v Her Majesty's Senior Coroner for Oxfordshire* [2020] UKSC 46, the Supreme Court has confirmed that the standard of proof for all short form conclusions at an inquest, including in relation to suicide, is the balance of probabilities. Whilst formally not before the court, the Supreme Court also held that the same approach applies to determinations of unlawful killing.

Lady Arden, giving the first judgment, identified why the criminal standard (i.e. beyond reasonable doubt) could have adverse public policy consequences:

73. The retention of the criminal standard for the short form conclusion of suicide is likely to lead to the assessment of when, where and in what circumstances did the deceased meet his death being left in a partially complete and incoherent way, which may give an inaccurate understanding of the position.

74. The reasons for suicide are often complex. It is important not to adopt a stereotypical attitude here as elsewhere. Society needs to understand the causes and to try and prevent suicides occurring. Statistics are the means whereby this can be done. If a criminal burden of proof is required, suicide is likely to be under-recorded. This is especially worrying in the case of state-related deaths. If there is an open verdict because the criminal standard of proof cannot be achieved, the circumstances of the case have to be analysed before it can be included in any statistics to show the true number of suicides. There is a considerable public interest in accurate suicide statistics as they may reveal a need for social and medical care in areas not previously regarded as significant. Each suicide

determination can help others by revealing how suicide risks may be managed in future. I accept that to some extent policy makers and researchers can seek to mitigate the under-recording of cases by examining cases of open conclusions but they may not be able to do so accurately and lowering the standard of proof would be a more satisfactory way of getting accurate figures.

Having explained why the appeal should be allowed as a matter of legal principle but then took a step back to ask **why** it should be challenged:

75. [...] In answer I should like to record some significant changes in the legislative background and in societal attitudes and expectations that have occurred in recent years.

76. As to legislative background, suicide used to be a crime, but it ceased to be such in 1961. Section 1 of the Suicide Act 1961 enacts that: "The rule of law whereby it is a crime for a person to commit suicide is hereby abrogated." Although the offence has been abolished, it is still a crime to encourage or assist a person to commit suicide (Suicide Act 1961, section 2).

77. There has been an unmistakable change in society's understanding and attitude to suicide. This change is charted by Lloyd LJ in *Kirkham v Chief Constable of the Greater Manchester Police* [1990] 2 QB 283. In that case, the court was faced with the argument that there was a defence to a claim for damages against a prison authority where a person had committed suicide in circumstances

where it was alleged that the prison authorities had been negligent, on the basis of the defence of *ex turpi causa*, namely that it was contrary to public policy for a person who had committed suicide to recover damages. Lloyd LJ rejected that defence, holding:

"It is apparent from these authorities that the *ex turpi causa* defence is not confined to criminal conduct. So we cannot adopt the simple approach favoured by the judge. We have to ask ourselves the much more difficult question whether to afford relief in such a case as this, arising, as it does, directly out of a man's suicide, would affront the public conscience, or, as I would prefer to say, shock the ordinary citizen. I have come to the conclusion that the answer should be in the negative. I would give two reasons. In the first place the Suicide Act 1961 does more than abolish the crime of suicide. It is symptomatic of a change in the public attitude to suicide generally. It is no longer regarded with the same abhorrence as it once was. It is, or course, impossible for us to say how far the change in the public attitude has gone. But that there has been a change is beyond doubt. The fact that aiding and abetting suicide remains a crime under section 2 of the Suicide Act 1961 does not diminish the force of the argument. The second reason is that in at least two decided cases courts have awarded damages following a suicide or attempted suicide. In *Selfe v Ilford and District Hospital Management Committee*, *The Times*, 26 November 1970, Hinchcliffe J awarded the plaintiff damages against a hospital for failing to take proper precautions when they

knew that the plaintiff was a suicide risk. In *Pigney v Pointer's Transport Services Ltd* [1957] 1 WLR 1121, to which I have already referred, Pilcher J. awarded damages to the dependants of a suicide under the Fatal Accidents Act 1846. Moreover, in *Hyde v Tameside Area Health Authority*, Court of Appeal (Civil Division) Transcript No 130 of 1981 another hospital case, the judge awarded £200,000 damages in respect of an unsuccessful suicide attempt. The Court of Appeal allowed the defendant's appeal, on the ground that there had been no negligence on the part of the hospital, but not on the ground that the plaintiff's cause of action arose *ex turpi causa*. *Selfe and Pigney* are not binding on us. But they are important for this reason. They show, or appear to show, that the public conscience was not affronted. It did not occur to anyone to argue in either case that the granting of a remedy would shock the ordinary citizen; nor did it occur to the court.

For the above reason I would hold that the defence of *ex turpi causa* is not available in these cases, at any rate where, as here, there is medical evidence that the suicide is not in full possession of his mind. To entertain the plaintiff's claim in such a case as the present would not, in my view, affront the public conscience, or shock the ordinary citizen." (p 291)

78. *Farquharson and Buckley LJJ* gave concurring judgments to the same effect.

79. However, it must be pointed out that there are those who consider that

suicide is a mortal sin, and suicide will constitute a stigma for the deceased and also for his family. In the more recent case of *Braganza v BP Shipping Ltd* [2015] UKSC 17; [2015] 1 WLR 1661, this court had to consider the application of the civil standard of proof where an employer alleged that the death of an employee, a chief engineer on a ship, who was lost overboard in the Atlantic, was suicide. The deceased was a Roman Catholic and considered that suicide was a mortal sin (per Lady Hale at para 41). If he had committed suicide, he would be disqualified from receiving a death in service benefit. In determining his entitlement, the employer had to take into account in forming its view the improbability of suicide having occurred. The deceased's view of suicide must be recognised but it could not any more be described as a generally prevailing social attitude.

80. *Braganza* illustrates that others may oppose suicide verdicts for a different reason: it may lead to the loss of employee and other benefits, such as the proceeds of life insurance.

81. The role of inquests has also changed (see paras 9 and 10 above). Inquests are concerned today not with criminal justice but with the investigation of deaths. They take a new and different purpose in a case such as this.

BMA assisted dying survey

The BMA published a report on its "[Physician-assisted dying survey](#)" on 8 October 2020. The survey was carried out following a call from the union's representative body in June 2019 for a poll of its members to ascertain their views as to

whether the BMA should adopt a neutral position with respect to a change in the law on assisted dying. The BMA's current position is that it is opposed to all forms. The survey involved 28,986 members, and was one of the largest surveys of medical opinion ever carried out on the issue. The survey included specific questions on the member's own personal views and what the member considered the BMA's position should be. In terms of trends, there were few surprises, including that members in Northern Ireland were generally more opposed than those in other nations; and medical students were generally more supportive. What is interesting is comparing those specialties that were more supportive (including anaesthetics, emergency medicine, intensive care and obstetrics & gynaecology) with those which were more opposed (clinical oncology, general practice, geriatric medicine and palliative care). The full report detailing the results is over 100 pages in length; and explains how the authors analysed statistical significance, which informed their conclusions on the trends and is available [here](#).

INTERNATIONAL DEVELOPMENTS

Human Rights Indicators on the CRPD

The Office of the UN High Commissioner on Human Rights has developed a set of [human rights indicators](#) on the Convention on the Rights of Persons with Disabilities (CRPD) as a key tool to facilitate understanding and implementation of the Convention's provisions.

Human rights indicators enhance human rights implementation and measurement by:

- highlighting the practical content of norms;
- measuring progress;

- bringing transparency and accountability; and
- strengthening follow up on recommendations.

The indicators are set out by article, and readers will be likely to focus primarily upon the indicators relating to Articles 12 (the right to legal capacity) and 14 (the right to liberty). They might pause also in relation to the indicators relating to Article 10 to note that, perhaps to the surprise of many disability rights campaigners, the indicators suggest that the High Commissioner would not see legislative provision for assisted dying as contrary to the right to life enshrined in Article 10.

World Psychiatric Association "call to action"

In a further mark of the impact of the UNCRPD and the activism that it has sparked, the WPA has published in October 2020 a [Position Statement and Call to Action](#): "Implementing Alternatives to Coercion: A Key Component of Improving Mental Health Care," the first two paragraphs of which merit reproduction in full (omitting footnotes):

The purpose of this Position Statement is (1) to recognize the substantive role of psychiatry in implementing alternatives to coercion in mental health care and (2) to support action in this regard, essential to improving mental health treatment and care. The call for alternatives to coercion in mental health care is growing both within the profession and among people with lived experience of coercion in mental healthcare. There is widespread agreement that coercive practices are over-used. Considerable

work is warranted across the mental health sector and in communities and governments to ensure that people living with mental disorders and psychosocial disabilities uniformly have access to high-quality care and support that meet their needs and respect their personhood and rights.

Of central concern is the protection of human rights, and the extent to which coercive interventions violate these. These include rights to: liberty; autonomy; freedom from torture, inhuman or degrading treatment; physical and psychological integrity of the person; non-discrimination; and a home and family life. These rights have been set out most recently in the UN Convention on the Rights of Persons with Disabilities (2006) as they apply specifically to people with disabilities, including those with psychosocial disabilities. The question of whether coercive interventions can ever be justified as part of mental health treatment, to protect rights holders' own interests or on other grounds, is highly contested. This Position Statement recognises the diversity of views and experiences among mental health professionals, people with lived experience and their families and carers. The WPA would like to stress that this Position Statement and Call to Action is relevant, important, and urgent to improving the quality of mental health care in low-, middle-, and high-income countries. It has been developed in consultation with member societies as detailed in the report attached here. The WPA views this initial consultation and position statement as the beginning of a longer-term process, which will require continued engagement with member societies, people with lived experience,

families and other partners to encourage and support the implementation of alternatives to coercion in mental health care. This statement has been crafted to set a direction and practical starting point for action, based on widespread agreement that coercion is overused in mental health systems and that implementing alternatives is crucial to delivering treatment and care that upholds the human rights of people with psychosocial disabilities.

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 a [report](#) from a project Alex worked on over the summer involving Kings College London and Ipsos MORI, examining public attitudes to intensive care resource allocation during a potential second wave of COVID-19 (the work being done before the potential became rather more actual). The core purpose of the project, involving four deliberative workshops, was to dig deeper than either sound-bites or pure theoretical exercises in ethics allow. The extent to which the participants were willing to grapple with the issues involved was both humbling and also suggests that 'the public' are willing to engage in much more sophisticated discussions about hard decisions that may need to be made than they may be given credit for. Alongside this, much remains to be done both to support ordinary clinical decision-

making in extraordinary times, and to make clear more broadly how those ordinary decisions are taken (see also this article co-written by Alex in the [British Medical Journal](#)).

SCOTLAND

What does the rule of law count for?

Are the forces of institutional ageism and disability discrimination in Scotland so powerful as to exclude some people altogether from the scope of the rule of law, and from the concept of the universality of human rights and fundamental freedoms? One might have thought that all that needed to be said on that question was reported in our September and October issues, and in the materials referred to in them. Two major and contrasting developments since our October Report have, by their very differences, confronted us starkly with the question of what sort of society we are, and what is the answer to the question that I have just posed. A third occurred as we went to press.

On the one hand, on 28th October 2020 Public Health Scotland published "[Discharges from NHS Scotland Hospitals to Care Homes](#)", inhabiting a world in which elderly people, and people with disabilities, were blockages occupying hospital beds needed by others, to be shifted out of the way with no acknowledgement of the need to do so lawfully, or even of the need in terms of basic humanity to deal with them in ways that recognised not only their status as holders of the same rights as others, but also the need to safeguard their welfare, in circumstances likely to be particularly distressing and potentially confusing and damaging for them.

Then on 20th November 2020 Equality and Human Rights Commission issued their statement "[Equality and Human Rights Commission reaches settlement on ending unlawful detention of adults with incapacity by](#)

[NHS Greater Glasgow and Clyde](#)", narrating the acknowledgement by NHS Greater Glasgow and Clyde and HC One Oval Limited (owners of a chain of care homes) that the practice of NHS GGC in placing patients in two care homes in Glasgow without legal authority was unlawful. The issues raised by EHRC were of long standing. They ought to have been well known to all those operating the practices described in the Public Health Scotland Report since long before the pandemic.

Growing concerns have been tracked in succeeding issues of the Report. On 1st 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 upon which we reported under "[Equalities and Human Rights Committee and related matters](#)". On the one hand the letter asserted the urgent need for relevant reform of the Adults with Incapacity (Scotland) Act 2000, but on the other the Annex to it demonstrated apparent situations of unlawful deprivations of liberty without due process, without any comment on the lack of legality. We mentioned the court action by EHRC, and also the example of the "blind spot" regarding potentially unlawful deprivations of liberty identified in the case of *Borders Council v AB*, which we described in the [December 2019 Report](#).

In the October Report, in the item "[... then take the other knee – Covid reveals endemic issues](#)", we referred to the six seriously disturbing case histories narrated in the Response dated 26th May 2020 by the Law Society of Scotland to the Inquiry on the Impact of Covid-19 by the Equalities and Human Rights Committee of the

Scottish Parliament (the case histories can be seen [here](#)), and then quoted several seriously worrying narratives subsequently provided by practitioners. Any hopes that the October Report might have concluded all that needed to be said on this theme were certainly quickly dashed by the Public Health Scotland Report issued on 28th October 2020.

That Report referred to 5,204 discharges from NHS hospitals to care homes in Scotland from 1st March to 31st May 2020. Largely, these were not discharges to care homes from which the patients had been admitted to hospital in the first place, though statistics about that are not given. The circumstances are accordingly more clearcut, as regards issues of potential deprivation of liberty, than the English case reported [here](#), where permission to proceed to a full hearing was granted, on 19th November 2020, and in which case it would appear that the discharges from hospital were back to care homes from which patients had been admitted in the first place.

For those 5,204 discharges in three months of 2020, the requirement for legality meant either the competent and well-informed consent, without being subject to undue influence, of the patient, or demonstrable compliance with Article 5 of ECHR. The Public Health Scotland Report does not acknowledge the need for legality. It tells us that patients were assessed for their ability to consent to testing for Covid, but it is silent as to whether they were tested for ability to give informed consent to the transfers to care homes. Clarification is awaited as to whether they were in fact so tested, how many were found to have adequate competence, how many of them did in fact consent, and whether such

consent was properly documented. It is a reasonable assumption that many of them did not have adequate capacity to give valid consent. 112 were, for one reason or another – most often lack of sufficient capacity – unable to consent to testing. The primary diagnosis of 272 was dementia. The primary diagnosis of a further 145 was delirium. Clarification is awaited as to whether, and if so how, discharge was lawfully authorised for all those lacking the ability to consent, or who cannot in fact be shown to have validly consented. That may have been achieved by an attorney, guardian, or appointee under an intervention order holding relevant powers. Even so, as exemplified by *Borders Council v AB*, adequate safeguards to ensure compliance with Article 5 of ECHR would have been required.

Neither the procedure for medical certification under section 47 of the 2000 Act, nor the procedure for “provision of services to incapable adults” under section 13ZA of the Social Work (Scotland) Act 1968, are relevant, because neither can provide a basis of legality for deprivations of liberty in accordance with Articles 5 and 6. In the case of section 13ZA, local authorities cannot use that procedure where the outcome would be a deprivation of liberty: see “Guidance for Local Authorities (March 2007): Provision of Community Care Services to Adults with Incapacity”, with which local authorities must comply under section 5 of the 1968 Act.

My further comments on the Public Health Scotland Report and related matters may be found in my paper “Every life matters: advance care and treatment decisions and planning, end of life, Covid-19”, available [here](#), following upon a

lecture delivered as part of the Centre for Mental Health and Capacity Law's Autumn 2020 series on 11th November 2020. See also the [press release](#) by the Law Society of Scotland, widely reported in the Scottish press.

The announcement by EHRC of the successful settlement of their action refers to improved discharge processes, to the position of those affected having been regularised, and in particular to NHS GGC having established a "Revised Patient Pathway". Details of all of these steps are awaited. In particular, it is a matter of considerable public interest that it be demonstrated that the "Revised Patient Pathway" guarantees lawfulness for the future, and that there be public visibility that it is in fact followed. It is also essential to know that equally effective protocols are in place and are being followed throughout Scotland.

Moreover, it appears to be difficult to see what excuse relevant authorities can have had for not ensuring the lawfulness of all discharges since well before the pandemic. It appears that the practices of NHS GGC, and concerns about their lawfulness, go back to around 2017, when a solicitor acted in the cases of several adults apparently unlawfully detained in units to which they had been discharged. That solicitor made applications to the Mental Health Tribunal under section 291 of the Mental Health (Care and Treatment) (Scotland) Act 2003, which allows persons unlawfully detained in hospital, and being given treatment there primarily for mental disorder, to obtain an order requiring detention to cease. Our information is that the unlawfulness was effectively conceded by rapid steps to detain those patients under compulsory treatment orders prior to the applications under

section 291 being heard. These cases were reported to EHRC, who – it is understood – were trying to have the issues addressed and resolved since then, but ultimately found it necessary to commence their court action.

It is notable that in a report dated 27th March 2019 on "[Glasgow City HSCP's Delayed Discharge Performance in the Acute Hospital System](#)", the concerns of EHRC are acknowledged, referring to "prospective legal challenges from [EHRC] in relation to the specialist AWI beds commissioned by GCHSCP on behalf of the Health Board". That report seems to assume that obtaining orders under Part 6 of the 2000 Act always has to be a seriously protracted process. Experience of practitioners in different parts of the country indicates considerable variations in that regard. I am aware of training and advice given to NHS GGC in 2012 and 2013 as to how the process of obtaining Part 6 orders can be accelerated, and the 2019 report referred to above does report substantial improvements since 2011, but also that HSCPs have "already exhausted the majority room for improvement over the period since 2011". The report nevertheless states that "an AWI-related delay may result in 200-300 bed days lost", and at another point asserts that "AWI delays place the greatest restraint on the Acute system as they typically involve delays of many months while guardianship powers are pursued to enable a patient to be moved to another location (invariably a care home) in line with legal requirements". There is no explanation of these excessive delays. One has to suspect poor management of resources in the sense of failing to invest adequately in key staff such as MHOs when – having regard to costs of "bed days lost" – proper management of the public purse would

seem to point towards an imperative on financial grounds, quite apart from patient care and human rights grounds. It would be interesting to know whether anyone can contribute information as to whether these issues are in fact being properly and effectively addressed.

In fairness, one must draw attention to the case histories at the end of the 2019 report, showing how very difficult can be situations which arise in reality. The extent of those difficulties, however, demonstrates the importance of all concerned being well aware of relevant legal and human rights issues and having access to the necessary support to ensure that they are promptly identified, and that lawful procedures are followed in every case.

Much more now requires to be done. A start has been made by Scottish Government in issuing on 24th November 2020 its document "[Key actions on managing the end-to-end discharge process of adults who lack capacity including legal measures](#)". Time does not allow us to comment in full on that document in this issue of the Report. In general terms, it is a valuable and prominent reminder of what should be done from now on. In essentials, it does not add greatly to the advice given in 2012 and 2013 referred to above. As regards two serious "pinch points" in processing Part 6 welfare applications, it is not yet accompanied with the necessary undertaking from Scottish Government to take immediate steps to redress the serious under-provision of mental health officers; nor does it provide the explicit guidance which seems to be required by some general practitioners (though not all) as to their duties in relation to issuing reports on their own patients for the purposes of Part 6 applications. On section 13ZA of the

Social Work (Scotland) Act 1968, it does mention that that procedure may not be used if the outcome would be a deprivation of liberty, though it lacks clarity as to the full range of circumstances that have been held (elsewhere in the United Kingdom and in Strasbourg, if not explicitly in Scotland) to amount to deprivations of liberty, and there is room for possible debate as to whether it overstates, at least by implication, the extent to which section 13ZA can properly be used.

It would probably have been beyond the scope of that Scottish Government document to remind all concerned of their duties in relation to persons whose discharges from hospital may have resulted in unlawful deprivations of liberty, or for whom constraints applied to them in care homes (whether they were discharged there from hospital or not) have amounted to unlawful deprivations of liberty. One trusts that local authorities will fully perform their obligations under sections 53(3) and 57(2) of the 2000 Act to ensure that a Part 6 appointment is made in every case where that may be needed to investigate and if necessary address any *prima facie* situation of potential deprivation of liberty. Everyone who is deprived of liberty has the right under Article 5.4 of ECHR to have the lawfulness of detention "decided speedily by a court", and release ordered if the detention is not lawful. Of course, a Part 6 appointee in any particular case may decide that it accords better with the 2000 Act's principles to sanction any deprivation but perhaps negotiate and agree appropriate terms for doing so. Article 5.5 gives every victim of unlawful deprivation of liberty "an enforceable right to compensation". In any particular case, a Part 6 appointee having considered the whole situation in the light of the section 1 principles in

the 2000 Act, and provided that the unlawfulness has not continued, might conclude that although such action could result in acknowledgement of the unlawfulness, there would be little prospect of obtaining more than nominal compensation, not justifying litigation.

However, it should not be lightly assumed that an unlawful deprivation of liberty, if established, did not have detrimental consequences in relation to the adult's health or welfare or wellbeing, including in relation to Article 8 rights to private and family life, warranting significant compensation. Aspects of discrimination on grounds of age or disability might be aggravating factors. Common law rights to redress for unlawful imprisonment are also relevant.

It may be important in this context to recognise the distinction between official advice on the one hand, and exercise of lawful powers on the other. It might or might not have coincided with advice effectively to imprison an incapacitated adult in a care home without contact with family and friends, but that will have amounted to an unlawful deprivation of liberty if not done with competent consent by or on behalf of the adult, or otherwise with lawful authority. Persons at large in the community may overwhelmingly have chosen to abide by advice, without legal compulsion, even if only because they feared the social consequences of not doing so, but ultimately they were in legal terms free to make that choice. It is quite another matter to impose such an outcome without legal authority upon someone who could not make that choice, and on whose behalf it was not competently made. It should not too readily be assumed that they would have made that choice if they could: a noticeable element of ageism in the context of

the pandemic seems to have been to impose the values of younger people on those closer to the end of life, for whom – increasingly – quality of life, and issues such as contact with loved ones, become increasingly more important than prolongation of life.

It would appear that in every case of potential deprivation of liberty, appointees will require to assess harm and damage, including to welfare, actually sustained. It is notorious that the very act of moving elderly people who might be confused by the move can be harmful. The number of moves must be minimised. The idea of moving them to a temporary "holding facility", then moving them further, would require to be robustly justified in that context. If a person contracted illness or suffered other harm as a result of being placed unlawfully in a particular care home, then regardless of overall statistics about probabilities provided in the Public Health Scotland Report, though subject to any competent defences available, significant compensation might be due.

Ultimately, proactive steps are required to eradicate the culture of institutional ageism and disability discrimination that the pandemic has revealed.

Adrian D Ward

Editors and Contributors



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

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



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

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



Neil Allen: neil.allen@39essex.com

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



Annabel Lee: annabel.lee@39essex.com

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



Nicola Kohn: nicola.kohn@39essex.com

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



Katie Scott: katie.scott@39essex.com

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



Rachel Sullivan: rachel.sullivan@39essex.com

Rachel has a broad public law and Court of Protection practice, with a particular interest in the fields of health and human rights law. She appears regularly in the Court of Protection and is instructed by the Official Solicitor, NHS bodies, local authorities and families. To view full CV click [here](#).



Stephanie David: stephanie.david@39essex.com

Steph regularly appears in the Court of Protection in health and welfare matters. She has acted for individual family members, the Official Solicitor, Clinical Commissioning Groups and local authorities. She has a broad practice in public and private law, with a particular interest in health and human rights issues. She appeared in the Supreme Court in *PJ v Welsh Ministers* [2019] 2 WLR 82 as to whether the power to impose conditions on a CTO can include a deprivation of liberty. To view full CV click [here](#).



Simon Edwards: simon.edwards@39essex.com

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



Adrian Ward: adw@tcyoung.co.uk

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



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

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

Conferences

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](#).

Jill Stavert's Centre for Mental Health and Capacity Law (Edinburgh Napier University)'s Autumn 2020/January 2021 webinar series will include a contribution by Alex on 2 December 2020 at a webinar about Psychiatric Advance Statements. Attendance is free but registration via Eventbrite is required. For more details, see [here](#).

Advertising conferences and training events

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

Our next edition will be out in December. Please email us with any judgments or other news items which you think should be included. If you do not wish to receive this Report in the future please contact: marketing@39essex.com.

Sheraton Doyle

Senior Practice Manager
sheraton.doyle@39essex.com

Peter Campbell

Senior Practice Manager
peter.campbell@39essex.com



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



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

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

LONDON

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

39 Essex Chambers is an equal opportunities employer.

39 Essex Chambers LLP is a governance and holding entity and a limited liability partnership registered in England and Wales (registered number OC360005) with its registered office at 81 Chancery Lane, London WC2A 1DD.

39 Essex Chambers' members provide legal and advocacy services as independent, self-employed barristers and no entity connected with 39 Essex Chambers provides any legal services.

39 Essex Chambers (Services) Limited manages the administrative, operational and support functions of Chambers and is a company incorporated in England and Wales (company number 7385894) with its registered office at 81 Chancery Lane, London WC2A 1DD.

MANCHESTER

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

SINGAPORE

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

KUALA LUMPUR

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