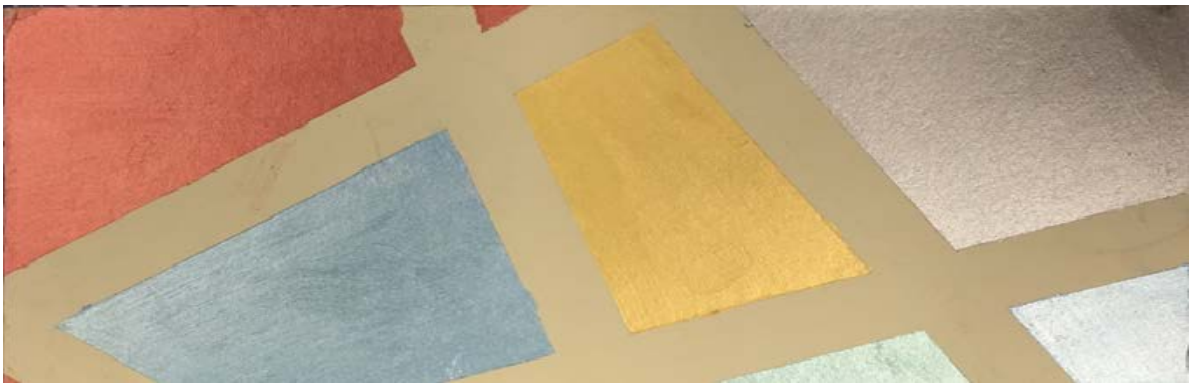

Welcome to the March 2024 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: sexual and contraceptive complexities and an important light shed on DoLS from Northern Ireland;

(2) In the Property and Affairs Report: the obligations on the LPA certificate provider, telling P their damages award, and dispensing with notification in statutory will cases;

(3) In the Practice and Procedure Report: when it is necessary to go to court in serious medical treatment cases, and a Scottish cross-border problem;

(4) In the (new) Mental Health Matters Report: medical evidence, mental disorder and deprivation of liberty, and the approach to propensity evidence;

(5) In the Wider Context Report: when not to try CPR, developments in the context of assisted dying / assisted suicide and with Martha's Rule, and news from Ireland;

(6) In the Scotland Report: a Scottish take on the *Cheshire West* anniversary and a tribute to Karen Kirk.

You can find our past issues, our case summaries, and more on our dedicated sub-site here, where you can also sign up to the Mental Capacity Report.

Finally, we should note March 2024 contains three ten year anniversaries. One is national – indeed international – significance: the decision in *Cheshire West*; one is of national significance: the House of Lords Select Committee post-legislative scrutiny report on the MCA 20025; and the third is of personal significance to Alex: the launch of his website.

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

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Re EE (Capacity: Contraception and Conception) [2024] EWCOP 5 (Poole J)

Mental capacity – sexual relations

Summary

Poole J is rapidly becoming the specialist sexual capacity judge at the Court of Protection. Following his decisions in *Hull City Council v KF* [2022] EWCOP 33, and *Re PN (Capacity: Sexual Relations and Disclosure)* [2023] EWCOP 44, we now have a further decision from him. This case concerned a 31 year old woman who wanted to become pregnant and have a baby; her capacity to engage in sexual relations, to decide about contact with others, and to make decisions about contraception, were all in issue and required the court's determination.

The parties agreed that EE had capacity to make decisions to engage in sexual relations and lacked capacity to make decisions about contact with others. The applicant local authority submits that EE lacks capacity to "make decisions about whether to use contraception." The Official Solicitor submitted that EE has capacity to make "decisions about contraception." As Poole J noted at paragraph 3:

> *The fact that the parties used different formulations for the matter in respect of which the court must evaluate P's capacity to make a decision for herself concerning contraception, points to an important issue for the court to address, namely what is the matter in relation to contraception which EE has to decide.*

Sexual relations and contact

Poole J's analysis of the position is sufficiently nuanced and detailed that it requires to be set out in full.

First, as regards sexual relations:

> *24. Dr Todd has advised, and the parties agree, that EE has capacity to make decisions to engage in sexual relations. I am not bound so to find. I have regard to the legal framework set out earlier in this judgment and, crucially, the authority of JB. Baker LJ's formulation of the information relevant to a decision to engage in sexual relations included "that a reasonably foreseeable consequence of sexual intercourse between a man and woman is that the woman will become pregnant." He did not include information about the possible consequences to P, or, if P is male, to P's female sexual partner, of becoming pregnant to P or the possible risks to the baby if conceived. However, the "specific factual context", including the existence of "serious or grave consequences" of a decision, or not making the decision, needs to be considered and Baker LJ did not purport to give an exhaustive or exclusive list of relevant information that would apply in every case. If a woman of child-bearing age were to have a high risk of suffering serious or grave complications of pregnancy of the kind to which P in DD was vulnerable, then it is arguable that the information relevant to her decisions to engage in sexual relations would include not only the prospect of her becoming pregnant but also that consequently she and her baby would be at a high risk of grave harm. These kinds of reasonably foreseeable consequences were not addressed by Lord Stephens in JB, but he was concerned with a man not a woman, and in any event it would not have been possible for him to have addressed every kind of information that would be relevant to every potentially incapacitous person's decisions to engage in sexual relations. Instead, he set down the general requirement for the court to consider the specific factual context of each case.*
>
> *25. However, having noted that it is at least arguable that in some cases where there are serious or grave risks of harm*

> *consequent on a pregnancy, the information relevant to engagement in sexual relations might include those risks, it is right to note that Lord Stephens warned that there were "practical limits" on what P should be expected to envisage as the "reasonably foreseeable consequences" of a decision or failing to make a decision. A line must be drawn so as to avoid imposing too high a requirement on persons who may potentially lack capacity to make a particular decision.*
>
> *26. In the present case, I consider that in the context of decision-making about engaging in sexual relations it would exceed the practical limits to require EE to envisage the risks to her or her baby should she become pregnant following intercourse. Firstly, the evidence does not establish that she or her baby would be at serious or grave risk of harm were she to become pregnant. The evidence suggests that there would be some risks to her, but they are not of a direct and severe kind. I address this more fully below. Secondly, many women will put their physical or mental health at risk by becoming pregnant. Some may consider those risks before engaging in sexual relations, some might not. To require EE to understand and weigh or use information about risks to her health during pregnancy or labour, in particular risks which were not grave, would stray beyond the practical limits to which Lord Stephens referred and would set the bar too high. Thirdly, and similarly, many women will engage in sexual relations with a view to conceiving when there is a risk that their baby will suffer harm in utero or be born with a congenital disability. Again, some women will consider those risks in advance of engaging in sexual relations, some will not: the bar should not be set too high for EE. Finally, these matters – risks consequent to pregnancy – have not featured significantly or at all in the case law regarding the information relevant to decisions about sexual relations including older authorities about capacity to consent to sexual relations. I proceed on the basis that it would only be in cases where there was a clearly identified, high risk of grave harm consequent on pregnancy or childbirth, that information about that might have to be envisaged by P and be included in the list of relevant information.*
>
> *27. I have found it necessary to address the question of information relevant to decisions to engage in sexual relations, notwithstanding the agreement of the parties as to EE's capacity in that respect, because it is necessary to consider the consistency between the determinations of capacity I have to make.*

On the facts of EE's case, Poole J considered that:

> *28. In my judgment the information relevant to EE's decisions to engage in sexual relations is that set out by Baker LJ in JB and I do not consider that any further relevant information should be added in this case. Dr Todd's written reports correctly address EE's ability to understand, retain, and weigh or use the relevant information. EE's responses in interviews with Dr Todd are conspicuous for the detailed understanding and ability to weigh and use information that she demonstrates. As Dr Todd said to the court, EE offered the information she knew and her opinions about decision making, largely unprompted. I have no hesitation in finding that she has capacity to decide to engage in sexual relations as Dr Todd and the parties have agreed.*

Second, as regards contact, the primary reason EE lacked capacity regarding contact was her inability to use or weigh the risks that others

posed to her. Poole J noted that he should comment briefly on whether the agreed positions regarding capacity to make decisions about sexual relations and about contact with others were consistent with each other, especially in light of his observation in *Hull City Council v KF* that it was difficult to see how a person who lacked capacity to decide to have contact with a specific person could have capacity to decide to engage in sexual relations with that person. Poole J continued:

> *30.* […] *However, in PN […] I was concerned with determining capacity to engage in sexual relations generally, not with a specific person and I found that PN lacked capacity to make decisions about contact with others but had capacity to engage in sexual relations with others. For the reasons set out in that judgment, in particular at [28], I did not consider those determinations to be inconsistent. Likewise, in the present case, I am content to find that EE lacks capacity to decide on contact with others, specifically those with whom she is not already familiar, but has capacity to decide to engage in sexual relations with others. EE's carers have devised and adopted a care plan which has been based on those positions in relation to capacity. It follows an approach of the kind set out by Baker J in A Local Authority v TZ [2014] EWHC 973 (COP) and discussed in his oral evidence by Dr Todd when he referred to "positive risk taking". The approach involves encouraging EE to consider the risks and benefits of meeting any particular person and the form of contact with them but ultimately to make best interest decisions to protect her from harm, or the risk of harm from contact with a person with whom she is unfamiliar, and to allow for interventions by a carer. However, once she has familiarity with a person and wishes to have sexual relations with them, her capacity to make that decision would have to be respected. The fact that JB had been found to lack capacity to make decisions relating to contact with others did not preclude the Court of Appeal and the Supreme Court from considering whether he lacked capacity to engage in sexual relations. The courts were clearly prepared, in principle, to find that he had capacity to engage in sexual relations notwithstanding that he lacked capacity to decide to have contact with others.*

Contraception and conception

When the expert was asked about contraception, he had questions put to him as if "contraception" included two questions: (1) deciding to conceive; and (2) to make decisions in relation to contraception. Poole J therefore considered "whether it is appropriate to consider EE's capacity to decide to conceive or to become pregnant alongside decisions about her capacity to make decisions about engaging in sexual relations and the use of contraception" (paragraph 31). At paragraph 34 he asked himself:

> *Ought the court to be even considering the question of EE's capacity to make decisions about conception given its determination that EE has capacity to decide to engage in sexual relations and that it will determine her capacity to decide on the use of contraception? In JB no distinction was made between decisions about engaging in sexual relations with a view to trying to conceive, and decisions about sexual relations which are not for any reproductive purpose. It is sufficient for P to understand, retain, and weigh or use information that sex might result in pregnancy. There was no suggestion in JB that the relevant information concerning pregnancy differs according to whether P and their consenting sexual*

> *partner wish to have sex without contraception. Furthermore, the non-exclusive list of information relevant to decisions to engage in sexual relations set out in JB does not include the risks consequent on pregnancy or childbirth to P or, if P is a man, to a woman with whom P has sex, or to a conceived child. Such information was not included within the "practical limits" of what needs to be envisaged. In the present case I have found that those matters were not part of the information relevant to EE's decision to engage in sexual relations. The freedom to make decisions about conceiving and having children, subject to the unavoidable restrictions imposed by biology, is a fundamental part of anyone's Article 8 right to respect for their private and family life and, in my judgment, it would be irrational, unnecessary, and an unjustified interference with EE's Article 8 rights, to find that she has no capacity to make decisions about conception on the grounds that she cannot understand, retain, or weigh or use that same information. Dr Todd and the Applicant have, I believe, fallen into that error.*
>
> *35. Clearly there is some overlap between decisions about contraception and decisions about conception, but they are different. Without needing to decide the matter, there may be cases, for example where P wishes to undergo IVF, in which P's capacity to make a decision about conception has to be determined. But in most cases, including EE's case, those specific considerations will not apply. EE has capacity to engage in sexual relations and that means she has capacity to engage in sexual relations with a view to becoming pregnant. I shall also consider her capacity to make decisions about the use of contraception. In the circumstances, no separate consideration of capacity to decide about conceiving or conception is required or justified.*

Poole J therefore found that it was not necessary or appropriate to frame the matter for decision as being about "conceiving/getting pregnant" as Dr Todd expressed it, or about conception at all. Rather:

> *36.* […] *In relation to the issue of contraception, in my judgment the appropriate formulation of "the matter" in respect of which the court must evaluate whether EE is unable to make a decision for herself, is "the use of contraception".*

As to contraception, Poole J reminded himself that in order to identify the information relevant to the decision in question, he had to consider the particular factual context within which EE would make such decisions. She was currently prescribed anti-anxiety medication, sleeping tablets, and an anti-psychotic. The probable advice to EE would be to continue with each of these during pregnancy. EE had said that that is what she would do. She had been compliant with her medication for some time and had not suffered a psychotic episode for a while. The medical evidence was that, if EE were to continue her medication throughout pregnancy, then at birth the baby might initially have to be cared for in the neonatal intensive care unit to monitor for signs of withdrawal from the anti-psychotic medication. Poole J noted (at paragraph 37) that there was no evidence that EE did not understand this information or was unable to weigh or use it.

Poole J noted that Dr Todd had concluded that "[EE] *does not have the mental capacity to make an informed decision whether to use contraception to prevent the risks associated with pregnancy to her mental health and the risks to her baby of a mental health relapse and the use of*

psychotropic medication during pregnancy." At paragraph 3.2 of the report, he explained his reasoning:

> *She stated that it is her right to have a child and all her physical and mental problems will go away once she has a child. This strongly held belief, in combination with her lack of insight into her care and support needs, leads her to be unable to use and weigh the risks to her mental health of becoming pregnant and being a new mother and the impact of the baby on her mental health and the risks to her baby of a mental health relapse and the use of psychotropic medication during pregnancy. In terms of pregnancy and the risks to her mental health, EE believed that she would be able to manage regardless of any impact on her mental health. In terms of pregnancy and the risks to her baby, she believed her mental health would have no impact on the child and any risks caused by psychotropic medication were not significant and, even in the worst case, she would be able to manage the impact on the baby.*

In his oral evidence, Dr Todd focused on the risk of EE suffering from a deterioration in her mental health or psychological state due to the combination of her autism and learning disability, and the stress of pregnancy and/or birth. However, as Poole J noted: "[h]e *had not specifically addressed that issue in his written evidence. More importantly, he had not addressed it with EE, so that there was a lack of evidence before me of what she might have said about the risk of a general deterioration in her mental or psychological condition*," such that:

> *40. I have virtually no evidence of the likelihood, nature, or severity of any deterioration in her mental or psychological state that EE might suffer as a consequent of pregnancy. Dr Alex does not comment on those matters in his report, Dr Todd does not give such evidence in his written reports, and he did not provide any specific evidence at the hearing, only referring to having dealt with a patient, whom I did not understand was pregnant at the material time, who had suffered what he called "an autistic meltdown". I do not doubt that as a woman with autism and learning disability, EE will have some difficulties adapting to the physical and emotional changes caused by pregnancy, but I have no evidence beyond Dr Todd's implication, that EE is especially vulnerable to suffering a severe crisis of the kind he described should she become pregnant.*

As Poole J identified, a relevant aspect of the case that EE had previously been pregnant, and that there was evidence that she experienced an autistic "meltdown" or other deterioration, although he had been given very little information about her previous pregnancy save that it ended with a termination. He continued (at paragraph 41): "[it] *cannot be known exactly what support EE would have were she to find that a pregnancy was exacerbating her mental or psychological health. The father might or might not support her, but she would be highly likely to have the support of care staff and therapists*." Further, and whilst it was clearly material to Dr Todd's oral evidence about EE's capacity to make decisions about contraception, that he had found (and no-one disputed) that EE lacked capacity to make decisions about her care, and that, "*his view appeared to be that because she lacks capacity to make decisions about care, EE cannot understand, or use or weigh, information about her care needs in the event of a deterioration in her mental or psychological health during pregnancy*." However, Poole J did not accept that reasoning: "Dr Todd's interview with EE about care and support focused on her independence and ability to live without day to day support and care, not on medical treatment or support in the particular

circumstances of a crisis or deterioration in her mental health or psychological condition caused by pregnancy" (paragraph 43).

As Poole J identified:

> *43. There are reasons to avoid setting the bar too high for capacity to make decisions about the use of contraception. As noted, at [75] of his judgment in JB, Lord Stephens adopted the caution expressed in In re M (An Adult) (Capacity: Consent to Sexual Relations) [2014] EWCA Civ 37, namely that the notional decision-making process attributed to P should not "become divorced from the actual decision-making process carried out in that regard on a daily basis by persons of full capacity". Daily, in GP surgeries and clinics, women make decisions about contraception without considering the risks to them or to the health of their baby if they were to get pregnant. The risk of becoming pregnant following intercourse is a core piece of relevant information, but not all the many and varied risks which may be consequent on becoming pregnant. Some may envisage all manner of risks, others will not do so.*
>
> *44. Nevertheless, for some women, there may be certain risks arising from pregnancy that would be highly relevant to their decisions about the use of contraception. Following paragraph 4.19 of the Code of Practice (above), and Cobb J's judgment in DD (above), serious or grave consequences of pregnancy to which P would be particularly vulnerable, might be considered to be part of the relevant information. In my judgment, this approach would be consistent with the approach to decision-making about engagement in sexual relations set out by Lord Stephens in JB as I have tried to describe earlier in this judgment. The information relevant to a decision is dependent on the specific factual context of each case but must be kept within practical limits so that the bar is not set too high and the requirements on a person who might lack capacity are not divorced from the realities of decision-making for capacitous persons.*
>
> *45. More remote consequences of pregnancy, labour and birth, such as the impact on the child of being born to a mother with mental health problems, physical illness, or disability, are not part of the relevant information (for a number of reasons including that they are not within practical limits or, as it was put by Bodey J in A Local Authority v Mrs A and Mr A (above) they are not proximate medical considerations).*

Therefore, considering the evidence in the case, the specific factual context in which EE might make decisions about contraception,, including whether to use contraception at all, and the need to respect practical limits when determining what reasonably foreseeable consequences should be included, Poole J decided to adopt the list of relevant information given by Bodey J in *A Local Authority v Mrs A and Mr A* [2010] EWHC 1549 (Fam), with no additions or subtractions, i.e. (i) the reason for contraception and what it does (which includes the likelihood of pregnancy if it is not in use during sexual intercourse); (ii) the types available and how each is used; (iii) the advantages and disadvantages of each type; (iv) the possible side-effects of each and how they can be dealt with; (v) how easily each type can be changed; and (vi) the generally accepted effectiveness of each.

Poole J was also at pains to explain why he had excluded certain information, at paragraph 47:

> *a. The risks and benefits to EE of continuing with anti-psychotic and other medication during pregnancy. I am not*

persuaded that serious or grave consequences to EE are brought into consideration. Moreover, I believe that these risks and benefits are not sufficiently proximate to the decision about contraception. The risk of thromboembolic disease which was pertinent to decision making in DD would arise directly from a pregnancy. Here, the risks of continuing or discontinuing medication are a secondary consequence of the pregnancy – they arise from a decision that has to be made in the event of the pregnancy. They are therefore further removed from the decision about contraception. If I am wrong and should have included this information, then I am quite satisfied that EE can understand, retain, and weigh or use the information. Dr Todd focused his discussions with EE much more on the potential impact of continuing the medication on any baby she might carry in the future, rather than on the impact to EE herself of ceasing medication, but he went through Dr Alex's report with her and EE appears to have aligned herself with Dr Alex's evidence and his opinion that EE ought to continue taking her current medication during any future pregnancy. I am satisfied that she did so having weighed and used the information provided. To underline my conclusion, EE's ability to weigh and use information in relation to the medical issues regarding the use of different forms of contraception shows her functional abilities in these areas.

b. The risks of a deterioration in EE's mental health or psychological condition due to pregnancy or labour. There is no, or no sufficient, evidence before me that this is a serious or grave consequence in the case of EE. I would accept that in principle serious or grave risks might be included as reasonably foreseeable consequences of deciding not to use contraception, but in the specific context of this case, the evidence does not justify treating these risks as serious or grave or as matters which any woman in EE's position would have to consider when making decisions about contraception. Aside from Dr Todd's comments during his oral evidence about the risk of "autistic meltdown", which were not backed up by any references or reliable experience, only by an anecdotal reference to a single case that did not relate to a pregnancy, no other evidence was provided that was relevant to EE's case. If, contrary to my determination, this should be regarded as relevant information then I would need to consider allowing for a further interview with EE in order to afford her an opportunity to address it and thereby to give the court evidence as to her ability to understand, retain, and weigh or use that information. This information has not been discussed with her. I do not need to decide whether I would indeed allow for further evidence to be adduced but I note that the onus is on the Applicant to establish that EE lacks capacity. Whilst the Court of Protection adopts an inquisitorial approach, it does not follow that if, after sufficient time has been given to gather relevant evidence, a party is unable to establish a case, then proceedings must be adjourned to enable more evidence to be obtained.

c. The potential effects on EE's baby of her continuing to take anti-psychotic and her other current medication during any pregnancy. Dr Alex's evidence is that,

> *"Use of aripiprazole [which EE takes] and other antipsychotics throughout pregnancy or near delivery has been associated with withdrawal symptoms in the neonate and/or poor neonatal adaptation syndrome (PNAS).*

> *These symptoms are likely to be more severe in infants exposed in utero to more than one CNS acting drug. Delivery should therefore be planned in a unit with neonatal intensive care facilities."*
>
> *Dr Alex has not said that withdrawal symptoms or PNAS would be a severe or grave condition for the baby. Care must be taken not to insist on P needing to envisage a wider range of risks than a capacitous woman might be expected to envisage, including women taking prescribed or other medication which might affect a baby if they became pregnant.*
>
> *d. The effect of EE's mental or psychological health on her newborn baby, the difficulties she might have caring for a baby or coping with the peri-natal period, or the prospects of a child being made the subject of protective orders by the court. Those issues are not "proximate medical issues" and are not within "practical limits" of what needs to be envisaged (JB at [75]).*

Having regard to the relevant information, Poole J had "no hesitation" in finding that EE had capacity to make decisions about the use of contraception.

Poole J, who had met with EE prior to the hearing, agreed with EE that he would write a letter to her explaining his decision. He noted that:

> 50. […] *With respect to her, although she has thought the matter through, many would think it unwise for her to try to conceive, but it is not for me to advise her, and it is certainly not the role of the Court of Protection to intervene in the autonomous decision-making of an adult who has capacity to make decisions about sex or the use of contraception, however unwise the court may consider the proposed decisions are. Many capacitous people make unwise decisions about sex and contraception, sometimes with awful consequences for themselves and others, but however strong is the impulse to protect, the follies of the capacitous are not the business of the Court of Protection.*

Comment

As might be expected, the ramifications of the decision in JB continue to make themselves felt, especially as to the vital importance of focusing on the information that is actually relevant to the decision in question. This, in turn, involves the recognition that determination of mental capacity has a clear element of social construction to it. For the avoidance of doubt, we are suggesting by this that this means that it is a concept that lacks validity, but rather that it is a concept that requires to be considered in a transparent fashion in exactly the way that Poole J has done here.

Poole J's analysis of the interrelationship between conception and contraception is also very helpful in terms of clarifying a matter which can otherwise cause undue complication, his clear-eyed analysis of the need for actual evidence of risk if such risk is to be asserted to be relevant both made all the difference on the facts of the case and is of wider relevance.

Care, residence and contraception – getting the calibration right

Re CLF (Capacity: Sexual Relations and Contraception) [2024] EWCOP 11 (Poole J)

Mental capacity – sexual relations – care – residence

Summary

In this case, Poole J had to consider the capacity of woman to make decisions about: (1) the

conduct of the proceedings; (2) residence; (3) care; (4) contact with others; (5) use of the internet and social media; (6) engagement in sexual relations; and (7) the use of contraception. He accepted the unchallenged expert evidence that CLF lacked capacity to make decisions about conducting the proceedings, care, contact and the use of internet and social media. He therefore focused on residence, engagement in sexual relations, and the use of contraception.

On residence, Poole J was troubled by the attempt to pull part care and residence on the facts of the case:

> *36. Dr Rippon's evidence as set out at paragraphs [10] and [11] of this judgment is that CLF is able to make a decision as between two options for her residence but only if adequate care was arranged at each one. CLF does not have capacity to make decisions about her care but, as I understand Dr Rippon's evidence, she can describe her care – she understands what care is and what kind of care she is receiving. Hence, she could not make a decision about residence if it involved an assessment of the appropriate level of care in each place available for her. But if the provision of care was decided for her, she would be able to understand, retain, and weigh or use the other information relevant to a decision about residence – see LBX at [43] (above). Mr Karim KC for the Local Authority submitted that the court should not accept the distinction that Dr Rippon had adopted but should apply LBX, avoid the trap identified in Re B, and find that CLF lacks capacity to make decisions about residence. Mr O'Brien KC, for the Official Solicitor for CLF, submitted that the danger of considering decision-making in silos, as identified in Re B, was that it may result in a situation that would be "practically impossible" for the Local Authority to implement – Re B at [63] (above). Here, it would not be practically impossible for the Local Authority to make decisions about the care provision CLF requires, make arrangements for that to be put in place at residence A and residence B, and then allow CLF to make a choice about which residence to live in. Where possible, her autonomy should be respected and protected.*
>
> *37. There is a risk, in my judgement, in dissecting areas of decision-making such that it becomes practically impossible for those caring for P to implement the assessments of capacity made. It would make it difficult for a Local Authority to implement a care plan if it had been determined that P had capacity to make decisions on, for instance, eight aspects of her care, but not on five others. Furthermore, the process of assessing capacity might become unwieldy. However, in this instance, Dr Rippon's evidence is that CLF would have capacity to make decisions about her residence but for the element of choosing the right level of care within those places. I can see that if care decisions could be removed from decision-making about residence, then a declaration that CLF had capacity to make decisions about residence provided that the care arrangements for each available residential option were made for her, would not necessarily be incompatible with a declaration that she lacks capacity to make decisions about her care. However, my concern is that the position is more complex than Dr Rippon has assumed. As well as compatibility with the declaration of incapacity to make decisions about care, I also have to consider compatibility with my finding that CLF lacks capacity to make decisions about contact with others and to use the internet and social media. When considering the practical implications of the declaration regarding residence*

> *decision-making sought on CLF 's behalf by the Official Solicitor, I do not see how a declaration of even conditional capacity to make decisions about residence, is compatible with declarations of incapacity that I make. What might seem an attractive solution in theory, could not be possibly to put into practice. Much of the information relevant to a decision about residence, even with a care package determined for her, will be relevant to care, contact with others and the use of the internet and social media. A choice about whether to live in house A or house B will involve information about access to activities and the community which entails questions about risk; about the neighbours and any risks of conflict with them, or harm from them; about the layout of the house or flat, the ability to monitor CLF within the accommodation, including her use of social media and the internet. Care is not simply a "given": the choice of residence will itself determine the level and kind of care required. Similarly, decisions about contact with others will be contingent upon where CLF lives. Whilst wishing to protect CLF's autonomy as much as is possible, I cannot see a way in which to divorce her decision-making about residence from other decision-making in relation to which it is agreed, and I have found, CLF lacks capacity.*

Poole J therefore found that CLF did not have capacity to make the decision about residence, although, importantly, noted that "*it does not follow that CLF may not take any part in decision-making. Clearly, her views about residence should be sought and she should be supported to be able to express her opinions and take into account relevant information*" (paragraph 38).

As to sexual relations, he noted the clear and consistent evidence of the expert that CLF had such capacity. He rejected the submission that her belief that the withdrawal method was a wholly effective method of avoiding pregnancy, such that she engaged in unprotected sex, meant that she lacked capacity to decide to engage in sexual relations. That might go to the question of contraception, Poole J considered, but not to sex:

> *41. CLF clearly understands that sex may result in pregnancy. She understands and can weigh or use the other relevant information identified by Baker LJ and the Supreme Court in JB (above). On the basis of the evidence before me, including Dr Rippon's opinion evidence, I find that CLF has capacity to make decisions about engagement in sexual relations. As explained below, I find that she presently lacks capacity to make decisions about the use of contraception. I do not consider that these two findings are incompatible. The bar should not be set too high for capacity in relation to sex. There are practical limits on what should be envisaged by the individual concerned. There is a danger in imposing requirements on their decision-making that are higher than those attained by many capacitous people making the same decisions. A lack of understanding about a particular method of contraception or birth control, should not deprive a person of being found to have capacity to engage in sexual relations. It is unhelpful to break down decision-making in relation to a particular area, here sexual relations, into sub-divisions such as the decision to engage in sex whilst relying on the man withdrawing before ejaculation to avoid pregnancy. Firstly, that route will often lead to a result that is "practical impossible" to manage: how can anyone manage a situation in which a person has capacity to engage in sex using a condom but not have capacity to engage in sex using the withdrawal method? Secondly, many otherwise*

> *capacitous individuals might be found to lack capacity to make very specific decisions. Thirdly, and related to the second objection, the more one breaks down an area of decision-making into sub-divisions, the more complex the relevant information within that area becomes, and the more difficult it will be for people with a learning disability or other cognitive impairments, to avoid conclusions that they lack capacity. The MCA 2005 directs those assessing capacity to support people to make decisions for themselves. Framing decisions with ever more precision risks undermining that purpose of the Act.*

Poole J did not consider that his conclusion that CLF had capacity to make decisions about engaging in sexual relations with the finding that CLF lacks capacity to make decisions about contact with others, expressly adopting the reasoning in the earlier decisions in *Re PN (Capacity: Sexual Relations and Disclosure)* [2023] EWCOP 44, we now have *Re EE (Capacity: Contraception and Conception)* [2024] EWCOP 4.

Finally, as to contraception, Poole J noted that Dr Rippon had been clear that CLF did not understand, and could not weigh or use, information about different forms of contraception, their effects, side-effects, and effectiveness. This is primarily because she understood that contraception involving medication or a device (not condoms) will render her permanently infertile. Her inability to do so was because of her Learning Disability and Autism Spectrum Disorder. In the circumstances, he concluded, as was accepted by all the parties, that CLF lacked capacity to make decisions about the use of contraception.

He noted, though, that:

> *46. CLF also told Dr Rippon that she believed that the withdrawal method was wholly reliable to prevent her from becoming pregnant. I recognise the sensitivity of referring to the withdrawal method as a form of contraception. It might better be described as a form of birth control. I would not accept any argument that faith in the withdrawal method as a form of birth control was in itself proof of a lack of capacity to make decisions about the use of contraception (or birth control). It is practised by many millions of people. However, I accept that in CLF's case, she does not understand, and is unable to weigh or use, information about birth control, including the withdrawal method, because of her Learning Disability and Autism Spectrum Disorder. Even if I am wrong, she clearly lacks capacity in that area for the reasons referred to in the previous paragraph of this judgment.*

Importantly, Poole J did not make a final declaration in respect of CLF's capacity but only an interim one, because there was evidence that a focused educational programme could lead to CLF gaining capacity in this area.

Comment

Whilst appreciating that care and residence are distinct questions, this case adds to others (including the characteristically clear decision of Sir Mark Hedley in *Re CMW* [2021] EWCOP 50) suggesting that, in the context of someone with needs for care, attempting to take the two together represents salami-slicing leading to problems.

In relation to the approach to contraception, by contrast (and with thanks to Ian Brownhill for making this point) it might be thought that the decision could have been broken down further. Putting aside the withdrawal method, and noting Poole J's observation on whether to characterise it as a method of contraception, this was a situation where it might be thought necessary to

consider separately CLF's capacity to make decisions about (a) contraception where (in effect) reliance was being placed on the partner to use a condom; and (b) contraception reliant upon her either taking medication or using a device such as an IUD. Given that Poole J only made an interim declaration in relation to CLF's capacity, it may be that this is a matter which still falls to be considered by him in due course.

Birth arrangements under a careful microscope

A Hospital Trust v CP [2024] EWCOP 7 (Henke J)

Best interests – medical treatment

Summary

This case concerned the obstetric treatment of CP, a 30 year old woman with a diagnosis of schizophrenia who was detained pursuant to s.3 MHA 1983 The acute Trust sought declarations and orders allowing it to provide a planned caesarean section to CP.

The capacity evidence (as is commonly the case in such cases) was provided jointly by CP's Responsible Clinician under the MHA (employed by the Mental Health Trust) and a clinician from the Acute Trust. It appears from the judgment that this issue was not the subject of challenge.

The best interests evidence appears to have been tested by the Official Solicitor (albeit there was by the conclusion of the hearing, no disagreement between the parties). In carrying out the best interests evaluation, the Court factored in the evidence of CP's parents that she "*is not good at handling pain and would find a natural delivery a very difficult experience. According to them, she becomes distressed when she has a headache*," together with their evidence that she "*would be unlikely to be able to cope with a normal labour of 12-16 hours duration*" and that CP would find that traumatic. The Court accepted that if CP were to have a vaginal delivery there was a real likelihood that medical intervention would be required in crisis and that CP would need to be restrained. This, the judge considered, would be likely to impact negatively on her mental health. Henke J factored in both CP's previously expressed wish for a vaginal delivery and her views as expressed to the Court, that she wanted a caesarean section. The Court concluded that the proposed planned caesarean section was in CP's best interests.

Henke J also considered, separately, what form of anaesthetic should be used – spinal block or general anaesthetic, concluding on the facts before her a spinal block was in CP's best interests.

Comment

There are three aspects of this case that make it worthy of comment.

The first is the fact that (increasingly rarely), the Trust's obstetric plan was to move straight to a caesarean section. There were sound reasons for this, not least as set out above, that is what CP herself wanted (or at least that was the case by the time the matter was before the court). However, it is more common to see care plans that provide for vaginal delivery to be tried first, with authority to provide a caesarean section as a last resort.

The second is that, reflecting the evidence before the court, there was a rather clearer recognition in the judgment than in some others that vaginal delivery "*has the best clinical outcome for a medically low risk of primigravida. Recovery time is quicker than after a caesarean, there is no uterine or abdominal scar, there are less use of lines and thus less likelihood of wounds and infections*" (paragraph 59).

The third aspect is the decision by Henke J not to join CP's parents as parties to the application. Henke J considered COPR 2017 9.13(2) which

provides: "*The Court may order a person to be joined as a party if it considers that it is desirable to do so for the purpose of dealing with the application*." At paragraph 22, Henke J observed that "[d]*esirability in this context means that their joinder would enable the court to better deal with the substantive application*." In circumstances where the parents themselves stated that they simply wanted to observe the proceedings, where their views (in particular about CP's inability to deal with pain), had been taken on board by the Trust witnesses and reflected in the Trust's evidence and decision making, and where the parents agreed with the application, had not filed any witness evidence, or sought to cross examine any of the witnesses, Henke J held that joinder would not enable the court to better deal with the substantive application. Part of the Henke J's reasoning for not joining the parents also included (i) that CP herself did not want them joined as parties, and (ii) the fractured nature of the relationship between CP and her parents. We can quite see why these factors were in Henke J's mind, and it is clear that she did not fall into error and consider the question of joinder to be a best interests decision as opposed to a case management decision. The views of P have been taken into account in deciding whether to remove a person as a party (see *London Borough of Southwark v P & Ors* [2021] EWCOP 46 at paragraph 42) this is the first reported case we are aware of where they have been taken into account in deciding not to join someone.

DoLS and the 'nuclear option'

Northern Ireland Health and Social Care Trust, Re Application for Judicial Review [2023] NIKB 78 is a decision of the High Court in Northern Ireland from June 2023, but which only appeared on Bailii at the start of 2024. It reinforces, by analogy, how nuclear are the options (1) not granting a DoLS authorisation; and (2) discharging an authorisation. The Review Tribunal (charged with oversight of the Northern Irish DoLS regime) discharged an authorisation relating to a person in a care home, on the basis that it did not consider that it was proportionate. In doing so, it understood that there would be a care package in place for her when she returned home, at least on a trial basis, but that it would not be in place immediately upon discharge of the authorisation. The Trust responsible for the woman's care challenged the decision of the Tribunal by way of judicial review. For present purposes, the relevant ground was that it was not lawful for the Review Tribunal to permit any period of 'legal lacuna' to come into being at the point between the discharge of the authorisation and the return of the person to their own home.

Larkin J noted that the Trust's position was understandable, because it was naturally "anxious to protect those persons conscientiously discharging difficult duties from being exposed unnecessarily to liability" (paragraph 34). However, he considered that this was to misunderstand the task of the Review Tribunal, which was to determine whether the authorisation criteria are met, which were not "*addressed to the administrative desiderata or even the perceived necessities of the Trust. Those criteria do not imply, far less express, a general test of the public interest*" (paragraph 35) but rather – in summary – were concerned with the best interests of the detained person. If the Review Tribunal found that the that the deprivation of liberty was not a proportionate response to the risk of harm then "*the Tribunal has no lawful option* […] *but to revoke the authorisation to deprive P of his liberty. If the Trust considers that P still needs to be cared for, then the Trust can continue to care for P but cannot rely on the authorisation that has been revoked in order to protect P's carers from any liability that can arise if P is still deprived of his liberty*" (paragraph 38). Larkin J also noted that

"*the Review Tribunal decision did not itself have the effect of altering the day to day care of Mrs Patterson; the decision simply revoked an authorisation that afforded specified protection against civil and criminal liability. It opened up the possibility of certain other forms of relief to Mrs Patterson but it was not itself equivalent, for example, to an order pursuant to a writ of habeas corpus requiring the release of an asylum seeker from a detention centre*."

Whilst directed to the specific position in Northern Ireland (as to which, for those interested, see here for a presentation by Alex), the observations are of equal relevance both to those considering whether to grant DoLS authorisations in England & Wales, and to courts considering whether or not to discharge such authorisations on s.21A applications.

PROPERTY AND AFFAIRS

The obligations on the certificate provider

TA v the Public Guardian [2023] EWCOP 63 (Lieven J)

Lasting Powers of Attorney

Summary

The obligations on the certificate provider In a case from December 2023 which arrived on Bailii too late for the February 2024 Mental Capacity Report, Lieven J has confirmed something which might have been thought obvious: namely that a certificate provider must actually engage their brain when they are deciding whether they can complete a certificate that, in their opinion, at the time when the donor executes the instrument:

(i) the donor understands the purpose of the instrument and the scope of the authority conferred under it,

(ii) no fraud or undue pressure is being used to induce the donor to create a lasting power of attorney, and

(iii) there is nothing else which would prevent a lasting power of attorney from being created by the instrument.

(paragraph 2(1)(e) of Schedule 1 to the MCA 2005)

The (perhaps slightly surprising) argument advanced on appeal to Lieven J in *TA v The Public Guardian* [2023] EWCOP 63 was that, in the event that the court was being asked to exercise its powers under s.22 MCA 2005 to determine whether one or more requirements for the creation of an LPA have been met, it would suffice simply for the certificate to be provided. The first instance judge (HHJ McCabe) had held that the 'ordinary words' of paragraph 2(1)(e)

> *38.* […] *plainly requires the certificate provider, in order to provide the certificate, to take some steps to satisfy themselves of the matters set out in section 2 (e), otherwise they cannot be considered validly to provide the opinion. This opinion is one of the requirements for the creation of an LPA, and what is required is the provision of an opinion, not merely the witnessing of a signature.*
>
> *39. If the Court is asked, as I am, to exercise its powers under section 22 of the MCA, namely to 'determine whether one or more of the requirements for the creation of a LPA have been met', it follows that the Court must be entitled to look for evidence that the requirements have been met. Such evidence has manifestly not been provided in the current case, limited as it is to simply the asking and answering of a question "are you happy with the LPA"?*

Lieven J agreed, holding that:

> *29. Paragraph 2(1)(e) requires the provision of a certificate, but it also requires that certificate to have particular content. The content is that the certificate provider has an opinion as to three specific matters. Therefore, on a pure black letter law approach, a valid certificate must be based on an opinion as to those three matters. If the evidence showed that the certificate provider did not have such an opinion because, for example, they had not spoken to the donor, then there would not be a valid opinion.*
>
> *30. It therefore follows from the words themselves that the Court is entitled to check that the requisite opinion has actually been formed. If this stage of the analysis is not accepted, and Ms Collinson's argument is taken at its highest, then paragraph 1(e) becomes a nonsense. The mere provision of a*

certificate in the right form cannot be sufficient on its own.

31. I do not accept Ms Collinson's submission that the Court can only look at the existence of the certificate and no more. For the certificate to meet the requirement of the MCA it must be a certificate as to the matters in paragraph 2(1)(e). This follows from the terms of s.22, which allows the Court to determine whether any of the requirements for the creation of the LPA have been met.

32. It is then necessary to consider the statutory context and the mischief being addressed. The certificate is an important part of the procedure to ensure that a valid LPA has been entered into. The nature of the scheme is that validity turns not merely on the provision of certain documents, but that those documents themselves provide reassurance on a number of key matters. The whole purpose of the MCA is to make provision for the protection of those who have lost mental capacity, or who may do so, as we all may, in the future. The latter issue is dealt with, inter alia, through the making of Lasting Powers of Attorney. Those documents are of the utmost importance in the making of future decisions for people who subsequently lose capacity.

33. Paragraph 2(1)(e) does not merely concern whether the donor has capacity. It is also there to provide some safeguards that the donor understands the instrument, is not subject to fraud or undue pressure and there are no other barriers to the LPA. Plainly these matters go beyond capacity. The donor might have capacity, but not actually have read the LPA and therefore not understand its purpose or scope. This would not later be grounds to set aside on the basis of lack of capacity, but is an important safeguard in the process.

34. The scheme of the MCA, and paragraphs 2(1)(e) also gives protection to the donor at the stage of making the LPA. Although the power to set aside exists in s.22, in practice that power rests on someone raising the issue of validity after the making of the LPA. In many cases such an issue will not be raised, perhaps because there is no other person concerned and the OPG is not aware of the circumstances. Therefore the power in s.22 does not mean that a purposive and careful approach should not be taken to the safeguards in paragraph 2(1)(e).

Lieven J's judgment is an important and helpful reminder not just of the position if the case comes to court, but also of the duties on the certificate provider. It is also of note that Lieven J appeared to take it as read that the certificate provider is considering the donor's capacity (as had Poole J in *The Public Guardian v RI & Ors* [2022] EWCOP 22 (see paragraph 27)). Proposals to amend the MCA 2005 to put this beyond doubt during the passage of the Powers of Attorney Act 2023 did not see fruit, but as the secondary legislation and – above all – the forms (including the digital forms) are being worked up to enable the Act to come into force, it will be interesting to see what can be done to ensure that (1) certificate providers are aware of the duties upon them; (2) are supported to engage their brains; and (3) to record the contemporaneous evidence of such.

For those wanting to ensure that they do their job as certificate providers correctly, we recommend this guidance available from the Mencap Trust Company.

Telling P their damages award

PSG Trust Corporation Ltd v CK & Anor [2024] EWCOP 14 (Hayden J)

Deputies – property and financial affairs

Summary

Hayden J has returned to the question of what, exactly, the 'decision' in question is where the issue is whether a person with cognitive impairments in receipt of a damages award should be told the amount of that award. Previous judges who had looked at this had approached it on the basis that the decision was whether the person should be told. Hayden J, however, was uncomfortable with the phrase "capacity to be told," because "[it]*does not seem to me to capture the matter with sufficient clarity. In many respects, we have no control over what people tell us and, it follows, no decision to take*." Having traversed the authorities, and with the benefit of counsel for the applicant deputies in two cases where the issue had arisen, and the Official Solicitor as Advocate to the Court, considered that the real question was whether the person had capacity to request the value of the funds.[1] The information relevant to that decision, he considered, was likely to include: (1) the nature of the information in question; (2) the risks of obtaining it; (3) the risks of not obtaining it; (4) the benefits of obtaining it; and (5) the benefits of not obtaining it. He continued at paragraph 29**:**

> *When assessing P's capacity to take the decision, her ability, or the extent of her ability, to recognise, retain, and weigh the above questions and specifically to recognise, retain and weigh her own vulnerability and its potential consequences, will frame the scope of the decision. It follows that if she does recognise, retain and weigh these problems and vulnerabilities, it is likely that the presumption that her decision is capacitous has not been rebutted. Of course, none of this causes the identified vulnerabilities to evaporate, they remain and they are real. However, the fact that she may make unwise decisions, in the future, which cause her to fall prey to exploitation, is, ultimately, to expose her, as we all must be to some degree, to the vicissitudes of life and human transgression. But the role of this court is to protect and promote human autonomy not to repress it with misconceived paternalism. A life wrapped in cotton wool is a restricted and diminished one.*

Responding to a request for further guidance as to such applications, Hayden J continued:

> *30. Where it is concluded that P lacks capacity then, inevitably, a 'best interests' decision must be taken. I do not consider that it is necessary for a deputy to make an application in every case. Sometimes, the decision will be clear, perhaps even just common sense. In some cases, however, it will be difficult and require resort to the court. In Re ACC [2020] EWCOP 9, Her Honour Judge Hilder was considering the authority to incur legal costs on behalf of P, conferred on a property and affairs deputy by the terms of a standard deputy order. At [§52], Judge Hilder considered to what extent a property and affairs deputy is authorised to incur costs on P's behalf in health and welfare proceedings. At [§52.5]:*
>
> > *"A property and affairs deputyship does not confer any authority in respect of welfare. If a welfare issues arises, there may be a body*

[1] This comes from paragraph 28, although it is phrased as "whether P wishes to request the value of her funds." A decision to "wish to request" funds is one stage removed, however, and it is clear that Hayden J intended to crystallise the decision as being the decision to request.

> *or institution more appropriately placed than the property and affairs deputy to make that application, at less cost to P".*

Judge Hilder went on to conclude that, as a property and affairs deputy's authority extends to only property and affairs matters, they are not authorised to conduct health and welfare proceedings on behalf of P. The Judge makes the converse point:

> *"In contrast, where the contemplated litigation is not in the realm of property and affairs, there is simply no line to be drawn. A property and affairs deputy's authority relates only to property and affairs; It extends no further than meeting the deputy's responsibility to draw to the court's attention that there is or may be a welfare issue for determination by seeking directions as to how such (potential) issue may be addressed. Without such application being made and granted, the deputy proceeds at risk as to costs".*

31. Miss Collinson submits that under the terms of the standard property and affairs property order (as here), the deputy has no power to make a decision that is one "predominantly affecting welfare". This, she contends, is primarily a welfare decision. I do not agree with this analysis. What is in issue is communication of the exact sum of a damages award. That strikes me as a property and affairs matter. The fact that welfare considerations flow from it does not change the nature of the matter. Many financial issues have welfare implications, taking out mortgages, finance agreements, sustaining an extensive overdraft. This view seems to me to be entirely consistent with Judge Hilder's observations, indeed, she uses the term "in the realm of property and affairs" which implicitly recognises that decisions in that sphere will sometimes have welfare implications. I do not believe, therefore, that it is necessary to extend a deputy's authority in every case. Neither, however, do I wish to be prescriptive. Precisely because the Court of Protection is such a highly fact-specific jurisdiction, it is perfectly conceivable that what might appear on the surface to be a Property and Affairs issue, is on a proper construction, nothing of the kind and truly a welfare issue. In these cases, an application can be made and a deputy's authority extended where appropriate.

In relation to the position where the question is whether an attorney should withhold equivalent information from the donor, Hayden J noted that:

> *32.* […] *A conflict of interest or a perceived conflict of interest might arise if the agent were to decide that the amount of P's funds under his control should not be disclosed to her. If an attorney under a Lasting Power considers that P should not be told the value of funds under his control, then the matter, Mr Holmes argues, requires to be referred to the Court for determination. I agree with this as, I understand, does the Official Solicitor. It has to be emphasised that the conflict of interest between the donor and donee of a Lasting Power of Attorney, identified above does not arise in the case of deputies who are appointed by the Court and not by P, required to submit annual accounts to the Public Guardian and subject to supervision.*

On the facts of the cases before him, Hayden J found that both Ps lacked the capacity to request to see the value of their award, and that it was in the best interests of one to have the sum disclosed, but not the other.

Comment

There are definite shades of the *JB* decision in the judgment of Hayden J, not just the self-direction about the importance of identifying the decision and the relevant information, but also in the recognition of those with cognitive impairments as active agents – in the JB case, deciding to engage in sex, rather than simply consenting; here, deciding to ask about the value of their award, rather than passively receiving information if others decide to tell them.

The analysis of the blurriness of the distinction between property and affairs and welfare matters is also of interest, and self-evidently correct,[2] even if, in relation to the disclosure of damages awards, it will require deputies to making their own judgment calls as to whether disclosure is clearly a financial decision with welfare implications, or whether it is, in fact, 'nothing of the kind,' but has in fact jumped tracks and is a pure welfare decision.

Short note: dispensing with notification in statutory will applications

Practice Direction Practice Direction 9E supplements Part 9 of the Court of Protection Rules and deals with applications relating to statutory wills, codicils, settlements and other dealings with P's property.

Paragraph 9 of PD 9E provides that:

> *The applicant must name as a respondent - (a) any beneficiary under an existing will or codicil who is likely to be materially or adversely affected by the application; (b) any beneficiary under a proposed will or codicil who is likely to be materially or adversely affected by the application; and (c) any prospective beneficiary under P's intestacy where P has no existing will.*

In *BH v JH* [2024] EWCOP 12, DDJ Weereratne had to decide whether to dispense with service on potential beneficiaries on an application to vary a statutory will. The decision, as a decision of a Deputy District Judge, does not have precedent value, but we note it here because it is the first reported case where the specific issue to which it gave rise has been considered.

There were 2 classes of beneficiary affected. One class were P's carers who were potential beneficiaries under a discretionary trust. It was proposed that the size of the trust be increased so that they would stand to benefit from the changes.

The other class was a residuary class benefitting under a gift to unnamed charities. The increase in the trust reduced pro rata the potential value of the residuary gift.

The applicant (P's deputy) argued that neither class should be notified. Regarding the carers, he argued that the fact that the effect was in their favour meant that the PD did not apply and that, in any event, there were exceptional circumstances pursuant to the guidance in *Re AB* [2014] COPLR 381 and *I v D* [2016] COPLR 432, namely that if they were notified, there was potential for discord and harm to P's care regime.

[2] And of wider application: a decision about a self-funder moving into a care home is one that it is far from obvious falls neatly into either box.

Regarding the residuary beneficiaries, the applicant argued that there would be no point and that notification would be disproportionate and in some way paternalistic towards him.

The OS argued that the Practice Direction was in mandatory terms, that it applied whether the material effect was positive or negative, but she agreed that there were exceptional circumstances as described to dispense with service on the carers.

As regards the residuary beneficiaries, the Official Solicitor argued that there was no reason to dispense with service, natural justice required it and the cost was not disproportionate to the size of P's estate (£12m).

DDJ Weereratne held that the Official Solicitor was correct in all respects, dispensing with service on the carers but not in relation to residuary beneficiaries (which would be on the Attorney-General). See paragraphs 40-52 of the judgement. In particular, the judge held that, in relation to the residuary beneficiaries, the deputy had fundamentally misunderstood the rationale behind the PD, namely that it is there to serve the interests of natural justice and is not in any sense dependent on P's best interests (see paragraph 49).

That finding, in particular, led to the Official Solicitor applying for a departure from the usual order for costs in cases involving property and affairs (that is to say that all parties' costs are borne by P's estate). DDJ Weereratne gave a separate judgment on that issue [2024] EWCOP 9. By a given date before the hearing, the Official Solicitor had agreed that service on the carers could be dispensed with and had made clear her objections in relation to the beneficiaries, citing the relevant case law. DDJ Weereratne referred to the relevant rules,, namely Court of Protection Rules 2017 (COPR) 19.2: "costs of the proceedings, or of that part of the proceedings that concerns P's property and affairs, shall be paid by P or charged to P's estate."

The court noted that it has a discretion to depart from the usual rule in COPR 19.2 "if the circumstances so justify": rule 19.5(1) and that rule 19.5(1) further provides that:

> *in deciding whether departure is justified the court will have regard to all the circumstances including -*
> *(a) the conduct of the parties,*
> *(b) whether a party has succeeded on part of that party's case, even if not wholly successful; and*
> *(c) the role of any public body involved in the proceedings.*

Rule 19.5(2) provides that the conduct of the parties includes -

> *(a) the conduct before, as well as during, the proceedings;*
> *(b) whether it was reasonable for a party to raise, pursue or contest a particular matter;*
> *(c) the manner in which a party has made or responded to an application or a particular issue;*
> *(d) whether a party who has succeeded in that party's application or response to an application in whole or in part, exaggerated any matter contained in the application or response; and*
> *(e) any failure by a party to comply with a rule, practice direction or court order.*

DDJ Weereratne held that, after the Official Solicitor had agreed to dispensation with regard to the carers, the deputy should have agreed to that and a draft consent order would have been all that was required. DDJ Weereratne therefore found that the deputy's conduct thereafter was unreasonable so from that date the deputy would have to bear his own and P's costs.

Testamentary capacity and keeping the Court of Protection at bay – a cautionary tale

Biria v Biria & Ors [2024] EWHC 121 (Ch) (Chancery Division (Deputy Master Bowles))

Other proceedings - probate

Summary

This was a challenge to a will which arose in somewhat unusual circumstances. When Mr Biria was 95, he purportedly executed a will. At the date of the will, there were extant proceedings in the Court of Protection. Those proceedings had commenced on 9 April 2020, seeking an assessment of Mr Biria's capacity to manage his own affairs and expressing a concern that Mr Biria was being exploited by his son and daughter, both of whom were made parties to the proceedings. In April 2020, the Court of Protection had made a declaration that there was reason to believe that Mr Biria lacked the capacity to consent to an assessment of his capacity to manage his own affairs and had directed one of his sons (Hamid) and one of his daughter (Nasrin) – who were living with him – to use their best endeavours to make Mr Biria available for an assessment of his capacity and, further, not to interfere with that assessment. They stymied that assessment for some time, and, in May 2020 – whilst that assessment was still pending – a will was purportedly executed at the offices of a notary, disinheriting another of his sons, Ali. The will was not prepared by the notary, but was brought to the meeting by those attending, having been prepared by an American attorney.

The Court of Protection Special Visitor, a psychiatrist, was ultimately able to assess Mr Biria, and concluded that he did not have the capacity to manage his property and affairs and that he was unable, by reason of dementia, to understand, retain, use, or weigh, relevant information. That conclusion was reflected in and formed the essential basis for orders by which, ultimately, a deputy was appointed to manage Mr Biria's property and affairs. In the interim, however, Hamid had been found to be in contempt of court for having failed to comply with the Court of Protection's order requiring him to assist in securing the assessment of his father. Hamid and Nasrin – again in contravention of an order of the Court of Protection – also stymied the ability of local authority social workers to carry out a Care Act assessment of Mr Biria's needs. They continued to prevent access by the local authority and a second Special Visitor so as to be able to report upon his needs.

Mr Biria died in January 2022, and a challenge was brought to the will by Ali on the basis that Mr Biria lacked testamentary capacity, that it was invalid for the want of Mr Biria's knowledge and approval of its contents, that the will was purportedly executed under and by reason of the undue influence exercised, or exerted, over Mr Biria by Hamid and Nasrin and/or because the will was the product of false beliefs as to the character and conduct of Ali inculcated in Mr Biria by Hamid and Nasrin, such that the will fell to be set aside as a fraudulent calumny.

The American attorney declined to answer the request for a *Larke v Nugus* statement, on the basis that he was not a solicitor, nor a person authorised to practice law in the United Kingdom, and asserted that, in consequence, the questions in respect of the preparation of the disputed will, his instructions in respect of the disputed will and the circumstances surrounding its preparation were not, in his words, 'properly directed'. Accordingly, the questions raised remained unanswered and, unusually, the court was left with minimal direct information as to the process and circumstances whereby the will came into being.

As to capacity, Dr Barker, the expert who had provided the report to the Court of Protection on Mr Biria's capacity to manage his property and affairs, provided a further report to the court determining the probate action. His clear conclusion was that, as at the day of the purported will, Mr Biria lacked the capacity to execute a valid will. As Deputy Master Bowles noted:

> *96. In tendering his expert opinion, Doctor Barker, as he explained in his 27 August 2023 report, had regard to the familiar 'test' for testamentary capacity established, long ago, in Banks v Goodfellow (1870) LR 5 QB 549. He was right to do so. There has been some recent debate as to whether the Banks v Goodfellow 'test' has been modified, or superceded, by the provisions of the Mental Capacity Act 2005. In my view, it has not. I agree, with respect with Falk J, in Clitheroe v Bond [2021] EWHC 1102 (Ch), at paragraph 82, that the Banks test has not been overridden by the Mental Capacity Act 2005. I agree, further, with the views expressed, in Walker v Bodmin [2014] EWHC 71 (Ch) and James v James [2018] EWHC 43 (Ch), to the effect that the Mental Capacity Act affords a test, or tests, for capacity in respect of transactions effected, or to be effected, by living persons, whereas the Banks test is applicable for the retrospective determination of capacity in respect of a past transaction, specifically, a will.*
>
> *97. Doctor Barker's conclusions as to testamentary capacity rest upon his view that Mr Biria's dementia prevented him from satisfying two of the criteria for such capacity, set out in Banks, namely the requirement that the testator have the ability, or capacity, to understand the extent of the property of which he was disposing and the further requirement that the testator comprehend and appreciate the claims to which he ought to give effect.*

Deputy Master Bowles reminded himself that it was for the court, rather than the expert, to make the final conclusion, but endorsed Dr Barker's report and found that the will was invalid through want of testamentary capacity.

Deputy Master Bowles further found that the highly unsatisfactory circumstances under which the will was created did not afford any evidence that he knew and approved its contents, nor, therefore to allay, in any way, the court's suspicions in that regard. This was therefore a second ground to find the will invalid. In significant part because of the conduct of Hamid and Nasrin in the course of the Court of Protection proceedings, Deputy Master Bowles found himself satisfied that the will was executed by Mr Biria at the direction and by reason of the undue influence exercised by Hamid and Nasrin. He did, however, find that the will failed on grounds of fraudulent calumny, because the allegation in question (that Ali had threatened to kill Mr Biria) did not arise from any action of Hamid or Nasrin, but rather from someone suffering from dementia.

Comment

Given both the evidence of Dr Barker and the conduct of Hamid and Nasrin in the course of the Court of Protection proceedings, it is perhaps not enormously surprising that the court reached the conclusions that it did both as Mr Biria's capacity and also the extent to which the will was created under circumstances which in truth did not represent his testamentary intent at all. One striking feature, though, is that, despite Deputy Master Bowles' observations about the relevance of the Mental Capacity Act 2005 to the question of testamentary capacity, it would appear very likely that, had Mr Biria survived any length of time, his deputy would have to have

considered whether to seek to apply to have a statutory will made for him – and, at that point, the test in the MCA 2005 would have applied. The mismatch between the two positions is one that may be resolved in due course if the Law Commission's provisional recommendations in their Making a Will consultation paper are taken forward.

Short note: not leaping unduly to a conclusion of undue influence

In *Rea v Rea & Ors* [2024] EWCA Civ 169, the Court of Appeal determined the latest in a very long round of litigation over the validity of a will made in 2015. It is of interest for wider purposes for its approach to proving undue influence. Newey LJ accepted:

> *31.* […] *that undue influence can be proved without demonstrating that the circumstances are necessarily inconsistent with any alternative hypothesis. On the other hand, the circumstances must be such that undue influence is more probable than any other hypothesis. If another possibility is just as likely, undue influence will not have been established. When making that assessment, moreover, it may well be appropriate to proceed on the basis that undue influence is inherently improbable.*

On the facts of the case, the Court of Appeal reached the – unusual – conclusion that it was driven to interfere with the finding of fact of the trial judge that the testatrix had been subject to undue influence, Newey LJ finding that the evidence did not entitle him to reach that conclusion:

> *57.* […] *Undue influence in this context connotes coercion such as to "overpower the volition without convincing the judgment", where the testator's volition is "overborne and subjected to the domination of another" and the testator would say if he could speak his wishes, "this is not my wish, but I must do it". This, to my mind, is a case in which it is appropriate to proceed on the basis that such conduct is inherently unlikely. Further, there was in the present case no direct evidence of coercion and, in my view, it could not reasonably be found, in the light of the matters mentioned in the previous paragraph, that the circumstances justified such an inference. For coercion to be proved, it had to be shown to be more probable than any other possibility. I do not think there is any question of coercion having been the most probable possibility here. As was pointed out by Mr Robert Deacon, who appeared for Rita, the Judge needed to consider whether the circumstances were as consistent with Anna deciding to make a new will either entirely of her own accord or after being encouraged to do so by Rita. Undue influence was, to my mind, clearly no more likely than at least the latter of these hypotheses.*
>
> *58. I have not forgotten that the Judge had the advantage of seeing the witnesses and found Rita an unreliable witness who had given untruthful evidence about both the circumstances in which the 2015 Will came to be made and the fact that the 2015 Will was not disclosed to anyone until after Anna's death. It appears to me that, even taken in combination with all the other factors on which the Judge relied, these matters are not such as to allow the finding of undue influence to be sustained. Apart from anything else, the aspects of Rita's evidence to which the Judge drew attention were consistent with the (inherently more probable) possibility of Rita having merely sought to persuade her mother to make the 2015 Will.*

> *59. In short, I do not consider that the evidence before the Judge was capable of supporting a finding of undue influence. That being so, the appropriate course is, I think, to confirm the validity of the 2015 Will.*

Court of Protection Property and Affairs Users group meeting minutes

The meeting minutes from the meeting of 17 January are now available. The next meeting will be on 23 April 2024.

OPG FAQs

The Office of the Public Guardian has published a series of 'your questions answered,' addressing completing forms, attorneys, witnesses and certificate providers, payments and fees, using your LPA, reporting and making changes to your LPA.

PRACTICE AND PROCEDURE

Revised help with Court of Protection fees process

A revised COP44A Help with fees application, and COP44B guidance notes have been published and are to be used with effect from Monday 12th February 2024. There will be a transition period between Monday 12th February 2024 until Thursday 29th February 2024 where old paper or digital applications will be accepted, however any applications received whether digitally or in paper form received by the Court from Friday 1st March onwards will be rejected, and returned to the sender for the new version of the form to be completed.

Under the updated scheme, there are quite a few changes to how applications are processed by courts and tribunals, learning from the court's experience of dealing with these applications over the years. These changes are needed to ensure timely, accurate decisions and these will be followed nationally. Some of the key changes are:

- Applications must be submitted to the court or tribunal within 28 days of an online Help with Fees reference code being generated or, for paper applications, within 28 days of the application being signed.
- Where the application is either not submitted within this timescale, completed incorrectly, has key information missing, or if the deadline to provide requested evidence is missed, it will be rejected and a fresh application will be required within the relevant time limits. You must therefore ensure you read the contents of the form and guidance carefully before completing your application and that accurate and up to date information is provided. This will help to reduce delays and time taken to process your application.
- If you are a legal representative or litigation friend and you believe your client is eligible for Help with Fees, you should ensure the application is completed fully to reduce the need for any further queries.
- Applicants retain the right to appeal the court's decisions based on the information they provided on the application which they believe makes them eligible for Help with Fees support. If you need to provide new information to the court or tribunal, this will require a new application.

When do you need to go to court in the serious medical treatment context?

GUP v EUP and UCLH NHS Foundation Trust [2024] EWCOP 3 (Hayden J)

Medical treatment – treatment withdrawal

Summary

In *GUP v EUP and UCLH NHS Foundation Trust* [2024] EWCOP 3, Hayden J was concerned with a situation of a woman in her late 80s who had sustained a serious stroke. In the period following November 2023, Hayden J identified that there had been:

> *6.* […] *increasing divergence between the growing hope of the family for some meaningful recovery and the view of the clinicians that comfort and dignity ought to be the focus of EUP's care, at what they assess to be the end of her life. Whilst these two perspectives of EUP's medical needs have diverged, I am concerned that the treatment she has received reflects a convergence between the two. In other words, the treatment plan has an air of compromise about it, a negotiation between the family and the medical team. There may, sometimes, be a place for that,*

> *but not if the person at the centre of it becomes marginalised. P (the protected party) must always be afforded care, which is identifiably in her own best interests. The family's views are relevant only insofar as they provide a conduit for P's own wishes and feelings. Families, however loving and well-meaning gain no dominion over their dying and incapacitous relatives. The family's role, which is crucial, is to promote and not subvert P's autonomy.*

From mid-November 2023, it had become impossible to provide her with nutrition, but the Trust had continued to provide her with hydration, which appeared to be a compromise reflecting the position above; a matter which troubled Hayden J considerably.

With the benefit of two external second opinions, the Trust reached the view that it was clinically inappropriate to continue to provide artificial nutrition. As Hayden J identified (at paragraph 48), GUP (EUP's son), and his family:

> *were never fully on board with that plan. It is certainly the case that there was a broadly co-operative relationship with GUP but I think it was equally clear that he had not accepted the medical consensus. The same applies to his sister, HUP [w]ho has expressed strenuous resistance to the hospital's plans at this hearing. GUP has told me that the hospital had indicated to him that they were to make an application to court to seek endorsement of their approach. I do not think this is in dispute. However, on 16th January 2024, the Trust confirmed to the family that they had been advised by their lawyers that it was not necessary for them to issue an application. The likely reasoning behind this is that the Trust considered that there was no ethical route to provide nutrition to EUP. The family disagreed and saw this as passivity, with profound consequences. They perceived an important decision having been taken, even though the decision was to take no action. They considered that the Court ought to be able to review that decision making process and identify its own evaluation of where EUP's best interests lay. I agree with the family. A decision not to provide nutrition is every bit as serious as a decision to withdraw nutrition. Where there is conflict, these cases must be resolved by the court.*

In his concluding remarks, Hayden J referred to the Serious Medical Treatment guidance he had issued in January 2020 thus:

> *50. Ms Dolan submits that the practice guidance, which I issued in January 2020, then as Vice President of the Court of Protection, indicates that the Trust, in circumstances such as these, should bring the case to court promptly. Whilst that document is expressly stated to be by way of guidance only, it is rarely departed from in cases of this gravity. Had the Trust followed it, and at an earlier stage, it would have greatly alleviated the stress to the family. Ms Dolan goes further in her written submissions but I do not. Neither can I imagine that the lawyers advising this Trust were unfamiliar with the guidance. It has been widely promulgated, see also [2020] EWCOP 2. Where there is conflict in these serious medical treatment cases, it is in everybody's best interests, but most importantly P's, to bring an application to court. That will be most efficiently achieved where it is driven by the Trust's application. There are many and obvious reasons why it is also to the Trust's advantage to have their treatment plans, in cases such as this, scrutinised by the court.*

Comment

We note and share, Hayden J's concern about the situation where, for the sake of compromise,

the Trust found itself providing treatment for which there was no clinical rationale. From our experiences both of cases, and of sitting on clinical ethics committees, such situations are not uncommon, both in relation to incapacitated adults, and in relation to neonates. His observations are, or should be, a helpful reminder that the focus must always be kept on the interests of the patient, not (as understandable as this can be) on the interests of others.

We have significantly greater reservations about the observations about the bringing of the application.

We fully appreciate that it is not always necessarily easy to distinguish between a dispute about clinical appropriateness (including, as a subset, futility) and a dispute about whether a treatment that is in principle appropriate is nonetheless not in the best interests of the person. But we suggest that a situation where – as here – the Trust had obtained independent second opinions from two doctors is a one where that dividing line has been properly tested.

We also fully appreciate that there may well be situations in which it is prudent for a treating body to bring an application to court to get confirmation that it is acting lawfully so as (for instance) to forestall arguments after the event before an inquest. We say 'court' here, because we remain very doubtful that the Court of Protection is the correct forum for seeking a declaration of lawfulness in respect of a determination that a course of treatment is not clinically appropriate – rather, we suggest that the correct forum is the King's Bench Division under Part 8 of the CPR, not least so as to avoid the slide into best interests language / analysis that (on one view) took place in *Re EUP*. We also have squarely in mind the Court of Appeal decision in *AVS v A NHS Foundation Trust & Anor* [2011] EWCA Civ 7, which made clear that disputes about best interests where the treatment option is not on the table should not be entertained by the Court of Protection – in strong terms:

> *38.* […] *A declaration of the kind sought* [i.e. that treatment was in the person's best interests] *will not force the respondent hospital to provide treatment against their clinicians' clinical judgment. To use a declaration of the court to twist the arm of some other clinician, as yet unidentified, to carry out these procedures or to put pressure upon the Secretary of State to provide a hospital where these procedures may be undertaken is an abuse of the process of the court and should not be tolerated.*
>
> *39. Like the President, I have also reached the conclusion that the continuation of this litigation by permitting a lengthy hearing to be urgently arranged for numerous busy medical practitioners to be cross-examined truly would be "doomed to failure". If there are clinicians out there prepared to treat the patient then the patient will be discharged into their care and there would be no need for court intervention. If there is no-one available to undertake the necessary operation the question of whether or not it would be in the patient's best interests for that to happen is wholly academic and the process should be called to a halt here and now.*

We have very considerable sympathy with the proposition that it should be the treating medical body which has responsibility for bringing applications where there is in fact a best interests decision to be made. It is undoubtedly likely to be more efficient (as Hayden J identified) in most cases. And we would also be the first to say that it is very unfortunate that the (welcome) expansion of non-means-tested legal aid to

parents in serious medical treatment cases involving children was not expanded to those potentially involved in such cases in respect of incapacitated adults.

However, we suggest that it is important to recognise the limits of the points set out above. To start with, and with due diffidence, given that Hayden J was making observations about Practice Guidance he himself issued, we note that the Practice Guidance does not, in fact, address the situation that was in play here. The Practice Guidance was specifically concerned with situations where there is a dispute about the best interests of the person. This is clear from paragraph 6, which explains how, normally, s.5 MCA 2005 will provide the basis upon which treatment is provided / stopped / withheld. Section 5 expressly applies where the person carrying out the act reasonably believes that they are acting in the best interests of the individual lacking the relevant decision-making capacity. Paragraph 7 of the Practice Guidance then goes on to identify that paragraphs 8-13 "set out the circumstances in which section 5 either will not or may not provide a defence. If section 5 does not provide a defence, then an application to the Court of Protection will be required." Paragraphs 8 and 9, which appear to have grounded the submission to Hayden J noted at paragraph 50, are therefore concerned with disputes about capacity or best interests, not about clinical appropriateness. If treating clinicians are not willing to offer a particular treatment on the grounds of clinical appropriateness, that does not become a best interests decision just by virtue of the fact that the patient lacks capacity to make their own medical treatment decisions.

We further suggest that it is going too far to propose that[3] that Article 2 ECHR requires an application to court in every situation where a medical body is contemplating withholding or withdrawing treatment or has decided to do so. If this was the case, then every decision by a clinical body to withhold a life-saving cancer drug on the basis that the person does not fit the strict cost / benefit criteria would need to be taken by that body to court if the person (or someone on their behalf) does not agree. Or, to focus squarely in on clinical appropriateness, what about a decision not to provide clinically assisted nutrition and hydration in late stage dementia, in circumstances where NICE guidance NG97 specifically states "[d]*o not routinely use enteral feeding in people living with severe dementia, unless indicated for a potentially reversible comorbidity?*"[4] We suggest that a difference of opinion with family / others close to the person about the provision of CANH in such a situation cannot itself give rise to an obligation on the part of the treating body to take the case to court.

When to bring an application to court (and who should bring it) will be likely to remain an issue that is regularly revisited. It was considered in this webinar held in Chambers on 27 February 2024 and in this blog post by Tor and Alex.[5]

But we do suggest that it is very important that an urban myth is not allowed to develop (in the same way that it did about CANH withdrawal cases following *Bland*, not dispelled until 2018 in

[3] As is done on this blog.

[4] Recommendation 1.10.8. Their decision aid on enteral feeding in advanced dementia explains that: "[s]*tudies have looked at the possible benefits from tube feeding for people living with severe dementia. These studies found no good evidence that people who had tube feeding lived any longer than people who did not. There was also no good evidence that tube feeding made any difference to people's weight or improved how well-nourished they were."*

[5] And *X NHS Foundation Trust v RH* [2024] EWCOP 150 makes clear the problems caused if applications are brought in a 'frenzied' manner, especially if they are flagged as being urgent when, in fact, they are not.

NHS Trust v Y) about what the law actually requires.

Not shutting the door improperly

VT v NHS Cambridgeshire And Peterborough Integrated Care Board & Cambridgeshire County Council [2024] EWHC 294 (Fam)[6] (Arbuthnot J)

CoP jurisdiction and powers

Summary

Arbuthnot J considered an appeal brought on behalf of VT by her litigation friend, the Official Solicitor, against a decision by a Circuit Judge ('the CJ') sitting in the Court of Protection, to conclude proceedings.

The background to this case had started in spring 2023. VT was 78 years old and had a historic diagnosis of schizophrenia but had previously always lived in her own home. She had been hospitalised for reasons which are not set out in the judgment, and Cambridgeshire County Council had made an application to authorise VT's move from hospital to a residential care home. 'VT was not represented at the initial hearing on 28th April 2023 or when a COP9 application was made on 10th May 2023 to change the discharge location.' [2] VT moved to the care home on 2 June 2023, and her deprivation of liberty was authorised by a standard authorisation on 16 June 2023. However, the Court of Protection proceedings continued, and VT was expressing a wish to return home.

The application was case managed, giving consideration to what arrangements would be required to facilitate VT's return home. The judgment notes:

- A s.49 report was to be filed by 29 September;
- The order of 12 July contained a recital "which said that the parties' shared aim, in principle, was to return VT home, with or without a package of care" paragraph 4);
- On 17 July, the court appointed an interim property and affairs deputy for VT;
- On 7 September 2023, the ICB was joined as a party as VT had been granted funding through the ICB as commissioner for services. It is not clear from the judgment whether this was NHS Continuing Healthcare, NHS-funded nursing care or s.117 aftercare, though it appears that the ICB became the primary funder of VT's care. The ICB was ordered to provide a witness statement setting out the services it would be willing to fund to facilitate VT's return home. It was also to provide details of any other residential options including a care home;
- The matter was listed for a one-hour directions hearing on 2 October 2023.

The CJ dismissed the application following submissions at the 2 October 2023 hearing after the ICB asked the court to determine the application summarily (a position that had only been announced to the other parties during pre-hearing discussions one hour prior to the hearing). The s.49 report had not been filed by

[6] We are unclear why this case has a Family citation, when it is clearly a Court of Protection case. Alex in particular can hear strongly the voice of Sir James Munby asking whether "*it* [is] *too much to hope that, ten years after the Court of Protection came into being, this simple truth* [that the Court of Protection is not part of the High Court] *might be more widely understood and more generally given effect to*" (*Re D* [2017] EWCA Civ 1695).

the time of this hearing, but it was said that VT's presentation had deteriorated (there does not appear to have been evidence filed about this). VT and the local authority sought for the court to make further directions "*for further evidence about [VT]'s current presentation and an exploration of the care that could be given to her on a return home. Those representing VT and CCC contended that this would enable a fair best interests decision to be made*" (paragraph 9). Conversely, the ICB invited the court to conclude the proceedings that day. The ICB said it was increasingly of the view that a return home would be clinically unsafe for VT and on that basis it was not prepared to commission a package of care at home. The Official Solicitor and local authority opposed this and said that a contested hearing was required to consider VT's best interests. The interim deputy stated that VT had private resources which might be able to fund private care at home but that they did not have the expertise or knowledge to put a package in place in a very short period of time. The deputy had provided a statement where she said it would take nine days for the property to be made suitable for VT.

After hearing submissions, the Circuit Judge made final decisions that VT lacked capacity to make decisions as to her residence and care, and to manage her property affairs. The judge additionally determined that the best interests requirement of the standard authorisation was met. The judge gave a judgment which stated that VT lacked capacity on the evidence and said that there was no point in waiting for the section 49 report as it would not add very much to the picture which was "fairly clear" from other evidence. The CJ additionally found that it was not in CJ's best interests to go home, and "all a further witness statement would do was to confirm what the Judge was being told in Court in submissions. The CJ did not see any purpose in prolonging the proceedings" (paragraph 15). The judge found that "*VT was in declining physical health and she would need a full-time care package. There was a real risk VT would decline help and then she would deteriorate rapidly and that would not be in her best interests. It was not the ICB's job to put together a package of care and the professionals would be put to too much trouble*" (paragraph 16).

The Official Solicitor appealed this decision. By the time the matter was heard by Arbuthnot J on1 November, VT had stabilised. The initial thoughts that she was in a rapid terminal decline were misplaced. By 28 November, however, VT's health had 'declined substantially.'

Arbuthnot J note that "[t]*his was the second case in a short period*[7] *where I had allowed an appeal against final decisions made by a CJ at a case management hearing when the parties had expected only a procedural hearing*." As a result, Arbuthnot J solicited principles and some suggestions for guidance from the parties.

After rehearsing the overriding objective and duty of the court to 'actively manage cases,' Arbuthnot J noted that while there was no express power for summary judgment, the Court of Protection may (under COPR 2.5) apply the Civil Procedure Rules or Family Procedure Rules to fill any lacunae. Arbuthnot J also surveyed Court of Protection case law regarding case management, including *KD & Anor v London Borough of Havering* [2009] EW Misc 7**,** *N v ACCG & Ors* [2017] UKSC 22, and *CB v Medway Council & Anor (Appeal)* [2019] EWCOP 5. Arbuthnot J also considered the European Court of Human Rights decision of *Sýkora v The Czech Republic,* 22 November 2012, on the issue of the

[7] The first one does not appear to have been reported.

quality of evidence required to determine capacity.

Arbuthnot J set out her conclusions following this survey of rules and authorities:

> *34. It plainly is possible for the Court of Protection to:*
>
> *a. decide matters of its own motion;*
>
> *b. decide which issues need a full investigation and hearing and which do not;*
>
> *c. exclude any issue from consideration; and*
> *d. determine a case summarily of its own motion.*
>
> *35. In any cases where such powers are contemplated, at a stage where the determination would dispose of the case, two matters will need to be given careful consideration:*
>
> *a. Whether the court has sufficient information to make the determination (per Hayden J "curtailing, restricting or depriving any adult of such a fundamental freedom will always require cogent evidence and proper enquiry" paragraph 33 CB supra); and*
>
> *b. Whether the determination can be reached in a procedurally fair manner.*
>
> *36. Deciding whether the evidence has reached a point at which the court can make a determination is a case management decision. Whether the evidence has reached that threshold will, necessarily, depend on the facts of each case.*
>
> *37. The requirements of procedural fairness are not set in stone; the requirements are informed by context. Notice to the parties is an element of procedural fairness. Whether such notice is required, and how much notice is needed, will depend on the context. Procedural fairness in this case, however, would seem to require more than one hour's notice that final decisions might be made.*
>
> *38. If an early final hearing is contemplated by the Court then an approach might be to include a recital to that effect in an earlier order. In some cases, notice that a final determination is contemplated might alter the evidence which is put before the court. In other cases, I accept that the provision of notice might have no impact on the preparation of the case.*
>
> *39. Active case management of course allows the Court to consider whether a final order could be made at a case management stage and to consider what needs a full investigation and what does not. The Court must take a proportionate approach to the issues.*
>
> *40. In allowing VT's appeal, I determined that the CJ [Circuit Judge] reached a decision which was not properly open to them. The section 49 report was not available and it was not appropriate for the CJ to make a decision on capacity when the CJ could only say that it was "fairly clear" from other evidence that VT lacked it. The decision as to best interests was contested properly by those acting on behalf of VT and CCC and was taken without permitting adequate exploration of the reasons why alternative options were not open to VT.*
>
> *41. In short, in this case, the CJ reached decisions which, in principle, were possible, but which were not sustainable*

> *on the material before the court. VT's interests were not properly considered. In the circumstances, it was not appropriate to reach such an important decision for VT based on submissions. The effect of the decisions taken were to deprive VT of a fundamental freedom. The decisions were taken without the cogent evidence required and in a procedurally unfair manner.*

Comment

The facts of this case are striking, and there is a strong implication from this judgment that VT's return home may have been quite plausible. She had both private funds and an entitlement to support from the ICB, as well as a deputy stating that her home could be rapidly made ready for her. She had only recently left her home, and the view of the local authority (which appeared to have the longer experience of working with her) appeared to believe that a return home was plausible. A s.49 report was pending. It was quite thus a striking decision to determine this matter summarily without expert evidence on capacity which had been considered necessary only a few months prior, and what appeared to be no concrete evidence either on VT's current presentation or the care which could be made available to her in her home.

The case is of interest for its articulation of how and under what circumstances judges of the Court of Protection should permit further exploration, and when it may be appropriate to take final decisions on the information available. As set out above, there are very limited authorities in the Court of Protection which explicitly consider these issues, and often, in our experience, a lack of agreement between parties as to when it is appropriate for matters to be determined on the evidence available. While *VT* does not set hard and fast rules for when an application may be summarily determined, it sets out a helpful road map for parties and courts who are considering whether further directions for evidence serve any useful purpose. It also provides a useful reminder of the importance of having clarity as between parties and the court as to what decisions may or may not be taken at a 'directions' hearing.

Scottish guardianship orders, deprivation of liberty and Article 5 ECHR: a serious cross-border concern

Aberdeenshire Council v SF (No 2) [2024] EWCOP 10 (Poole J)

Article 5 – deprivation of liberty

Summary

In this case, Poole J took the very unusual step of declining to recognise and enforce a foreign order under Schedule 3 to the MCA 2005. It was particularly unusual because the order in question was not 'foreign' in a conventional sense, but emanated from Scotland, in the form of a guardianship order made in June 2021 in favour of SF's mother and father (but now only relevant in respect of SF's mother as her father had died).

SF's case had been before the court before, Poole J having determined in 2023 that she was habitually resident in Scotland, notwithstanding that she had been living in England and Wales for a number of years, first as a patient detained in hospital under the Mental Health Act 1983 and then, since 2022, in a supported living placement in the community. As Poole J noted at paragraph 2:

> *It is agreed, as is clear from the evidence, that SF is not free either to move from her current residence, or to come and go from it. She is subject to physical restraint at times and lives behind doors that may be locked to restrict her movement. She is under the*

> *continuous supervision and control of carers. The objective circumstances meet the "acid test" for the deprivation of her liberty set out in the judgment of Lady Hale in Cheshire West v P [2011] UKSC 19. The arrangements that amount to continuous supervision and control are imputable to the state. SF herself is unable, by reason of her mental incapacity, to consent to the arrangements that amount to a deprivation of her liberty. However, the SGO* [Scottish Guardianship Order] *gives power to SF's mother to authorise the arrangements and to consent to the same. If the SGO is recognised in this jurisdiction then SF's deprivation of liberty will have been authorised to date and will continue to be authorised so long as the SGO remains in force. If not, then in the absence of authorisation, her deprivation of liberty will have been unlawful and will continue to be unlawful until either it ceases or lawful authorisation is given.*

Poole J was referred to *K v Argyll and Bute Council* [2021] SAC (Civ) 21, in which the Sheriff Appeal Court determined that orders appointing a guardian (the equivalent in Scotland of a deputy) can include the power for the guardian to authorise the deprivation of the incapacitous adult's liberty. He proceeded on the basis that the Adults with Incapacity Act 2000 (1) allowed a guardianship order to confer on the guardian the power to authorise or consent to the deprivation of the incapacitous adult's liberty; and (2) that the guardianship order in question did confer such powers.

After some procedural juggling, the application was before the court made by the relevant Scottish local authority seeking recognition and enforcement of the SGO. The other parties did not seek to challenge the process of making guardianship orders in Scotland was systemically defective; Poole J also reminded himself at paragraph 18 that "[w]*hilst I need to consider some of the factual circumstances concerning the making of the SGO, I remind myself that I must conduct a "limited review" as advised by Baker J*". This "limited review," outlined in *Re PA, PB and PC* [2015] EWCOP 38 is required in cases where the order being put before the Court of Protection for recognition and enforcement gives rise to a deprivation of liberty of the adult, and requires "*the court being satisfied that (1) the Winterwerp criteria are met and (2) that the individual's right to challenge the detention under article 5.4 is effective (i e that they have a right to take proceedings to challenge the detention and the right to regular reviews thereafter)*."

Poole J also focused on paragraph 19(3) of Schedule 3 to the MCA 2005, which gives the court a discretion to refuse recognition of a protective measure if the case in which it was made was not urgent, the adult was not given an opportunity to be heard, and that omission was a breach of natural justice. All three of these have to be met.

Poole J was clear that the case in which the SGO was made in June 2021 was not urgent:

> *21.* […] *The application had been made more than three months before the protective measure was granted. There was ample time to have afforded SF an opportunity to be heard. Urgency may explain or excuse the failure to provide an adult with the opportunity to be heard, but there was no such urgency in the present case.*

As regards the other two conditions, Poole J noted that:

> *22.* […] *It is relevant to consideration of those conditions that the protective measure was for seven years, was likely to cover the transfer of SF from hospital detention into the community, and that*

it included provisions for her physical restraint. These factors point to the importance of protecting SF's fundamental Convention rights in this particular case. It is also relevant that at the time when the SGO was made, SF was detained as a patient in a psychiatric unit and was already the subject of a guardianship order that permitted the authorisation of the deprivation of her liberty. The European jurisprudence such as MS v Croatia (No. 2) (above) raises an expectation that an adult in SF's position in June 2021 ought to be heard or, if their condition does not allow for that, ought to have representation.

[…]

25. As a matter of fact SF was not heard by the Sheriff: she was not notified of the proceedings and did not attend the hearing. There was no direct or indirect evidence of her wishes, feelings, or views. She did not have legal or other representation. There was no person acting as her guardian or similar. There is no evidence that SF was provided with the opportunity to secure representation or to give her wishes, feelings, or views to the court. The s37 certificate did not relate to guardianship or personal welfare. Even if one accepts that Marcin Ostrowski intended to certify that discussions about capacity in relation to personal welfare could be harmful to SF, he did not advise that it would pose a risk to SF to ask her for her views about where she should live, her care, her freedom to come and go, the use of restraint, or whether she was content for her parents to make decisions on her behalf.

[…]

28. There can be little doubt that SF was not in fact heard in relation to the protective measure (the SGO), but the relevant question is whether she had an opportunity to be heard. An adult may be unable or unwilling to take up the opportunity to be heard, but the requirement is that the opportunity is afforded to them. If they cannot express a view themselves, or could not do so to the court, then steps might be taken, as envisaged by COPR r1.2, and under AISA by means of appointing a safeguarder or advocate, to allow their voice to be heard. An adult who has a guardian, an advocate, and/or legal representation, as was the case in PA, PB and PC (above), will clearly have had an opportunity to be heard. SF did not have any such assistance. As COPR r1.2(e) indicates, there may be other means of securing the adult an opportunity to be heard, but in the present case there is no evidence that any attempts were made to ask SF her views about residence, care, freedom of movement, restraint, or decision-making about her life.

29. In my judgment therefore, no opportunity was provided to SF to be heard in the case in which the protective measure was made. Furthermore, having regard to the wide powers granted to the guardians, including authorisation of the deprivation of SF's liberty, and the application of those powers to any future community placement, and given the duration of the order (proposed to be indefinite and made for seven years), the failure to give SF an opportunity to be heard did amount to a breach of natural justice. I am sure that all those involved sought to protect SF's best interests and that SF's parents were properly assessed

> *as being suitable guardians. I do not doubt that SF lacked capacity at that time to make decisions about her personal welfare. However, there was no opportunity for her wishes, feelings, and views to be communicated to the court and no provision made for her interests to be represented. There were no safeguards for the protection of her Art 5(1) rights.* ***Natural justice required that in a case where SF's liberty was being put into the hands of others for a period of seven years, she should have had an opportunity to be heard and/or an opportunity to be represented. SF's access to the court should not have been dependent on her taking the initiative. Effective access should have been secured for her. As it is, there were no measures taken to ensure that her Art 5(1) rights were upheld*** (emphasis added)

Poole J was struck by the contrast with the cases where orders had been put forward for recognition and enforcement from Ireland, providing for representation and continuing judicial oversight, noting (carefully) at paragraph 30: *"*[t]*his not an observation that the system for authorising deprivation of liberty under a guardianship order in Scotland is defective in any way, but only a comparison of the particular facts of the reported cases that came from Ireland, and the case before me."*

Aware of the high bar that should be met before finding that the processes of a court in another jurisdiction breached natural justice, Poole J accepted the submissions made on behalf of the Official Solicitor and the English local authority that SF was not given an opportunity to be heard and the omission amounted to a breach of natural justice, which engaged his discretion to refuse recognition of the order.

Before deciding whether to exercise that discretion, Poole J then also considered recognition of the protective measure would be manifestly contrary to public policy (19(4)(a)) or would be inconsistent with a mandatory provision of the law of England and Wales (19(4)(b)). He looked first at the Human Rights Act 1998, making it unlawful for a public authority to act in a way which is incompatible with a Convention right. A public authority includes a court or tribunal. He noted that:

> *32.* […] *Article 5(4) of the Convention provides that "Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful." In Winterwerp (above) it was confirmed that this provision requires "review of lawfulness to be available at reasonable intervals" [55]. In the present case the SGO was made for seven years. There is no mechanism within the SGO for reviews within that period. Although SF now has the Official Solicitor acting on her behalf within these proceedings, that provision has been triggered first by the application by Sunderland City Council and now by the application by Aberdeenshire Council for recognition of the SGO. Neither were a party to the SGO application. If SF had a right to apply for a review of the guardianship order, there was no mechanism provided to give effect to that right. As a person of "unsound mind" steps should have been taken to secure the effective exercise of her art 5(4) rights but no provisions were made. In the absence of any representation for SF or any scheduled review, it was likely that the guardianship order would remain in place, without review, for seven years. This was so even when it was known at the time when the SGO was made that SF was considered fit for discharge from*

her hospital detention. Significant changes in her living conditions were anticipated but no review was provided for when those changes took place. The period of seven years is far longer than the maximum one year period in the MCA 2005 for the authorisation of a deprivation of liberty pursuant to Sch A1, para 29(1). The standard term of guardianship under the Scottish system is three years.

33. It is not for me, a judge in the jurisdiction of England and Wales, to lay down a maximum period for a Scottish Guardianship Order. In any event, what is a reasonable period would depend on the circumstances of the case. But, in this case, given the considerable powers the guardians were being granted, the likely change in living arrangements, and SF's vulnerabilities and her inability to trigger a review herself, and the absence of any representation to do so on her behalf, seven years without ensuring an effective review of the guardianship order was manifestly beyond a period that could be considered to be reasonable.

In consequence, therefore,

34. In my judgement, recognition of the SGO would be contrary to a mandatory provision of the law of England and Wales in that it would breach Art 5(4) of the ECHR and therefore be unlawful under the HRA 1998 s6. By the same reasoning, the absence of any opportunity for SF to be heard in the proceedings in which the SGO was made, was contrary to Art 5(1)(e) ECHR and therefore would have been unlawful under HRA 1998 s6.

35. Not only would recognition be contrary to mandatory provisions of the law of England and Wales, but those breaches of law would relate to fundamental human rights, not only under Art 5, but also under Arts 6 and 8. I have already found that the failure to provide SF with an opportunity to be heard was a breach of natural justice. In the premises, and on the same grounds, it appears to me that it must follow that it would be contrary to public policy to recognise the SGO and that therefore MCA 2005 Sch 3 para. 19(4)(b) is established.

36. The Official Solicitor submits, and I agree, that it is difficult to contemplate a scenario in which the Court of Protection determines that either of the grounds in sub-paragraphs 19(3) or 19(4) were made out, and goes on to recognise the order anyway. Here, I have found that the SGO was made in breach of natural justice and that recognition of it would be manifestly contrary to public policy. Whilst respecting the importance of comity and recognising the differences in the legal framework and jurisprudence as between Scotland, and England and Wales, the failure to uphold SF's fundamental human rights in this particular case means that I should exercise my discretion to refuse recognition of the SGO made in June 2021.

Poole J reminded himself that Parliament had authorised a system of recognition and enforcement of foreign orders, and that it was not his role to refuse recognition purely on the grounds that certain procedures or substantive provisions in Scotland were different from those in England and Wales. However:

> *37. As noted, no party sought to challenge the Scottish guardianship system itself. However, on the particular facts of this case, important aspects of the SGO and the procedure under which it was made were contrary to SF's fundamental human rights such that recognition should be refused. Schedule 3 provides an opportunity for the courts of this jurisdiction to carry out a limited review of protective measures made in another jurisdiction. It is not a "rubber stamp" exercise, as this case demonstrates.*

Comment

Whilst of no little interest for those in England and Wales, especially as a reminder that the Court of Protection will not simply rubber stamp foreign protective measures, this judgment is of particular significance for those concerned with the law in Scotland (and Jill gives her own observations in the Scottish section of the report). Whilst Poole J was at pains to say that he was not seeking to pass comment on the guardianship system in Scotland more broadly, the detailed scrutiny that he undertook of the circumstances under which the order was granted in SF's case is one that shines a light on a system which is largely unreported. It is to be hoped – and expected – that Scottish Government will read it with care as they respond to the Scottish Mental Health Law Review.

Short note: transparency and the ending of proceedings

Re VS (Deceased) [2024] EWCOP 6 concerns the aftermath of proceedings in the Court of Protection in respect of Vincent Stephens. He was a party to those proceedings, acting through a litigation friend, the Official Solicitor. The general rule in Court of Protection proceedings is that hearings are conducted in private, as set out in Rule 4.1 of the 2017 Rules. However the "ordinary" approach, as set out in Rule 4.3 and Practice Direction 4C, is that hearings are held in public but subject to an order which imposes restrictions on the publication of information which identifies or may lead to the identification of the protected person (and others) or their whereabouts. This order is commonly referred to as the 'transparency order.' Such an order was made in this matter, more or less in the standard terms provided in the Practice Direction, by Her Honour Judge Owens on 30 January 2023, expressed to have effect until further order of the Court. The last order in the substantive proceedings about Mr Stephens was made on 16th June 2023. That order was made at a hearing and at the end of it, no party raised any issue about the transparency order – as is entirely usual in Court of Protection hearings. Mr Stephens died on 18th June 2023.

Professor Carolyn Stephens then sought discharge of the transparency order. That application was supported by Professor Celia Kitzinger, joined by HHJ Hilder for the purposes of the application as intervenor. The application was opposed by Dr Sorensen, who was a respondent in the substantive proceedings. Professor Stephens was the only child of Vincent Stephens; after her mother/his wife died, Mr Stephens formed another companionship; Dr Sorensen was the daughter of that companion, who had herself now died.

Granting the application, HHJ Hilder found (at paragraph 21) that:

> *the scales come down very heavily in favour of discharge of the transparency order. Mr Stephens himself is no longer in need of its protection. The family of his marriage actively wish to be able to discuss their experiences, including in court. It is not the role of the Court of Protection, still less within its practical ability, to control the accuracy and fairness of reporting. In any event, that is not the meaning of freedom of speech. The answer to any concerns of 'balance'*

> *in reporting is probably more openness, not less - that Dr Sorensen too should be free to discuss her experiences.*

Such coverage is now to be found here, although the underlying judgment in the proceedings does not appear to have been published.

HHJ Hilder noted, finally, at paragraph 24:

> *Finally, although it is not within the scope of this decision, it may be helpful to note that the Rules Committee is currently considering the terms of the standard transparency order template. One focus of its concerns is the expressed duration of the transparency order when it is made. Had the transparency order in this matter been expressed to have effect "until final order", it would have ceased to have effect on 16th June 2023 – Professor Stephens would not have had to make this application; Dr Sorensen would not have had the opportunity to argue against it in circumstances where she is aware of the applicants' intentions to publicise. Had the order been expressed to have effect "until the death of VS", it would have ceased on 18th June 2023, and the same could be said. The time between the making of the discharge application in September and today's hearing is partly explained by an earlier listing being vacated because the respondent was not available to make submissions. Restriction of freedom of speech is always a serious matter but there has been no argument made to me today of any real prejudice caused by the time allowed to facilitate argument against the application.*

How to address continuing contempt

The seemingly endless contempt saga of Liubov MacPherson continues, the most recent judgment being delivered on 22 January 2024: *Sunderland City Council v MacPherson* [2024] EWCOP 8.

Ms MacPherson's daughter is a protected person who was until very recently the subject of Court of Protection proceedings which lasted for five or six years. Those proceedings have recently concluded. Her daughter was diagnosed and is treated for paranoid, treatment-resistant schizophrenia, which causes her, amongst other problems, to have delusions about being persecuted by others. Ms MacPherson believes that her daughter is indeed being persecuted by others, namely healthcare and other professionals and the courts. She describes all healthcare professionals who have dealings with daughter to be corrupt and that they are part of a conspiracy to torture daughter. In addition, she believes that the Court of Protection and the Court of Appeal are also corrupt. She believes that her daughter is being poisoned with medication that she does not need. She is convinced that a wrong turn was taken with her daughter's treatment some time ago. These beliefs are, the court had repeatedly found, deeply entrenched. Indeed, today once more she has demonstrated that. She is convinced that the mission that she must accomplish is to reveal this supposed conspiracy and corruption. She has tried to do so throughout the Court of Protection proceedings, including when seeking to appeal decisions of the Court. She has made multiple complaints to regulators, professional bodies who govern medical and legal professionals, the Court of Protection, and the police. She has brought, multiple appeals against decisions of the Court of Protection, all of which have been dismissed with permission to appeal refused, most certified as totally without merit.

Poole J had determined that it was in the daughter's best interests to have face-to-face contact with her mother. However, Ms

MacPherson has refused to give her daughter the opportunity to see her on the grounds that she will not visit her daughter unless or until changes which she believes are necessary are made to her medication regime. Those changes would be contrary to professional medical opinion, and contrary to her daughter's best interests.

In January 2023, Poole J found Ms MacPherson to be in contempt of court for having breached previous injunctive orders not to post and, having posted, to take down material from the internet. She was found on her admissions to have been in breach of the previous court orders. Those breaches also interfered with her daughter's right to a private and family life. These posts clearly identified her daughter. Indeed, they included recordings of her daughter, usually in conversation with the defendant during contact times between them. Her daughter does not have capacity to consent to the defendant using the recordings as she did so. Breaches of injunctions amounting to contempt of court were admitted by Ms MacPherson on the application for her committal on that occasion. The sentence imposed was one of 28 days' imprisonment concurrent for each established breach, suspended for 12 months. That suspension was effective until 15 January 2024 - *Sunderland City Council v Lioubov MacPherson* [2023] EWCOP 3. Ms MacPherson's appeal against the order was unsuccessful - *Lioubov MacPherson v Sunderland City Council* [2023] EWCA Civ 574.

Further injunctions, supported by a penal notice, were made against Ms MacPherson in June 2023, requiring her not to record her daughter, by video or audio for any purpose or in any way; b) record, whether by video, audio or photographing, staff from the placement, where she was cared for, or any other health or social care staff concerned with her daughter; c) in any way publicise these proceedings or any evidence filed in the proceedings, including by way of posting on social media, YouTube or any internet platform or website, including private or public sites; d) cause to be publicised on any social media, video or streaming service including YouTube, any video or recording of her daughter recorded at any date.

An application was made to commit Ms MacPherson to prison for breaches of these injunctions – committed during the currency of the suspended sentence passed in January 2023. Attempts to bring Ms MacPherson to court were unsuccessful, and she indicated that she was claiming political asylum in France. The court ultimately proceeded in her absence and, having found the breaches proved, determined that the appropriate sentence of imprisonment is one of three months for the contempts of court committed in September 2023. Additionally, the 28 day sentence of imprisonment that was passed and suspended on 16 January 2023 was now imposed as an immediate sentence which shall run consecutively to that three-month period of imprisonment. Poole J noted that:

> *41. The defendant is in France. I have to take into account that, realistically, she would have to return to England for any warrant of committal to be executed. I note that I issued a warrant for her arrest on 7 December 2023, and she has not returned to this country in the meantime, and clearly has no present intention of doing so. Therefore, for her to commence any sentence of imprisonment would require her to return to this country, in effect.*
>
> *42. The Court has no desire to pass a sentence of imprisonment on the defendant, not least because in some sense that is exactly what she is provoking the Court to do. She wants to highlight her complaints about the treatment of her daughter. She has, for*

example, I understand, tweeted about the hearing today, no doubt to try and draw attention to herself and her allegations of conspiracy, corruption, and the torture of her daughter. In many ways, by bringing this committal application, the Local Authority has helped the defendant draw attention to her own position and campaign. On the other hand, the Local Authority is seeking as best as it can to protect FP, the protected party in the Court of Protection proceedings.

43. However, very importantly, a purpose of sentencing is to uphold the authority of the Court and discourage others from flagrantly breaching court orders. The law applies equally to all, even to those who believe, contrary to all the evidence, that they are conducting a justified campaign. The defendant has openly and intentionally defied the court in a brazen manner. I cannot allow the defendant to treat herself as beyond the law.

Short note: reaching too quickly for intermediaries?

In West Northamptonshire Council v KA & Ors [2024] EWHC 79 (Fam), Lieven J made observations about intermediaries in family proceedings which might be thought to be applicable before the Court of Protection. Lieven J noted that the following principles could be drawn from the decision of the Court of Appeal in the criminal case of *R v Thomas (Dean)* [2020] EWCA Crim 117:

a. *It will be "exceptionally rare" for an order for an intermediary to be appointed for a whole trial. Intermediaries are not to be appointed on a "just in case" basis. Thomas [36]. This is notable because in the family justice system it appears to be common for intermediaries to be appointed for the whole trial. However, it is clear from this passage that a judge appointing an intermediary should consider very carefully whether a whole trial order is justified, and not make such an order simply because they are asked to do so.*

b. *The judge must give careful consideration not merely to the circumstances of the individual but also to the facts and issues in the case, Thomas [36];*

c. *Intermediaries should only be appointed if there are "compelling" reasons to do so, Thomas [37]. An intermediary should not be appointed simply because the process "would be improved"; R v Cox [2012] EWCA Crim 549 at [29];*

d. *In determining whether to appoint an intermediary the Judge must have regard to whether there are other adaptations which will sufficiently meet the need to ensure that the defendant can effectively participate in the trial, Thomas [37];*

e. *The application must be considered carefully and with sensitivity, but the recommendation by an expert for an intermediary is not determinative. The decision is always one for the judge, Thomas [38];*

f. *If every effort has been made to identify an intermediary but none has been found, it would be unusual (indeed it is suggested very unusual) for a case to be adjourned because of the lack of an intermediary, Cox [30];*

g. *At [21] in Cox the Court of Appeal set out some steps that can be taken to assist the individual to ensure effective participation where no*

> *intermediary is appointed. These include having breaks in the evidence, and importantly ensuring that "evidence is adduced in very shortly phrased questions" and witnesses are asked to give their "answers in short sentences". This was emphasised by the Court of Appeal in R v Rashid (Yahya) [2017] 1 WLR 2449.*

At paragraph 46 Lieven J noted that

> *46. All these points are directly applicable to the Family Court. Counsel submitted that there was a need for intermediaries because relevant parties often did not understand the proceedings and the language that was being used. However, the first and normal approach to this difficulty is for the judge and the lawyers to ensure that simple language is used and breaks taken to ensure that litigants understand what is happening. All advocates in cases involving vulnerable parties or witnesses should be familiar with the Advocates Gateway and the advice on how to help vulnerable parties understand and participate in the proceedings. I am reminded of the words of Hallett LJ in R v Lubemba [2014] EWCA Crim 2064 at [45] "Advocates must adapt to the witness, not the other way round". A critical aspect of this is for cross-examination to be in short focused questions without long and complicated preambles and the use of complex language. Equally, it is for the lawyers to explain the process to their clients outside court, in language that they are likely to understand.*
>
> *47. Finally, it is the role of the judge to consider whether the appointment of an intermediary is justified. It may often be the case that all the parties support the appointment, because it will make the hearing easier, but that is not the test the judge needs to apply.*

Long-term s.17 MHA leave: a further go-round (by analogy) before the Supreme Court

Re RM (Application for Judicial Review) (Northern Ireland) [2024] UKSC 7 (Supreme Court (Reed, Sales, Stephens, Rose and Simler SCJJ))

Article 5 – deprivation of liberty

Summary

In this case before the Supreme Court, the provisions of the Mental Health Order (Northern Ireland) 1986 came under scrutiny, shedding light at the same time on the operation of s.17 Mental Health Act 1983 in England & Wales.

In 2018 the Supreme Court held in *Re MM* that conditional discharge under the 1983 Act could not authorise deprivation of liberty in the community. In consequence, and in both jurisdictions, the use of extended periods of authorised leave of absence as a tool for enabling detained patients to continue their rehabilitation in a community setting where appropriate has assumed greater clinical importance.

RM, a restricted patient in Northern Ireland, had sought discharge before the Mental Health Review Tribunal but had been unsuccessful. The Tribunal had accepted the recommendation of his responsible medical officer that his long term leave of absence under article 15 of the 1986 Order (the equivalent of s.17 MHA 1983) would shortly be authorised, and he would move to a community-based setting as a means of transition from secure conditions to ultimate discharge. The Tribunal considered that as a patient subject to leave of absence, RM would nonetheless remain a patient detained in hospital for treatment for the purposes of article 77(1)(a) of the 1986 Order (the equivalent of s.72 MHA 1983). RM challenged this decision by way of judicial review, arguing that, as a matter of law, he should have been discharged unless "a significant component" of his medical treatment was being administered or was to take place within a hospital or equivalent health care facility. Since no treatment in hospital was envisaged in RM's case, he argued that should have been discharged from hospital and the only remaining issue was whether the discharge should be absolute or conditional.

The reference to "significant component" was an allusion to the situation in England where the courts had reconciled full-time leave of absence under s.17 MHA 1983 with the need for continued detention for treatment in a hospital by adopting a test that permitted leave of absence where a "significant component" of the treatment plan for the patient was treatment in a hospital: see, in particular, *R (on the application of DR) v Mersey Care NHS Trust* [2002] EWHC 1810 (Admin) (Wilson J) and *R(CS) v Mental Health Review Tribunal* [2004] EWHC (Admin) 2958.

While it was accepted on RM's behalf that the significant component test for the connection with a hospital could be gossamer thin, he argued that, on the evidence in this case, where no medical treatment of any kind was taking place at a hospital, nor was any envisaged at any time in future, that connection was not made out.

The High Court upheld the Tribunal's decision. RM then took matters to the Northern Ireland Court of Appeal, which allowed his appeal. It considered that article 15 "*cannot and should not be used as a mechanism for providing legitimacy for what amounts to detention in the community when the grounds for detention in hospital for medical treatment no longer exist and it cannot and should not be seen as a means of avoiding the difficulties presented by the MM decision in respect of the conditions which can be imposed upon a patient who is subject to a conditional discharge*" (paragraph 40

of the NICA decision).

The Department of Justice and the Tribunal appealed.

Before the Supreme Court two questions arose. The first was whether the NICA was justified in drawing distinctions between the 1986 Order and the MHA 1983 so as to support the conclusion that authorities from courts in England and Wales could not be relied on to construe the requirement of detention in hospital for medical treatment. The Supreme Court had little hesitation in finding that the differences in wording did not bear the weight placed upon them by the NICA, such that English authorities could be relevant.

The second question – of relevance both in Northern Ireland and, by analogy, in England & Wales – was set out by Lady Simler, giving the judgment of the Supreme Court, at paragraph 10 as being:

> *whether the grant of leave of absence under article 15 of the 1986 Order is inconsistent with a conclusion that a patient still satisfies the test for detention in hospital for medical treatment and should have no bearing on the decision whether detention for medical treatment is warranted.*

If so, Lady Simler continued,

> *such leave which may form an important and valuable part of a detained patient's treatment plan, that can and frequently does support a safe transition from the institutional setting of a hospital to a less secure, less institutionalised setting in the community, as part of the continuum from detention to discharge, is considerably restricted in its availability.*

Having examined the statutory wording of the 1986 Order, the clear conclusion of the Supreme Court (at paragraph 79) was that a period of leave under article 15 of the 1986 order could be regarded as detention in hospital for medical treatment, so that the Tribunal had been correct to regard RM as continuing to be regarded as a detained patient. Lady Simler continued at paragraph 80 that:

> *The NICA's observation that article 15 leave is not to be used to legitimise detention in the community when the grounds for detention in hospital for medical treatment no longer exist or for avoiding the difficulties presented by MM is unfortunate. While I agree that article 15 leave should not be used illegitimately, that is not what the review tribunal did in this case, and I see no justification for this implied criticism. To the contrary, the proposed treatment plan included a regime of care, support, rehabilitation, and supervision that constituted "a significant amount of medical supervision and treatment" on the review tribunal's findings. Initially the medical supervision and treatment was planned to take place in the community in circumstances that were more restrictive than those then imposed on RM in hospital. There was uncertainty as to how RM would cope with leave of absence. It was evident from Dr Devine's evidence that the package of care, treatment, support and supervision that would be in place in the community would be tested by the leave of absence and that it would have to be developed and adapted to meet RM's needs. This was "medical treatment" under the 1986 Order. The review tribunal also concluded that it was necessary for the treatment to continue while RM met the statutory conditions for detention and remained liable to recall from leave. In other words, the review tribunal's conclusions meant that even when on leave, RM has a hospital at which he is detained when not on leave.*

Importantly, however, Lady Simler noted that, in agreement with the NICA (but for different reasons), she did:

> *not regard the "significant component" test as necessary, or indeed helpful, when deciding whether a patient's ongoing treatment is treatment in a hospital. The test has no statutory basis and is a gloss on the statutory words. I agree with the submission on behalf of RM that it risks unnecessary treatment being devised in an effort to ensure that the test is met and is arbitrary and subject to happenstance. For these reasons, it should no longer be followed. As explained, even when on authorised article 15 leave, the patient has a hospital at which he or she is detained when not on leave, and article 15 (with the liability to recall in article 15(5)) itself provides a sufficient connection to a hospital for a patient who is liable to be detained.*

The appeal was therefore allowed, and the decision of the review tribunal restored that the statutory test for detention in hospital for medical treatment was met notwithstanding the responsible medical officer's decision that RM should reside on a long-term basis in a community setting, initially on article 15 leave.

Comment

One oddity of this case is that the Supreme Court made no reference to the decision of Lieven J in *Cumbria, Northumberland Tyne & Wear NHS Foundation Trust & Anor v EG* [2021] EWHC 2990 (Fam), in which the operation of long-term s.17 leave with no medical treatment taking place in hospital was considered in considerable detail. It is perhaps because this case was decided at the same time as RM's case was going through the Northern Ireland courts. Lieven J had reached the conclusion that EG could be maintained in the community in such a situation, albeit by having to read the provisions of the MHA through the prism of s.3 HRA 1998.

By contrast, the Supreme Court here reached the same conclusion through a rather more direct route, dismissing the relevance of the 'significant component' test altogether. The observations of Lady Simler in relation to the test are just as applicable to s.17 MHA 1983 as they are to the 1986 order – something of which she was no doubt aware because (although only referred to indirectly), the English Department of Health and Social Care and Ministry of Justice had intervened in RM's case.

The observations of Lady Simler therefore reinforce the ability to use long-term s.17 MHA 1983 as a work-around for situations where a restricted patient cannot be discharged into the community other than under circumstances giving rise to a deprivation of liberty. However, the use of s.17 leave in this way is sufficiently problematic (for instance as regards the continued operation of Part 4 MHA 1983 and the implications for s.117 aftercare) that it is to be hoped that the primary legislation can be amended in due course in England & Wales so that the recourse does not have to be had to it, and s.17 can be returned to its proper, more limited, purpose.

A final irony of the case is that it concerns legislation that should no longer be in force, the Mental Capacity Act (Northern Ireland) 2016 having been supposed to have swept away standalone mental health legislation in favour of a capacity based-framework applicable to both mental and physical health matters. Unfortunately, and causing considerable ongoing difficulties, the 2016 Act is only partially in force, and the 1986 Order remains operative in respect of those with mental health conditions warranting admission and treatment.

Discharge from mental health inpatient settings

DHSC has published a new statutory guidance, 'Discharge from mental health inpatient settings.' The guidance is issued pursuant to several legislative powers, including s.82 NHS Act 2006, s.74 Care Act 2014 (as a guidance issued under NHS England) and is for NHS bodies (including NHS England, special health authorities, NHS Trusts, and ICBs) and local authorities.

The purpose of the guidance is to clarify what the *"duties to cooperate…mean in practice in the context of discharge from all mental health and learning disability and autism inpatient settings for children, young people and adults. It aims to share best practice in relation to how NHS bodies and local authorities can work closely together to support the discharge process and ensure the right support in the community. It provides clarity in relation to responsibilities in the discharge process, including funding responsibilities. In addition, the guidance incorporates best practice in relation to patient and carer involvement in discharge planning."* The guidance sets out a series of eight principles for how NHS bodies and local authorities should work together for effective discharge planning from mental health inpatient services:

- *principle 1: individuals should be regarded as partners in their own care throughout the discharge process and their choice and autonomy should be respected*
- *principle 2: chosen carers should be involved in the discharge process as early as possible*
- *principle 3: discharge planning should start on admission or before, and should take place throughout the time the person is in hospital*
- *principle 4: health and local authority social care partners should support people to be discharged in a timely and safe way as soon as they are clinically ready to leave hospital*
- *principle 5: there should be ongoing communication between hospital teams and community services involved in onward care during the admission and post-discharge*
- *principle 6: information should be shared effectively across relevant health and care teams and organisations across the system to support the best outcomes for the person*
- *principle 7: local areas should build an infrastructure that supports safe and timely discharge, ensuring the right individualised support can be provided post-discharge*
- *principle 8: funding mechanisms for discharge should be agreed to achieve the best outcomes for people and their chosen carers and should align with existing statutory duties*

The document also contains specific guidance relating to children and young people, people with a learning disability and autistic people, people with dementia, people in forensic settings, people who are homeless or at risk of homelessness, people with co-occurring drug and alcohol conditions and people with no recourse to public funds. The guidance *'sets out roles and responsibilities of organisations in the discharge process, including commissioners of services, NHS trusts and local authorities. In the annex, there is additional statutory guidance on how budgets and responsibilities should be shared to pay for section 117 aftercare.'* The guidance also contains a s.117 'maturity matrix', which is described as a *'quality assurance tool is*

designed to assist local systems in self-assessing their current compliance with the national guidance on section 117 aftercare. It is designed to enable local systems to identify areas that might need further operational, strategic, commissioning and financial development, and agree actions to initiate improvement for people subject to this legal entitlement.'

The s.117 guidance at Annex B is notable, and arises out of *"the recommendation of the Independent Review of the Mental Health Act 1983 that there should be guidance 'on how budgets and responsibilities should be shared to pay for section 117 aftercare."* This guidance is for England only and applicable across all ages to include section 117 responsibilities for children and young people (CYP) and adults.' It emphasises that:

- *Funding decisions must be conducted in a timely manner prioritising and promoting the least restrictive approach while promoting the strengths of the individual. No assessment, care or support arrangements should be refused or delayed because of uncertainty or ambiguity as to which public authority is responsible for funding an individual's health and/or care provision.*

- *Section 117 funding arrangements and associated funding decisions should be based upon clear and transparent funding arrangements which can be evidenced by each partner organisation.*

- *Section 117 funding arrangements should therefore be determined in accordance with local agreement between NHS and LSSAs to meet the needs of the eligible persons. Local systems will choose to administer a joint funding process which will fall within different broad categories of aligned or pooled budget arrangements.*

- *health and local authorities 'should conduct a joint review of the section 117 care plan no later than every 12 months, which must take into account the views of the person who is receiving the aftercare. The timetable of review arrangements should be refreshed and updated in the event of potential change in circumstances for example a hospital admission and discharge plan.*

- *Specific reference to the application of funding for young people subject to section 117 needs to be made in local section 117 policies and procedures, referencing the role of the various agencies that might be involved with the experience of transition. It is incumbent on CYP commissioning managers to bring people entitled to section 117 to the attention of adult commissioning colleagues in a timely manner to support effective future planning, and it is incumbent on adult commissioning colleagues to request details of those young people subject to section 117 who may require adult services from their CYP counterparts. Local CYP and adult commissioners from NHS bodies and local authorities should convene on a regular basis to review the circumstances of young people who are subject to section 117 and ensure that suitable preparations are being made to support a structured and smooth transition allowing for the forecasting of care costs and necessary market provision.*

- *'The involvement of the person and their carer where applicable is essential in the decision-making process for the successful ending of aftercare.'*

We would also note that the guidance appears to contemplate that a stay in prison would not extinguish an entitlement to s.117 aftercare, stating 'Individuals being released from prison, an IRC or the Youth Justice Estate who have a section 117 aftercare entitlement should be referred by the prison mental health team or IRC healthcare team to the relevant ICB and local authority as soon as is practicable so as to facilitate maximum opportunity for a section 117 aftercare plan to be drawn up prior to release.' We would note the contrast between the position here and the obiter dicta at paragraph 49 of the *Worcestershire* judgment, which appeared to suggest that a s.117 duty would end due to incarceration (we would emphasise that this issue was not part of the factual scenario in *Worcestershire* and this comment was not part of the decision of the court):

> *49. As a matter of linguistic analysis, the answer to this argument, in our view, is that the duty under section 117(2) is to provide after-care services "for any person to whom this section applies". The duty will therefore cease not only if and when a decision is taken that the person concerned is no longer in need of after-care services but, alternatively, if the person receiving the services ceases to be a person to whom section 117 applies. As Mr Sharland KC pointed out, that would be the case if, for example, the person concerned were to die or was deported or imprisoned. Although there is nothing in section 117(2) which says that the duty will cease in that event, there would then be no person to whom section 117 could apply.*

'Who Pays?' Guidance updated following the *Worcestershire* s.117 Supreme Court decision

NHS England has published an update to the 'Who Pays?' guidance to consider the effect of the *Worcestershire* s.117 decision in the Supreme Court. The update states in relevant part:

> *The position under the Integrated Care Board (ICB) Responsibilities Regulations, under which the originating ICB retains responsibility for care during subsequent detentions, even if the patient moves to a different part of the country, is not affected by the Supreme Court's judgment in the case of R (on the application of Worcestershire County Council) (Appellant) v Secretary of State for Health and Social Care concerning which local authority was responsible for the provision of aftercare under section 117 of the Mental Health Act 1983….*
>
> *In the case of the ICB Responsibilities Regulations, the continuing obligation of the originating ICB derives from the regulations, not section 117(3) itself. In particular, regulations 5 and 7 have the effect that if an ICB has core responsibility for a patient individual when a "relevant application" is made for detention, then it retains responsibility for commissioning mental health services during detention and aftercare even if it would otherwise not be responsible (eg because the patient had moved out of area). A relevant application is an application made either before or after an "exclusion period" beginning with detention and ending with a person's "next discharge from aftercare services". So, unlike the local authority position in Worcestershire, a second detention made before the person is actively discharged from after care does not bring to end the responsibility of the originating ICB.*
>
> *Similarly, where under the transitional provisions in regulation 6, an ICB had core responsibility for a person who was detained or in aftercare on 1 July 2022, the responsibility for mental health services continues during any second or*

> *subsequent detention and related aftercare, and is not brought to end by a second or subsequent detention, only by an active discharge from aftercare.*

Associate Hospital Managers – their employment status

In *Lancashire and South Cumbria NHS Foundation Trust v Moon (Jurisdiction – Employee, Worker or Self-Employed)* [2024] EAT 4, Ellenbogen J has held (in dismissed an appeal from the Employment Tribunal) that Associate Hospital Managers are workers and employed by the Mental Trusts in question. The decision gives rise to a number of thorny employment law issues outside the remit of this Report, but of note was Ellenbogen J's conclusion at paragraph 31 that:

> *the status of worker and its associated rights do not themselves serve to compromise the independence or integrity of the role, which, to paraphrase Mr Young's submission, is what it is and has no impact upon a patient's rights under Article 5 ECHR; indeed — see Gilham [36] — independence and integrity are likely to be promoted by enabling an AHM to make public interest disclosures without fear of retribution. It follows that worker status does not serve to defeat the purpose of section 23(6) of the MHA.*[8] *Nothing in that conclusion is inherently undermining of the requirements of the Code (as Dr Morgan acknowledged in discussion), or of Article 5 ECHR.*

If you do not know you are doing wrong, can you sue for not being prevented from doing it?

Alexander Lewis-Ranwell v G4S Health Services (UK) Ltd & Ors [2024] EWCA Civ 138 (Court (Court of Appeal (Dame Victoria Sharp P, Underhill LJ and Andrews LLJ))

Other proceedings – civil

Summary

If you have been found by a criminal court that you did not know what you were doing was wrong when you killed someone, should you able to sue those statutorily charged with assessing your mental health for failing to stop you?

That was the stark question before the Court of Appeal in *Alexander Lewis-Ranwell v G4S Health Services (UK) Ltd & Ors* [2024] EWCA Civ 138. On 10 February 2019, in the course of a serious psychotic episode, the claimant had attacked and killed three elderly men in their homes in Exeter in the delusional belief that they were paedophiles. He was charged with murder but following a trial in Exeter Crown Court he was found not guilty by reason of insanity: in law, this meant that because of his mental illness he did not know at the time of the killings that what he was doing was wrong. He was ordered to be detained in Broadmoor Hospital pursuant to a hospital order with restrictions under sections 37 and 41 of the Mental Health Act 1983. In the two days before the killings he had twice been arrested, and detained for some time before being released. During both periods of detention the claimant behaved violently and erratically and was apparently mentally very unwell. He was seen or spoken to by mental health professionals employed by G4S Health Services (UK) Ltd and Devon Partnership NHS Trust. A face to face assessment by the mental health nurse employed by the Liaison and Diversion Service of the NHS Trust was discussed but did not take place. The need for a Mental Health Act Assessment was discussed with an Approved

[8] Which provides that the power of discharge conferred on the Trust "may be exercised by any three or more persons authorised by the board of the trust in that behalf each of whom is neither an executive director of the board nor an employee of the trust."

Mental Health Professional employed by Devon County Council but was not arranged.

On 4 February 2020 the claimant commenced proceedings in the High Court against G4S, the Police, the Trust and the Council. In broad terms it was his case that it should have been obvious to all concerned during both detentions that if he were released there was a real risk that he would injure other people, and that the necessary steps should have been taken to keep him in detention until it was safe for him to be released. The claims were advanced in negligence and under section 7 of the Human Rights Act 1998. The heads of damage pleaded in the Particulars of Claim were for personal injury, loss of liberty, loss of reputation, and "pecuniary losses". The claimant also sought an indemnity in respect of any claims brought against him "as a consequence of his violence towards others on 9-11 February 2019".

All of the organisations involved (bar the police) sought to have the claim struck out on the basis, broadly, that they were entitled to rely "the illegality defence" – that is, the rule that the Court will not entertain a claim which is founded on a claimant's own unlawful act – because the claim was based on the consequences of the claimant's three unlawful homicides.[9]

As Underhill LJ (one of two judges in the majority, along with Andrews LJ) noted, the question of whether the illegality defence operated in a case where the claimant was insane at the time that he or she did the unlawful act was not the subject of any binding authority. In *Clunis v Camden and Islington Health Authority* [1998] QB 978, the Court of Appeal held that a mentally ill person who had been convicted of manslaughter by reason of diminished responsibility was barred by illegality principle from bringing a claim against his doctors for negligent treatment which was said to have caused or contributed to his committing the offence; and that decision had since been upheld by the House of Lords in *Gray v Thames Trains Ltd* [2009] UKHL 33, and by the Supreme Court in *Henderson v Dorset Healthcare University NHS Foundation Trust* [2020] UKSC 43 However, as Underhill LJ identified, the reasoning in those decisions, though clearly relevant to this case, was not determinative because diminished responsibility is not the same as insanity. The issue had, however, been directly considered in some U.S. and Commonwealth cases, and also in a recent decision of the High Court, *Traylor v Kent & Medway NHS Social Care Partnership Trust* [2022] EWHC 260 (QB).

Underhill LJ considered that the public authorities should not be able to rely on the illegality defence, and after an extensive review of the case-law, took each the arguments in favour of the defence in turn to explain why they did not avail the public authorities.

First, as regards the inconsistency that would arguably arise between the civil and criminal law, he accepted the claimant's case that the "*verdict of not guilty by reason of insanity was an acquittal. Accordingly the law has not treated him as criminally responsible for his actions, and there is no inconsistency in allowing him to recover for the loss that he has suffered in consequence of them*" (paragraph 93). He noted that "[t]*hat approach also seems to me to accord with the fundamental justice of the matter. At a superficial level you could still say that it was inconsistent to allow a person to recover for the consequences of an unlawful act which they have done. But at a more fundamental level the criminal law is concerned not with acts as such but with personal responsibility for those acts, and a difference in*

[9] Using Latin terms which should no longer be in use, the defence is often described as depending on "the *ex turpi causa* principle" (or "rule"), referring to the maxim *ex turpi causa non oritur actio*.

treatment based on differences in personal responsibility cannot be said … to undermine 'the integrity of the justice system.' This reflects the basic perception reflected in the authorities […] based on the requirement of moral culpability" (paragraph 96). Underhill LJ emphasised that he was only dealing at this stage with the inconsistency principle, and that the argument that the claimant should not be entitled to recover compensation for the consequences of his criminal act (albeit one for which he had no criminal responsibility) could still be deployed in the context of the public confidence principle, considered further below.

Second, there was said to be an inconsistency within the civil law that it was clearly established by case-law that the claimant's insanity would be no defence to any action in tort that his victims' families might bring. However, Underhill LJ considered, "[t]*he question of the liability of the Claimant to his victims for the injury which he caused them is self-evidently different from the question of the liability of the Appellants for the loss which they have caused him. In the former case justice requires that the interest of the victim in receiving compensation comes before any question of moral culpability … In the latter it is the Claimant who is the victim of wrongdoing and the question whether he should nevertheless be denied recovery because his loss was the result of a criminal act has to be considered in that quite different context. Again, I am not saying that it has to be answered in his favour, only that to allow recovery would not be inconsistent with the rule that his insanity does not preclude his liability to his victims*."

Third, Underhill LJ considered the public confidence principle, identified in the *Henderson* case as being the potential that allowing a claimant to be compensated for the consequences of his own criminal conduct would risk bringing the law into disrepute and diminishing respect for it because that is an outcome of which public opinion would be likely to disapprove. He noted at paragraph 103 that:

> *In my view it is this principle which is at the heart of this appeal, as it was for Santow JA in* [the Australian case of] *Presland, and I have not found it easy to decide whether it should operate in this case. I do not doubt that it would – at least as a first reaction – stick in the throats of many people that someone who has unlawfully killed three innocent strangers should receive compensation for the loss of liberty which is a consequence of those killings, however insane he was and however negligent his treatment had been. To the extent that that reaction reflects, in Santow JA's language, "considered community values", we should be very slow to disregard it: the law ought so far as possible to give effect to such values.*

However, Underhill LJ came to the conclusion that:

> *104.* […] *although that first reaction is entirely understandable, the values of our society are not reflected by debarring a claimant from seeking compensation in this kind of case. It is necessary, as Santow JA accepted, to go beyond "instinctive recoil" and to consider what justice truly requires in a situation which most humane and fair-minded people would recognise as far from straightforward. Taking that approach, although of course those who are killed or injured must always be treated as the primary victims, it is fair to recognise that the killer also may be a victim if they were suffering from serious mental illness and were let down by those responsible for their care. I rather suspect that some such view underlies the observations of the jury at the Claimant's trial which I quote at para.*

> *11 above.*[10] *But, whether it does or not, I believe that the considered view of right-thinking people would be that someone who was indeed insane should not be debarred from compensation for the consequences of their doing an unlawful act which they did not know was wrong and for which they therefore had no moral culpability. As we have seen, the law does not generally apply the illegality defence where the claimant does not know that what they are doing is wrong and has no moral culpability; and in my view that reflects ordinary and comprehensible principles of fairness. I do not believe that it is rational, or would accord with community values, that the position should be different where the claimant's lack of knowledge or culpability was the result of insanity. In short, I would align myself with the approach taken by Spigelman CJ at para. 95 of his judgment in Presland: see para. 55 above.*

Two further potential anomalies were pointed out by the public bodies in support of their argument that the law would be brought into disrepute. The general one was that claimants would be entitled to claim compensation from their doctors for what they had lost as a result of not being prevented from committing their unlawful acts, the victims of those acts (or their estates or dependants) would have no claim against the doctors. Underhill LJ was:

> *107.* […] *prepared to assume that at least in the generality of cases victims in a situation such as the present would have no right to recover against the authorities whose negligence had allowed the attack to take place. But I do not accept that that gives rise to an anomaly. Victims may not have a right to compensation against the doctors, but they have a straightforward claim against their assailant, whose insanity would be no defence to a civil claim for assault. It is true that, unlike a doctor or health authority, the assailant may not be in a position to meet a substantial award of damages. However, as we have seen, one of the heads of damage claimed by the Claimant in this case is an indemnity against any liability to his victims. I can see no reason why that would not be an admissible head of claim; and, if it is, it would afford a route by which victims could be assured of payment of any damages that they were awarded. However, Ms Ayling did not accept that a claim for such an indemnity would lie, though she did not advance any developed reason for that position. In the absence of full argument I am not prepared definitively to decide the point. But even if the claimant were not entitled to such an indemnity, the fact that they might not be able to meet any award of damages to the victim does not seem to me to be a principled reason for denying them recovery for their own loss.*

The more specific anomaly would arise in the case where the victim of the claimant's unlawful act was also the defendant – for instance where a mentally ill patient attacked the negligent doctor. Underhill LJ fully accepted that:

> *110.* […] *seems unjust that someone who has suffered unlawful injury at the hands of another can be required to pay damages to them for the consequences that they have suffered as a result of inflicting that injury. Of course the victim would have a cross-claim, but even if that exceeded the value of the claimant's claim, so that there was no net liability, their net recovery would*

[10] The jury sent a note to the judge during the trial in the following terms: "*We the Jury have been concerned at the state of psychiatric health service provision in our county of Devon. Can we be reassured that the failings in care for* [the Claimant] *will be appropriately addressed following this trial*."

> *necessarily be less than the full compensation for their loss. The position would be worse still if the claimant, as in this case, claimed an indemnity against any such liability: that would on the face of it reduce the victim's recovery to nil while still leaving them liable for the claimant's loss. (It is true that they might be insured against their liability to the claimant – in my two examples, both the doctor and the driver would almost certainly be insured – but that ought not to affect the position in principle.)*
>
> *111. I do not, however, believe that the problems that would arise in that scenario are a reason for barring a claim in the typical case where, as here, the defendant is not a victim of the claimant's unlawful act. I ought not to seek to determine in advance how the Court would address such a situation; but since we are concerned with questions of public policy, it would have the tools to produce a just outcome.*

Fourth, Underhill LJ considered two other considerations that had also been raised in *Henderson*: (a) the impact on NHS funding of allowing a claim of the present kind; and (b) deterring unlawful killing and providing protection to the public, there being no more important right to protect than the right to life. Whilst Underhill LJ agreed that they appeared to be in play, he considered that the question was whether it was proportionate to treat them as outweighing the public interest in claimants in insanity cases receiving due compensation for the wrong that they have suffered. He did not believe that it was:

> *116. The balance is quite different from in the diminished responsibility cases because the claimant has no moral culpability. That point is clearly made if one looks at how Lord Hamblen struck the balance at paras. 138-143 in Henderson. In those paragraphs he emphasises the importance of the fact that the claimant knew that what she was doing was legally and morally wrong: see paras. 139 and 142. In the absence of that element, and where, essentially for that reason, the consistency and public confidence principles are, as I would hold, not engaged, I do not believe that either the impact on NHS resources or the general deterrent effect of a rule against recovery could justify the denial of the claim in these proceedings.*

A final consideration was the fact identified by the appellant public bodies that there was no sharp distinction between a finding of diminished responsibility and a finding of insanity: the distinction is one of degree only:

> *117.* […] *That may be so, but the criminal law proceeds on the basis that the distinction is nevertheless real and that in any given case it will be possible to say on which side of the M'Naghten line the defendant falls. That being the case, there is nothing irrational about the application of the illegality defence depending on the selfsame distinction. If I had any unease about this aspect, it would, rather, be about the possibility that in some cases the distinction may reflect not a finding by a court but a forensic choice by the defendant or their advisers. Pleas of not guilty by reason of insanity are in practice rare; and there must be cases where a defendant tenders, and the Crown accepts, a plea of manslaughter by reason of diminished responsibility where the facts might arguably have justified a special verdict (Henderson may be an example). But if that results in the illegality defence being unavailable in some cases where it might have been available if the defendant had made a different choice I do not think that can affect the decision in principle which we*

have to make.

Whilst Underhill LJ identified (at paragraph 119) that he did not consider the question as an easy one, he therefore allowed the appeal.

Dame Victoria Sharp P gave a shorter judgment explaining her reasoning for allowing the appeal, her central reasoning being that each of the key English cases:

> *161.* […] *draws a coherent and bright line distinction for the purposes of the ex turpi causa doctrine, between those who are criminally responsible for their acts whether fully or partially, and those who are not responsible for their acts because they do not know what they are doing is morally and legally wrong. In my judgment, this common thread running through the criminal and civil law, is consistent with principle, a proper understanding of the true implications of acute mental illness and is one that would not offend the sensibilities of ordinary right-thinking members of the public or undermine public confidence in the law.*

Andrews LJ dissented, finding herself unable to agree with the majority that:

> *122. […] a lack of knowledge or understanding by a person who intentionally takes the life of another human being that what he was doing was wrong is a sound and principled basis for allowing that person to make a claim in negligence against someone for putting them in a position which enabled them to commit an act which was both deliberate and tortious.*
>
> *123. I agree with Underhill LJ that in an era where there is much greater understanding of mental health issues, it is fair to recognise that, as well as the primary victims, the killer also may be a victim, if they were suffering from serious mental illness and were let down by those responsible for their care. However, I am not persuaded that an absence of the state of knowledge of wrongdoing, which would afford the mentally ill perpetrator of a deliberate fatal assault a complete defence to criminal liability for murder or manslaughter, justifies drawing a bright line between the present case and similarly tragic cases such as Clunis, Gray and Henderson.*
>
> *124. There are all kinds of reasons why a defendant suffering from a serious mental illness who faces a charge of murder might prefer to opt for running the partial defence of diminished responsibility rather than pleading insanity, even though it may be open to them to do so. The most obvious of these is the prospect of indefinite incarceration in a secure mental health unit. Moreover, it is not difficult to conceive of examples of situations where a person who is guilty of the criminal offences of murder or manslaughter, or causing death by careless driving, might be regarded by the public as less blameworthy for the death than a person in the position of the Claimant, who intended to kill his victims. Yet such a person would be precluded by their conviction from making a claim of this nature even if they were seriously mentally unwell at the time.*
>
> […]
>
> *137. I have not reached this conclusion lightly. However it does seem to me that there is nothing disproportionate about precluding someone who intended to kill, and did so, from bringing a claim in negligence in reliance on that deliberate and unlawful act, and that the policy rule preventing such claims from being made should not rest on nice distinctions between having little or no*

> *personal responsibility for the killing because of the state of the claimant's mental health at the time. For those reasons, I would have allowed this appeal.*

Comment

It is very important to make clear that the decision of the Court of Appeal is not that the public authorities did, in fact, fail in their duties towards the claimant. Rather, it was whether, as a matter of principle, the claimant could even bring his claim. Further, as Underhill LJ identified, there also remains in play issues such as whether his contributory negligence should eliminate in whole or in part any obligation on their part to pay him damages. Furthermore, it is important to remember in any commentary or discussion of the case that underpinning it is a tragedy where three entirely innocent older people were killed.

However, given the wider implications of the analysis of the law in play, the determination of the majority to carry through the logical implications of the meaning of a finding of not guilty by reason of insanity – i.e. that a person is truly to be taken not to be responsible for their actions – stands out at a time of considerable media interest (to put it neutrally) in the implications of a person being found not guilty by reason of insanity as a result of the Valdo Caldocane case. It is perhaps not surprising that that all three of the judges found the case a difficult one, and that Underhill LJ identified that the approach that underpinned it would – at least by way of first reaction – stick in the throats of many.

For those steeped in matters of mental health law from the disability rights angle, one striking feature of the case was the absence of discussion of the UN Convention on the Rights of Persons with Disabilities. Even if not part of English law, the CRPD is part of the modern context within which the approach to mental illness is considered,[11] and which appears to have played a part in the thinking of the majority. And, given that the Court of Appeal were grappling with principles, the CRPD might be thought to have provided a useful stress-test of those principles.

On one view, it might be thought that, albeit perhaps unknowingly, Andrews LJ's dissent reflects the most CRPD-compliant approach to the difficult question before the court. Put shortly, if a central tenet of the right to equal recognition before the law in Article 12 CRPD[12] is that those with disabilities should not be denied agency on the basis of their impairments, then it might be said that it flows that they should not be identified as lacking responsibility for their actions when they act upon that agency: no matter the consequences. That would, in turn, seem to point to a conclusion that the illegality defence should be available in all cases where the person's actions were both intentional and wrongful (even if that 'intention' was based upon delusional beliefs).

In saying this, I should say that I am aware that some might contend that: (1) none of the public authorities should have had the power to detain the claimant prior to his attacks on the basis of his mental ill-health, such that his claim should fail at the very first base; and (2) the CRPD would dictate the abolition of the very concept of a defence of not guilty by reason of insanity, such that he should, in fact, have been convicted of their murders. Both of these points show the complexities of the CRPD in this regard,

[11] See, for instance, the part that it played in shaping the thinking of the independent Review of the Mental Health Act 1983.

[12] For those unfamiliar with this, this reading list may be useful: Legal and mental capacity – a reading list – Mental Capacity Law and Policy.

especially as interpreted by the Committee on the Rights of Persons with Disabilities. And they arguably also show the limits of the 'abolitionist' arguments advanced by the Committee.[13] But if the current case does go further (as it is possible to imagine it might given the finely balanced nature of the judgments, and the absence of prior binding authority), it is to be hoped that the CRPD can get at least a walk-on part in testing the proposition whether it is right to expand the range of circumstances in which English law identifies that that a person with cognitive impairments is not to be seen as seen as responsible for their own actions.

[13] See for a nuanced discussion of the CRPD and criminal law, Jill Craigie, Against a singular understanding of legal capacity: Criminal responsibility and the Convention on the Rights of Persons with Disabilities. *International Journal of Law and Psychiatry*, *40*, 6-14.

THE WIDER CONTEXT

Reminder: visiting arrangements in care homes and hospitals from April 2024

On the basis that our experience is that the changes coming into force in April 2024 in England appear not to be on the radar of many, we remind people of the important changes coming in through the prism of an amendment to the regulated activities regulations applying to care homes, hospitals and hospices. See our February 2024 report for more details.

When NOT to attempt CPR

NHSE has published *Guidance to support the decision-making process of when not to perform cardiopulmonary resuscitation in prisons and immigration removal centres*. The short document states that it has been prepared due to inappropriate resuscitation attempts being made in these settings as well as some failures to attempt CPR when it was appropriate, evidenced in Prison and Probation Ombudsman investigations. The focus of the document is on attempts at CPR when the patient is already dead. Seven conditions where CPR is clearly futile are identified, including the presence of rigor mortis. Where any of these conditions is present, there is no chance of success in terms of survival. If staff who first come upon the patient are not able to recognise rigor mortis, they should start resuscitation until advised otherwise by someone who is competent to give that advice, and prison or immigration staff are not to overrule a decision by a health professional not to attempt CPR.

Whilst expressly aimed at those working in prisons / removal centres, the principles set out in the guidance are equally applicable elsewhere. A robust decision-making process around (1) making recommendations about CPR; and (2) carrying out CPR must provide for situations where CPR should not be carried out as well as those where it should.

Assisted dying / assisted suicide developments

The House of Commons Health and Social Care Committee has published the report of its inquiry into assisted dying / assisted suicide ('AD / AS').

The report does not make any recommendations for or against changing the current law in England & Wales, but rather seeks to inform debate covers Parliament and the current law, the Government's role in the debate, international examples of jurisdictions where AD/AS is available in some form, the involvement of physicians and assessments of eligibility and capacity to give informed consent, and palliative and end-of-life care.

The Committee identified the pursuit of high-quality compassionate end-of-life care as a common theme in the evidence it received. Also important was agency and control for the person dying.

AD/AS is currently being considered in both Jersey and the Isle of Man, and the Committee concludes that the Government should be "actively involved in discussions" on how to approach possible divergence in legislation between jurisdictions.

During the course of its inquiry, the Committee visited Oregon, which became the first US state to legalise the practice, and collected both written and oral evidence from international witnesses. The report concludes that many of the jurisdictions which have legalised AD/AS did so recently, with still much to learn as time passes.

Despite the UK being a world leader in palliative and end-of-life care, the report concludes that access to such care is patchy.

The report recommends that the Government ensures universal coverage of palliative and end-of-life services, including hospice care at home, and more specialists in palliative care and end-of-life pain relief. The report urges the Government to commit to guaranteeing that support will be provided to any hospices which require funding assistance.

The report also calls for new guidance from the GMC and the BMA to provide clarity to doctors on responding to requests for medical reports for applicants seeking AD/AS abroad.

Amongst the many who submitted evidence was Alex, who led on work by the Complex Life and Death Decisions research group on the considerations that arise in relation to models that base themselves upon the capacity of the person.

For an 'informer' about assisted dying / assisted suicide, some might find useful this shedinar from Alex.

The report came shortly after news that the author and campaigner Wendy Mitchell has died. Her last blog sets out her reasons for deciding to voluntarily stop eating and drinking (VSED), rather than waiting for her dementia to run its course. There is more information on VSED on the Compassion in Dying website, along with a call for clearer guidance to be available as to the obligations on medical professionals where a person expresses a desire to stop eating and drinking.

Martha's Rule developments

NHSE has published further information about the scope of 'Martha's Rule,'[14] ahead of its implementation in England from April 2024.

The three proposed components of Martha's Rule are:

- All staff in NHS trusts must have 24/7 access to a rapid review from a critical care outreach team, who they can contact should they have concerns about a patient.
- All patients, their families, carers, and advocates must also have access to the same 24/7 rapid review from a critical care outreach team, which they can contact via mechanisms advertised around the hospital, and more widely if they are worried about the patient's condition.
- The NHS must implement a structured approach to obtain information relating to a patient's condition directly from patients and their families at least daily. In the first instance, this will cover all inpatients in acute and specialist trusts.

As to implementation, the NHS will take a phased approach, beginning with at least 100 adult and paediatric acute provider sites who already offer a 24/7 critical care outreach capability. The focused approach at the initial provider sites will inform the development of wider national policy proposals for Martha's Rule that can be expanded in a phased way across the NHS from 2025/26. NHSE notes that it will also identify ways to roll out an adapted Martha's Rule model across other settings including community and mental health hospitals where the processes may not apply in the same way.

IRELAND

In this issue I discuss two recent High Court decisions. The first, *EF,* is likely to be of interest

[14] We note that, strictly, it is not a 'Rule,' in the sense of a legal requirement, at least at this stage.

to probate practitioners in determining when an application pursuant to the ADMCA is required in place of a section 27(4) application to appoint an administrator *ad litem*. It may also be helpful to consider the decision of In *The Matter of The Estate of Mary Moore* [2023] IEHC 607 wherein Ms. Justice Stack held that an administrator *ad litem* appointed for the limited purpose of substantiating proceedings has 'no substantive duties or obligations to the estate or beneficiaries' and that it is 'open to them not to take active steps in the defence of the proceedings'. Given the summary in *EF* outlined below, one might conclude that an ADMCA application is required where a party to intended probate proceedings 'stands to lose' from the proceedings and lacks the capacity to defend them. The second, is one for those who enjoy statutory interpretation and the novel issues recently enacted legislation, such as the ADMCA, presents. The decision in *MC* considers whether the review of a ward of court who is the subject of a detention order is required pursuant to Part 10 of the ADMCA even if (s)he does not have a responsible consultant psychiatrist and never had a mental disorder.

The interaction of probate law and the ADMCA

In The Matter of The Estate of E.F., Deceased [2023] IEHC 720, Ms. Justice Stack refused to appoint an administrator *ad litem* pursuant to Section 27(4) of the Succession Act 1965 where the executor, who now lacks capacity to conduct her affairs, is a beneficiary of the estate and there is a challenge to the will.

Three siblings made an application to grant liberty to an independent solicitor to extract letters of administration in place of the named executor, 'G', who was stated to be of 'unsound mind not so found'. G was the sole executrix and sole beneficiary of the main asset in the estate of her late mother, namely a substantial dwelling house situate in a major city. The three siblings intended to challenge the will on the grounds of testamentary capacity, and on this basis the court distinguished the circumstances from the ordinary non-contentious situations. The court appointed a *guardian ad litem* (GAL) to convey G's will and preference to the court, and from the statements made by G to the GAL the court formed the view that 'G does not understand the significance of the application or the proposed challenge to the 2014 Will'. The court ultimately found that the proposed administrator *ad litem* was not 'asked to represent the executrix or to act in her best interests' and that it was 'G alone who stands to lose from the institution and possible success of' the intended proceedings, and for those reasons the procedures envisaged by O.79 R.27 ought to be followed i.e. the appointment of a DMR for G to administer the estate and defend the proceedings in her interest.

Lex non cogit ad impossibilia

("The law requires nothing impossible")

In The Matter of M.C., A Ward of Court [2024] IEHC 47, President Barniville considered Part 10 of the ADMCA and whether a ward of court's detention had to be reviewed pursuant to section 108 if the ward neither suffered from a mental disorder nor had a responsible consultant psychiatrist. One might recall that the ADMCA impacts existing adult wards of court in two ways. Firstly, Part 6 requires that the capacity of all adult wards of court must be reviewed, and they must be discharged from wardship by 25th April 2026. Secondly, Part 10 provides for the review of the detention of wards who are the subject of detention orders whether in approved or non-approved centres.

This case did not fall foul of the issues identified, and previously discussed in this report, in *K.K. (No. 1)* and *K.K. (No. 2)* because MC was the

subject of a detention order at the time the ADMCA was commenced.

The court ultimately favoured a plain or literal interpretation of the legislation and found that it was required to review the ward's detention pursuant to Part 10 despite the ward did not have a 'mental disorder' and did not have a 'consultant psychiatrist responsible for their treatment and care'. The court found that it was not precluded from reviewing the wards detention under Part 10, despite section 108 stating that the court 'shall' hear from the responsible consultant psychiatrist. The two options provided to the court under Part 10 are to continue the ward's detention where the ward continues to suffer from a mental disorder, or if the court is satisfied that the ward is 'no longer suffering from a mental disorder' the ward must be discharged from detention. The court found that having reviewed the ward's detention it was satisfied that no order was required pursuant to Part 10 because the ward did not have a 'mental disorder' such would warrant a continuation of her detention, but similarly a discharge order was not required because it could not be said that the ward was 'no longer suffering from a mental disorder' in circumstances where she did not have a 'mental disorder' to start with.

The significance of this decision is that *all* detained wards of court must have their capacity reviewed 'as soon as possible', instead of only those detained wards who have a 'mental disorder' and 'consultant psychiatrist responsible for their treatment and care'. This is significant because, as President Barniville pointed out (at par 117), '*many, if not most, wards the subject of detention orders made by the High Court before the enactment of the ADMCA, who met and continue to meet the test for wardship, do not have a "mental disorder" within the meaning of that term in s. 3 of the 2001 Act*'.

Emma Slattery BL

SCOTLAND

Scotland ten years post-Cheshire West: the advantages and disadvantages of not legislating!

Introduction

It's been ten years since the UK Supreme Court *Cheshire West* [15] ruling, so where are we in Scotland in terms of responding to this?

Well, one could argue that at least we haven't tied ourselves in the Deprivation of Liberty Safeguards and halted Liberty Protection Safeguards knots that our cousins South of the Border seem to have. However, in fairness to such cousins, that is probably because whilst we have *considered* how to address the issues the judgment raised we haven't actually *done* anything concrete yet! That being said, the Scottish Government's current programme of reform for mental health and capacity law will result in steps to address the issues, and the importance of doing this swiftly was recently brought into even sharper relief by, somewhat ironically, the English and Welsh Court of Protection *Aberdeenshire Council v SF*[16] ruling.

ECHR issues

In a nutshell, Article 5(1)(e) ECHR allows the deprivation of liberty of 'persons of unsound mind'. This is, of course, subject to safeguards, such as the ability to challenge the lawfulness of this through a court or tribunal and to be discharged as soon as the reason for detaining the person has ceased and/or it is not lawful (Article 5(4) ECHR). The 2004 European Court of Human Rights *Bournewood*[17] ruling made it clear that Article 5 is engaged where a person lacks capacity to consent to a deprivation of their liberty and they are therefore entitled to Article 5 protections.

The Court stated that a deprivation of liberty engaging Article 5 is where a person is under continuous supervision and control and is not free to leave[18]. This was confirmed by the UK Supreme Court in *Cheshire West*[19] – its 'acid test' for a deprivation of liberty – which also made it clear that the Article 5 reach extends to all health and social care situations. We also know that simply dealing with the issue about how a deprivation of liberty can be authorised is insufficient. Article 5(4) challenge safeguards must be practical and effective for persons with mental disabilities[20]. Whilst this might not dictate that automatic judicial review occurs it certainly means that the ability to challenge the lawfulness of a deprivation of liberty must be within the realistic grasp of the person subjected to it.

What this means for Scotland

Bournewood and *Cheshire West* led to a questioning of the Article 5 ECHR compatibility of Adults with Incapacity (Scotland) Act 2000 (AWIA) measures where adults who lack capacity are deprived of their liberty, and also those under section 13ZA of the Social Work (Scotland) Act 1968 (SWSA) (allowing local authorities to move adults who lack capacity to residential care). Detention under the Mental Health (Care and Treatment) (Scotland) Act 2003 is, however, largely Article 5 compliant although questions arise about Articles 5 and 8 ECHR

[15] *P (by his litigation friend the Official Solicitor) (Appellant) v Cheshire West and Chester Council and another (Respondents); P and Q (by their litigation friend, the Official Solicitor)(Appellants) v Surrey County Council (Respondent)* [2014] UKSC 1 (*Cheshire West*) .

[16] *Aberdeenshire Council v SF* [2024] EWCOP 10.
[17] *HL v UK* (2005) 40 EHRR 32.
[18] *Ibid*, para 91.
[19] *Cheshire West* at 49, per Lady Hale.
[20] *MH v UK* (2013) ECHR 1008.

compatibility and non-consensual treatment whilst on Short Term Detention Orders[21], and levels of restriction whilst in low secure facilities, as well as the reminder that the lawfulness of detention on the basis of mental disorder depends on the availability of suitable care and treatment[22].

The Scottish Courts appear to have accepted that Article 5 ECHR compatibility can be achieved through appropriate guardianship powers[23]. However, this has seemingly glossed over the fact that there is an absence of accompanying Article 5(4) safeguards. In 2024, the Court of Protection *Aberdeenshire Council v SF* ruling helpfully pointed this out! Nor would the argument that guardians are effectively the person giving consent to the deprivation of liberty hold given the lack of Strasbourg endorsement here.

In response to *Cheshire West*, the Mental Welfare Commission for Scotland also issued guidance in 2014 warning against the use of Section 13ZA SWSA where the person is being moved to a care setting where they will be, or are likely to be, deprived of their liberty[24].

Post-*Bournewood and Cheshire West* actions in Scotland

Prior to the Scottish Mental Health Law Review (2019-2022) the Scottish Law Commission and Scottish Government both considered and consulted on the issues raised by *Bournewood* and *Cheshire West*. The recommendations made, and draft Bill provided, by the Scottish Law Commission [25] were ultimately not taken forward. Although there have been several 'near misses' in terms of *Bournewood/Cheshire West* situations reaching court hearings none, rather surprisingly given the time lapse, have been judicially considered in Scotland with *Aberdeenshire Council v SF*, in England in 2024, being the first.

The need to address the *Bournewood* and *Cheshire West* 'gaps' therefore fell to the Scottish Mental Health Law Review. By this stage, frustration was mounting over the lack of action to address these particular human rights concerns [26] , although they are admittedly complex which involve a need to both achieve ECHR compatibility whilst not creating unnecessary levels of bureaucracy. Moreover, so far we have been of course only considered ECHR requirements here. CRPD challenges to the denial of the exercise of legal capacity and deprivation of liberty on the basis of a diagnosis of mental disability and related impairment (based on mental capacity assessments) is something else that requires consideration given that the UK is a CRPD state party and because the Scottish Government intends that CRPD rights, along with those in other international human rights treaties, will, to some extent at least, become legally enforceable in Scotland. This was a fundamental issue that was considered by Scottish Mental Health Law

[21] *X v Finland* (2012) ECHR 1371.
[22] *Rooman v Belgium* (2019) ECHR 105.
[23] *K v Argyll and Bute Council* (2021) SAC (Civ) 21.
[24] This 2014 guidance is also reflected in the Commission's *Deprivation of Liberty: Advice Notes*, updated March 2021, https://www.mwcscot.org.uk/good-practice/guidance-advice
[25] Scottish Law Commission (2014), *Report on Adults with Incapacity*, (Scot Law Com No 240), https://www.scotlawcom.gov.uk/law-reform/law-reform-projects/completed-projects/adults-with-incapacity/
[26] See, for example, Law Society for Scotland (2021), *Our 2021 priorities: Incapacity, mental health and adult care and protection*, https://www.lawscot.org.uk/news-and-events/blogs-opinions/our-2021-priorities-incapacity-mental-health-and-adult-care-and-protection/

Review and reflected in its recommendations[27].

Its reasoning and recommendations on deprivation of liberty can be found in Section 3 of Chapter 8 of its Final Report. Whilst a full reading of this section of the report is strongly advised, it in essence recommended that in the short term the Scottish Government should establish a legislative framework for situations where a person may be deprived of their liberty that:

- Respects the wishes of a person who cannot make an autonomous decision but can, with support, express a will and preference to remain in their current living arrangements (even where these arrangements would otherwise constitute a deprivation of liberty).
- A practical and effective standalone right of review available to the adult deprived of their liberty, or a person acting on their behalf (where the adult is not subject to any order) and the ability of the Mental Welfare Commission to intervene where it has concerns.
- Powers of Attorney may grant advance consent to deprive the granter of their liberty, subject to safeguards. Although the Review recognised the lack of direction from the European Court of Human Rights on the Article 5 compatibility of this, it decided that provided that rights protecting measures were in place, this represents the will of the granter.
- A court or tribunal may authorise a Decision Making Representative, or an intervention order, to deprive the person of their liberty.
- Where a person cannot consent to their care arrangements, even with support, and is being deprived of their liberty but does not have a welfare attorney or a Decision Making Representative, a court/tribunal may grant a Standard or, to preserve life or health, an Urgent Order for Deprivation of Liberty, either lasting for only as long as needed to achieve the protection required, with regular review dates and a right of appeal at the time of granting.
- Before proceeding to apply for a Standard Order for deprivation of liberty, an evaluation of the human rights implications must be completed.

The Review also stated that in the longer term this framework should be revised as its Human Rights Enablement, Supported Decision Making, and Autonomous Decision Making recommendations are developed.

In its high level 2023[28] response to the Review's recommendations the Scottish Government accepted such recommendations in broad terms. It announced a 10-year programme of reform of mental health and capacity law specifying various priorities throughout this period, one of the first being adults with incapacity law reform, including the deprivation of liberty challenges. We understand that the Scottish Government will shortly consult on proposed changes to the law here and that these will include enhancing AWIA guardianship provisions to ensure greater respect for a person's autonomy but also to specifically recognise that guardians may be empowered to authorise deprivations of liberty with accompanying Article 5(4) safeguards. The outcome and resultant legislation are therefore

[27] Scottish Mental Health Law Review (2022), *Final Report*, Chapter 8, section 3.
[28] Scottish Government (2023), *Scottish Mental Health Law Review: Our Response*, https://www.gov.scot/publications/scottish-mental-health-law-review-response/

awaited.

Jill Stavert

Karen Kirk, Solicitor Advocate

12th April 1979 – 15th February 2024

A sense of shared loss and grief has spread through the Scottish legal profession upon the death of Karen Kirk, at the tragically young age of 44, survived by her husband and her two young children. There is also palpable shock, particularly among all those who dealt with her in her many roles unaware of the underlying illness which she herself never seemed to allow to define her, or to intrude upon her enthusiasm for the work that she did, or her life.

"Formidable" is not a word readily associated with her warm and friendly personality. It is a word that nevertheless defines all that she achieved in her profession and more widely, and her overriding motivation to making available, and delivering, justice for people most in need of it, people who, in our topsy-turvy world, face marginalisation and discrimination in a legal environment that by its own fundamental principles ought to place them at its centre.

Karen specialised in litigation, and in disability, incapacity and mental health law, from her graduation in 2002 from Strathclyde University, spending 16 years with Legal Services Agency in roles all the way from trainee to partner. As well as her specialist practice as a solicitor, she was regularly appointed as safeguarder under the Adults with Incapacity (Scotland) Act 2000 and as curator ad litem under the Mental Health (Care and Treatment) (Scotland) Act 2003. She became a solicitor advocate in 2009. From 2014 she held the two key Law Society of Scotland recognised specialisms of mental health law and incapacity and disability law. She became a legal member of the Housing and Property Tribunal in 2017, of the Mental Health Tribunal in 2018, and of the Social Security Tribunal in 2022. Also in 2022, she became a part-time summary sheriff. She and Deirdre Hanlon were long-serving colleagues, and friends, at Legal Services Agency, before forming their own firm of Kirk Hanlon, Solicitors, in March 2020, established to provide a specialist legal service for clients in the area of incapacity and disability law in Scotland. Their firm always achieved to a high standard their core values of providing quality, specialist services with integrity, and with a flexibility that placed the needs and circumstances of each client at its centre. It speaks for itself that throughout the long history of the Law Society of Scotland's Mental Health and Disability Committee, Karen and Deirdre were the only two partners of the same firm both to serve simultaneously as members of that committee. Both gave generously of their time and abilities to make major contributions to the work of the committee, in Karen's case from June 2017 until her death. Deirdre continues to do so. Respect for both developed into friendships within the committee, from those now endeavouring to provide support to Deirdre in both her personal loss and the demands upon her as now sole partner.

It was typical of Karen that she gained widespread respect for her ability, tenacity and professionalism, as well as for her humanity, as much from her opponents as from her colleagues. That was my experience. She challenged as an unlawful deprivation of liberty the placement of her client in a nursing home by a relative who was her client's attorney. She demonstrated all of those qualities by pleading that a power of attorney could never lawfully authorise a deprivation of liberty, and that in any event the attorney in that case was not empowered to do so. Those are questions still not answered in Scots law. I was consulted and instructed by the attorney. I first met Karen when she came to my office to discuss the case. I was

impressed by the clarity with which we were able to map out the key issues in ways in which the questions which the court would have to answer were defined. But we were both equally troubled that we represented factions of a family which was tearing itself apart over this issue. It would undoubtedly have been to the great advantage of the development of the law for the issues that we identified to be judicially determined, but it was difficult to see how the process of determining them would be of long-term benefit to her client and his entire surrounding family across both factions. We took the further step of identifying a compromise solution that we were both able properly to recommend to our respective clients: and the matter was resolved that way. That initial experience remained with me as validating all that I subsequently learned and experienced of Karen as a huge contributor to the work and standing of our profession in all the ways in which she became involved, as well as being a person whom it was a privilege to know. Her loss will be very much felt in so many ways and by so many people – including me.

Adrian D Ward

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

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Conferences

Members of the Court of Protection team regularly present at seminars and 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.

Adrian will be speaking at the following open events: the Royal Faculty of Procurators of Glasgow Private Client Conference (14 March, details here), the World Congress on Adult Support and Care in Buenos Aires (August 27-30, 2024, details here) and the European Law Institute Annual Conference in Dublin (10 October, details here).

Peter Edwards Law has announced its spring training schedule, here, including an introduction – MCA and Deprivation of Liberty, and introduction to using Court of Protection including s. 21A Appeals, and a Court of Protection / MCA Masterclass - Legal Update.

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

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