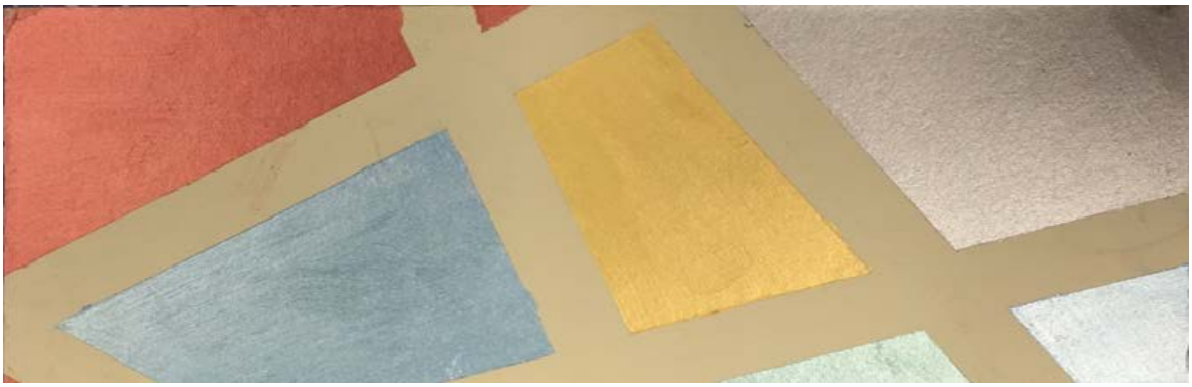

Welcome to the May 2024 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: a rare successful capacity appeal, evicting someone from P's house and holistically approaching hoarding;

(2) In the Practice and Procedure Report: when you can remove deputies, and publishing judgments in serious medical treatment and closed material procedure cases;

(3) In the Mental Health Matters Report: when not to rely on capacity in the mental health context;

(4) In the Wider Context Report: capacity, autonomy and the limits of the obligation to secure life, and the European Court of Human Right raises the stakes for psychiatric admission for those with learning disabilities;

(5) In the Scotland Report: licence conditions and deprivation of liberty, and Executor qua attorney – a few steps back?

In the absence of relevant major developments, and on the basis people have enough to do without reading reports for the sake of reports, we do not have a property and affairs report this month. But some might find of interest the blog by Alex prompted by a question in the property and affairs context of whether you need to have capacity to consent to having your capacity assessed.

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.

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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HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

Residence, care, sex and marriage: an (unusual) successful appeal on capacity

Re ZZ (Capacity) [2024] EWCOP 21 (Theis J)

Mental capacity – assessing capacity

Summary

This is an example of a relatively rare species of case, namely a successful appeal in relation to capacity. At first instance, HHJ Burrows had found that ZZ had capacity to make decisions about residence, sexual relations and marriage. The local authority appealed his conclusions, the appeal being opposed by ZZ through his litigation friend the Official Solicitor.

As Theis J described him:

> *5. ZZ is a 20 year old man with a diagnosis of mild learning disability ('LD'), attention deficit hyperactivity disorder ('ADHD') and possible obsessive compulsive disorder ('OCD'). He suffered sexual abuse as a child and has himself been convicted of sexual assault on a 5 year old family member, resulting in an Intensive Referral Order for 12 months and a Sexual Harm*

> *Prevention Order ('SHPO'), which expires in October 2024. It is a condition of the SHPO that ZZ does not live or sleep in any premises where there is also a child under the age of 18 years unless approved by the local authority and does not have unsupervised contact with a child.*

A particular concern was what was said to be a very high risk of committing harmful sexual acts towards others. ZZ was said to be at high risk of absconding from the placement he was in, repeatedly making it clear that he wished to live with his girlfriend (with whom he wanted to enter into a sexual relationship).

Theis J summarised the judgment of HHJ Burrows as follows (Dr Rippon being the independent expert appointed to assist on the question of capacity):

> *46. In relation to the decisions under scrutiny the Judge dealt with residence at [35] – [37] where, having referred to the matters listed in LBX, he then posed the question whether ZZ understood that care is an important aspect of the place where he would have to live. He accepted the submissions on behalf of the Official Solicitor that care is not part of the relevant information in ZZ's case, as what the local authority submit brings into the mix another placement that ZZ has to consider, namely one without the proper level of support, and that simply is not an option at the present time, so the Judge concluded 'If one removes the 'care' point from the LBX list as it applies to this case, there is no doubt ZZ has the capacity to decide on residence' [36]. The Judge continues that he has reached that conclusion as ZZ 'does not actually have a decision to make over whether he lives in a care setting'[37] although he recognises the situation could change and if it did, ZZ's capacity would need to be re-assessed.*
>
> *47. In relation to capacity to engage in sexual relations he referred to the test in JB and the fact specific nature of any decision. He referred to Dr Rippon's evidence on the relevant matters and noted that Dr Rippon's evidence on the issue of consent has vacillated, her focus is on ZZ's insight into his ability to control his behaviour and stop himself from engaging in behaviour he knows is wrong and situations where ZZ may find himself in where he may find it difficult to stop himself because of his sexual urges. The Judge stated at [46] "Clearly, urges are, by their very nature, difficult to control, and it would be setting the bar too high if capacity to consent to sexual relations were to be ruled out because a person was unable to control an urge (for instance) to carry on with the sexual act. Having said that, ZZ is a sexual offender who is unable to control his urges to engage in very harmful and criminal sexual behaviour, as I have already found."*
>
> *48. He then set out his conclusion at [47] as follows:*
>
> *'All that being said, I agree with the Official Solicitor's submissions on this. I do not accept that a sixth factor or limb ought to be introduced into the JB test, namely, to have insight into and the ability to control one's urges. I also agree the conclusion I have reached, namely that Peter has capacity in this area, fits in with Cobb J's statement in Re Z [2016] EWCOP 4, namely that ordinary risk taking, which may be unwise does not render the decision incapacitous. I would go further. A person can have the capacity to engage in sexual relations, understanding that his partner may withdraw her consent at any moment, and that with that he must stop the sexual act. If, however, when that withdrawal of consent happens the person is unable to overcome his urges,*

> *that is nothing to do with capacity to consent to sexual relations.'*
>
> *49. Turning, finally, to the issue of marriage he concluded in [50] that in the light of his conclusion regarding sexual relations ZZ has capacity to enter into a marriage.*

Theis J reminded herself of the fact that:

> *75. The Judge below had the benefit of hearing the evidence, in particular from Dr Rippon, and this court recognises that the test is not whether this court would have reached the same conclusion, or a different one. The question is whether the Judge was able to reach the conclusions he did on the evidence he had, within the relevant legal framework.*
>
> *76. Ms Roper was right to remind the court of the importance of the presumption of capacity, it is an important principle that underpins the MCA. Also, that the court needs to consider whether it is satisfied on the balance of probabilities that that presumption is rebutted. In relation to capacity to engage in sexual relations, cases such as JB have reiterated that the bar must not be set too high. Further, that the court should guard against the protection imperative.*
>
> *77. Equally, Mr O'Brien was right to emphasise the need for the court to consider the serious grave consequences for ZZ and others, as referred to in JB at [74], the need for the Court of Protection to guard against approaching questions of capacity in silos (see Hull CC v KF at [24]) and to have in mind the overlap between different decisions.*

Theis J was critical of the evidence of Dr Rippon, noting that it was at times confused and confusing (paragraph 78), and that whilst this "*perhaps reflected the complexities in this case,* [it] *also made the task facing this experienced Judge much more difficult*."

Residence

Theis J noted that the decision reached by HHJ Burrows was founded on his conclusion that the case that ZZ received was not a relevant matter for him to consider when making current decisions about where he should live. However, Theis J identified that he had not taken into account the issue of whether ZZ's wish to live with his girlfriend and her mother was "*a pipe dream*" or not. Dr Rippon had identified that it was not, as "*…during the course of both interviews that was what he wanted, that's where he wanted to live, that was his…the place that, you know, that they'd identified as where he did want to live*" (para 80).

At paragraph 82, Theis J found that HHJ Burrows had fallen into error in the following ways:

> *(1) He did not properly analyse the evidence regarding whether ZZ's wish to live with TD and her mother was a pipedream or not, as had been asserted by the Official Solicitor on ZZ's behalf. In her oral evidence Dr Rippon considered it was more than that and gave her reasons for saying that. In addition, this was the view ZZ had expressed over a period of time to a number of people.*
>
> *(2) On the particular facts of this case, the Judge fell into error by not properly considering that the requisite care needed was relevant information to the issue of residence. In my judgment arguably it was. Ms Roper accepted that the declaration made by the Judge would have been more accurate if it stated that the declaration about residence was in the context of the care being provided. To do that would have required the Judge to analyse ZZ's ability to understand relevant*

> *information about the need for the care and support and use or weigh it in reaching a decision. That would include considering, in the context of residence, the evidence that ZZ did not consider he required the care and support that was being provided.*
>
> *(3) The risk in the Judge's approach to this issue is that it has been considered in a silo, with implications for the local authority in being able to coherently manage a care plan for ZZ in the light of the declarations made which, although referred to at [48], was not properly addressed by the Judge.*

Sexual relations

Theis J found that this was a particularly difficult issue, but that (at paragraph 85) "*not without some hesitation*" she had reached the conclusion that the decision on this aspect was wrong because:

> *(1) The Judge did not properly deal with various aspects of Dr Rippon's evidence in particular (a) whether ZZ was able to use or weigh information about consent in the context of ZZ's sexual impulsivity and the complexity of the causes of that, including his mental impairment; (b) that ZZ's disinhibited sexual behaviour was due to a combination of his mental impairment, which included his cognitive functioning and executive functioning and gave disproportionate weight to the significance of ZZ's ordinary sexual urges/desire.*
>
> *(2) The Judge wrongly equated ZZ's sexual disinhibition with the usual risk-taking of a person of commensurate maturity (as Cobb J did in Re Z). The Judge failed to properly weigh in the balance the evidence that ZZ has a record of sex offending and has been assessed as manipulative and presenting a very high risk. His sexually disinhibited behaviour falls into a different category than that envisaged by Cobb J in Re Z, with the result that the ability to use or weigh the question of consent needs to be considered in that context.*
>
> *(3) The Judge erred in not following the approach set out in JB by asking himself first is the person unable to decide the matter for himself by reference to the matter and the relevant information, second is there a clear nexus between his inability to make a decision in relation to the matter and an impairment of, or disturbance in the mind or brain. If he had taken that structure it would have directed him to the relevant parts of Dr Rippon's evidence.*

Marriage

As regards regards marriage, Theis J declined to resolve the difference of judicial opinion as to between Parker J and Mostyn J as to whether it is a pre-condition of capacity to marry that the individuals concerned have capacity to enter into sexual relations. On the facts of ZZ's case, however, she found that the ground of appeal was also made out, because it was a consistent feature of the evidence that ZZ wishes to marry his girlfriend and for them to have children.

Outcome

Theis J was sitting as an appeal judge. On the facts of the case, she did not take the path of herself declaring that ZZ lacked capacity in the material domains. Rather, she remitted the case to reconsider the question of capacity.

Comment

This is the second case in relatively quick succession to emphasise the difficulty of disentangling residence and care (see also *Re CLF* at paragraphs 36 and 37). In the context of a person with care needs, we would strongly

suggest that it would be an unusual case in which it is possible to address residence and care separately without falling into the hole between two silos (to mix metaphors).

The case is also of note for Theis J's observation that following the order of considering capacity set down by the Supreme Court in *JB* is important, not just because that is what the law requires, but because it does actually make a difference when it comes to considering whether the 'causative nexus' is made out. In this regard, it is perhaps also worth flagging that, albeit somewhat belatedly, the *White Book* now helpfully has the ordering the correct way around for the benefit of those considering litigation capacity in the conduct of civil proceedings.

Holistically approaching hoarding

A Local Authority v X [2023] EWCOP 64 (Theis J)

Mental capacity – assessing capacity

Summary[1]

X had lived in her local authority rented maisonette for over 27 years. Over the last two years of proceedings, strenuous and creative attempts had been made from a range of services to address the significant risks posed by the level 9 hoarding within the property. Environmental health had served access notices under s87 of the Public Health Act 1936 and warrants to enforce clearance, but access was mostly refused, with X threatening self-harm if there was entry. Mental health tried to assist with her OCD and hoarding disorder, and a specialist hoarding therapy service was engaged, unsuccessfully. The position and risks remained largely the same as X's anxiety that something would be thrown away prevented progress to clear the clutter and carry out repairs. Accordingly, the local authority sought an order to temporarily remove X from her home to enable the risks to be addressed.

Taking a holistic approach that looked at X's capacity to make decisions about her residence, her care/support and her items and belongings, Theis J identified the relevant information as including:

1. the obligations under the tenancy agreement;
2. what areas X needed support with;
3. what type of support;
4. what were the consequences if X did not have that support or she refused it;
5. the volume of belongings and the impact on use of rooms;
6. safe access and use;
7. creation of hazards;
8. safety of the building and
9. the removal or disposal of hazardous levels of belongings.

The evidence established that, because of her mental impairments, X was unable to use and weigh the impact of her actions on the tenancy agreement, or to engage in the therapeutic support offered to address the chronic situation (paragraph 95). She also lacked capacity to make decisions about her property and financial affairs, with impulsive purchasing of items which impacted upon the health and safety concerns, and restricted movement within X's property.

As to best interests, X strenuously objected to any sort of removal of either herself or her

[1] Note, this case, although decided in 2023, only appeared on Bailii recently.

possessions. To do either would cause very great distress, acute anxiety and could tip her over into a suicidal state of mind. The fire risk was substantial, the hoarding level at 8/9, and the risk to X of tripping or falling and of the emergency services, if required, being unable to get to her, remained significant. Theis J concluded that there was no further support that could be given to bring about any real change. The various services had worked patiently, creatively and with resilience over a number of years but little had changed. The action required to remove the clutter from the home could only take place in the absence of X.

It was in X's best interests to be removed (with restraint as a last resort) and deprived of her liberty at a nearby supported living placement for a limited period of time to enable the clearance to take place, with a plan to return her once the works required had been undertaken. Theis J held:

> *105. I have reached the conclusion that X's best interest are served by the local authority application being granted. In doing so I readily accept the considerable risks that are being taken in overriding X's expressed wishes and the consequences for her of such a step being taken, bearing in mind her mental disorder and the suicide threats she has made. Those matters weigh heavily in the balance. Having said that, I consider the balance is tipped the other way by what I regard as the substantial and increasing risks X would be left exposed to if this order was not granted. They are serious risks that would have a direct impact on X's health and safety. There is no prospect of any other step being taken that would bring about out any meaningful change. The evidence set out in the detailed contingency plan includes provision that would seek to mitigate the impact on X of what is proposed by the multi-disciplinary approach, where X would have the continuing involvement and support of the Official Solicitor and a hearing to review the next steps by the court.*

Comment

This is the second reported MCA hoarding case and endorses the *Re AC and GC* approach. Together they paint a similar picture of professional support and patience being required to exhaust all less restrictive options to address the hoarding risks before compulsory measures are sought. They also make an interesting contrast with the case of *Parkin* noted in the Wider Context section of this report.

In *Re AC and GC*, specifying the hoarding decision regarding items and belongings was particularly important for GC who was generally able to make decisions. Whereas in this case, a more holistic approach was taken to capacity which combined the information relevant to residence, care and hoarding, perhaps to avoid potentially incompatible decision silos.

Upholding P's property rights

A Local Authority v Sam M and Helen [2023] EWCOP 68 (HHJ Burrows)

Best interests – property and affairs

Summary[2]

Whether it was in Sam's best interests for his mother to move out of his bungalow was the main issue in this case. He was in his 30s with a serious assault having caused quadriplegia, non-epileptic attack disorder, dysphagia and left him at constant risk of aspiration. With a financial

[2] Note, this case, although decided in 2023, only appeared on Bailii recently.

deputy to manage his funds, he received 2:1 carer support. His mother, Helen, lived there with permission (a 'bare licensee') but her behaviour led to suboptimal care, a toxic atmosphere, and the risk of the breakdown of the care package. Suffering from depression, she self-medicated with alcohol and prescription drugs which led to her being abusive to staff. But having not had a drink for a month, she was now intending to receive support for alcohol addiction.

With the Official Solicitor not having been involved in the other parties' agreement to seek a 6-month adjournment to give Helen the opportunity to demonstrate she could keep with the rehabilitation she had started, His Honour Judge Burrows felt a best interests decision was called for given that Sam's incapacity was not in dispute, and the toxicity and dysfunctional culture and conflict within his home was affecting his level of care and rehabilitation, and increasing costs by £30,000-40,000 per year. Sam did not want his mother evicted but also wanted peace in his house and proper rehabilitation.

Having considered the Article 8 rights of them both, with Sam's best interests as the court's primary concern, it was not in his best interests for Helen to live in the same house at the present time. Her moving out after being given reasonable notice of 14 days, with steps taken to ensure they can have a good relationship and she can visit but not interfere with the care workers. This would enable Sam to get the care he needs and avoid the risk of him being placed in residential care if there was a breakdown in the care package.

Comment

This case is a good example of how useful it is to carefully identify the decisions that P could make with capacity, particularly in the context of proprietary rights. Recognising that Sam's mother was a licensee albeit with Article 8 rights, the court was clear as to the options it had available. The case also illustrates that "it is never a good idea to leave any party out of discussions, but when the one left out represents the person concerned, the Official Solicitor, that is 'suboptimal' practice'" (paragraph 2). Whether Sam was deprived of his liberty in his own home remained to be seen.

Children, capacity and accepting the diagnosis

Y NHS Foundation Trust v AN & Anor [2024] EWHC 805 (Fam) (Family Division (Cusworth J))

Other proceedings – family (public law)

Summary

This case (which we note here, because it could easily have been in the Court of Protection), concerned a 16 year old girl, AN, who had very recently been diagnosed with acute leukaemia. After one night in hospital, she had discharged against medical advice but with the support of her parents. At the time, the doctor concerned was satisfied that she had the capacity to take that decision. Shortly afterwards, the consultant haemotologist visited AN at home to explain to her the urgency in starting treatment, and that why it would usually be done as an inpatient. AN explained that she was not refusing treatment, but needed time to come to terms with her diagnosis. She didn't believe that she would become unwell over several days at home. The haemotologist considered that she had capacity to understand the diagnosis, and the proposed need for inpatient treatment, and the risks of not having treatment. The haemotologist agreed to give her limited time at home before seeing her again ideally to admit her for treatment two days later. At that point, AN returned to hospital, where blood tests that she had "*an aggressive, rapidly progressive form of blood cancer that untreated would be expected to result in life*

threatening complication within a matter of days or weeks. With appropriate treatment, however, there is a very high chance of remission, and a good chance of long-term cure" (paragraph 6). The intention was that AN should be immediately admitted, but after many hours of conversation, AN remained of the view that she did not wanted to be admitted:

The view of the haemotologist was that, whilst AN had no impairment or disturbance in the functioning of her mind or brain, AN "*was not accepting of her diagnosis, or of the inevitability that she would become unwell in the absence of urgent treatment. This led her in her statement to conclude that AN 'does not display sufficient capacity today to make decisions about her treatment/safety*'" (paragraph 8).

In circumstances where it was clear that AN would not remain in hospital to start treatment and that her mother would only accept delaying admission, providing supportive medication and continuing blood tests, the hospital brought an urgent out of hours application. Cusworth J conducted the proceedings remotely so that he was able to hear from AN's mother, and saw AN. As Cusworth J noted:

> *11.* […] *As AN is 16, she remains a minor and so would in those circumstances usually be represented through Cafcass as her guardian. I have been referred to the January 2023 guidance provided jointly by Cafcass and the Official Solicitor dealing with out of hours medical cases involving children. However, given that the issue of capacity has been raised, and in light of AN's age, this may yet become a case that should appropriately proceed in the Court of Protection, in which case the court could appoint the Official Solicitor as AN's litigation friend. In circumstances where no officer of Cafcass was available at short notice, and pursuant to the Attorney-General's Memorandum of 19 December 2001, paragraph 3, the Official Solicitor was satisfied that this was a case where 'there is a danger of an important and difficult point of law being decided without the court hearing relevant argument', as reconfirmed and explained in the President's Guidance dated 26 March 2015.*

Cusworth J, in a written judgment delivered after the events of the night, summarised the case law on the operation of the inherent jurisdiction in relation to capacitous minors, and continued:

> *16. In this case, the factual background is clear and not in dispute. I accept the evidence of Dr X of the risks to AN if she goes home over the weekend and begins her treatment, but without the intravenous fluids that would protect her kidneys and the regular and reliable testing that would come with her admission. There is a clear and very serious further risk to AN's already compromised health if she is not admitted for treatment tonight. And she is currently in a bed in the hospital and allowing treatments to be administered to her.*
>
> *17. Furthermore, the fact of an existing underlying infection suggests that the prospects of unmanageable damage occurring before the matter can come back before a court remain significant. Given that to be effective, once necessary tests have been administered to AN, after allowing final decisions about her representation to be taken, and then to get her further instructions, a court hearing next week cannot be before Wednesday 14 February, the period of concern for the court is some 5 nights. Unless AN has a change of heart, or there is a further emergency, the question of her admission would next fall to be considered then.*

18. In all of those circumstances, this is clearly a case in my judgment where intervention would be appropriate, if justified in the interests of AN's welfare. I do however pay serious regard to her expressed views and wishes and to those of her parents, both in supporting her and for their own part in advocating for a return home for their daughter. She is clearly an intelligent and articulate young person who, despite the most traumatic of circumstances has nevertheless been able to converse at length with her doctors and in so doing impress on them her capacity and her awareness of her situation. It is not a surprise that she has found the final step, of acknowledging the gravity of her diagnosis and consenting to immediate and demanding treatment a hard one to take over such a short period of time. I remind myself that just this time last week, all of the events since her diagnosis were completely unforeseen and unforeseeable. She has in fact coped remarkably well with the most terrible of situations. It is completely understandable that she would like to be at home.

19. In that situation, I have given very careful thought to whether AN's autonomy should be respected, and she should be given the additional time to process her position which is in effect what she feels that she needs. However, I have come to the very clear view that, notwithstanding her age and her expressed wishes, her welfare needs do dictate that she must now remain where she is and commence inpatient treatment as Dr X urgently recommends. I bear in mind that this is not a young person who is refusing treatment, but rather one who clearly says that she wants to be treated, but simply wishes to delay the commencement of that treatment. The evidence is very clear that such a delay risks seriously compromising the efficacy of the treatment. The potentially extremely serious side effects of the steroids which AN would be taking at home would not be mitigated by the intravenous hydration which could be provided in a hospital setting. Further, chemotherapy, which would otherwise begin at the start of next week, would almost certainly be delayed, increasing further the risk of the cancer proving fatal.

20. In this case, both the likelihood of an infection causing a serious negative impact on AN's health if the treatment outlined by Dr X is not now started, and the extreme consequences of such an impact for AN, are clear. As against those dangers, alongside of course AN's own clearly expressed wish for more time, I have to weigh the very positive potential outcomes if the treatment is commenced immediately without those risks being run. In those circumstances I am clear that the balance falls comfortably in favour of intervention, and in acceding to the Trust's application for an order which will keep AN in hospital where she is now, so that the life-saving treatments which are available can be administered to her.

21. I hope that she will understand this decision and accept the treatments as offered, as Dr X anticipated that she would. I was gratified to understand from Ms David that the Trust do not propose any physical or chemical means of restraint in order to administer AN's treatment, but rather just to ensure that she is not free to leave the hospital, in the expectation that while she is there, she will permit the treatment that she so badly needs.

At the time of writing, there is no record of what happened at the subsequent hearing; one hopes that, by that time, an agreement had been

reached between AN and the treating team about the way forward.

Apart from being a useful reminder of how the courts are available 24 hours a day / 7 days a week for truly urgent cases, the decision is also of interest for the extent to which the questions in issue were filtered through the prism of capacity. This was clearly right, but the whole question of decision-making in the context of 16-17 year olds is riddled with unnecessary complexity: see further here for my attempt to make things slightly clearer.

The case also stands as an interesting counterpart to the decision in *ST* in the context of patients who find it difficult to accept a diagnosis and prognosis: *ST* was heard in the Court of Appeal on 1-2 May; whilst judgment is awaited, the Court of Appeal has made clear that the parents' appeal will be allowed on the basis that Roberts J erred in her approach to the question of whether a person who does not believe their doctor necessarily lacks capacity to make decisions about their medical treatment.

Short note: forced marriage and travel planning

In *Re AG (Welfare: Forced Marriage Protection Order)* [2024] EWCOP 18,[3] Theis J considered the position of a 24 year old woman with a mild learning disability. She had undergone a marriage ceremony in 2019 in circumstances which were unclear, Theis J ultimately finding that she could not conclude that she had been forced to marry by her parents, noting that "[t]*his uncertainty is founded largely on the failure of the local authority to properly investigate and analyse the evidence, or keep it under review*" (paragraph 134). She was, however, satisfied that the marriage was not entirely free from family influence, in particular from her parents. She had subsequently been divorced under Sharia law, and was at the time of the hearing in a shared lives placement, having made a capacitous decision to move there.

The local authority responsible for her sought orders:

1. Under the Forced Marriage (Civil Protection) Act 2007 for a Forced Marriage Protection order ('FMPO') for one year to prevent the parents from forcing AG to get married, for the local authority to continue to retain AG's travel documents, prevent the parents from applying for more travel documents for AG and to prevent AG from travelling abroad unless accompanied by her shared lives carer. Her parents opposed this and the Official Solicitor sought interim orders for 6 months to enable further risk assessments to be undertaken.

2. Under the MCA 2005 for approval of the current care plan as being in AG's best interests and for an order authorising the local authority to deprive AG of her liberty in her current placement. The parents and Official Solicitor support the order approving the current care plan but opposed any orders that authorised the deprivation of liberty as being not required or justified on the evidence.

The Official Solicitor sought short term orders under the inherent jurisdiction to provide a structure around AG's contact with her family and to enable AG to retain her capacity regarding such contact in accordance with the principles outlined in *DL v A Local Authority and others* [2012] EWCA Civ 253.

[3] Katie having been involved in this case, she has not contributed to this note.

The judgment is lengthy and detailed. In summary, Theis J acceded to the application for an FMPO for a limited period of time:

> *with detailed directions for the necessary risk assessments to be undertaken to include an informed analysis of the risks and protective factors with Article 3, including informed effective and consistent engagement with the family by someone with real expertise in this area and an analysis of the risks of any trip to Pakistan. This work should include an assessment of AG's capacity to travel and a framework to underpin any travel, as suggested on behalf of the Official Solicitor. The proposed framework is set out at the end of this judgment. It is aimed to assist professionals working with AG, but may also be of relevance when care planning in similar cases involving travel abroad.*

The framework was as follows:

> *1. Where is it proposed that AG travels? Research the destination, travel options to get there, the facilities available there (including access to medical care), accessibility and transport options*
> *2. What are the dates of travel?*
> *3. Where is it proposed that AG will stay?*
> *4. Who will be travelling with AG?*
> *5. What care and support will be required during the stay?*
> *6. Who will provide that care and support?*
> *7. Consider writing and/or carrying a "travelling letter" which provides a brief description of AG's needs and any diagnos(es) and the details of her doctor. If appropriate, include details of any difficulties that could occur and what assistance might be needed.*
> *8. Consider whether international roaming is available (so that AG can use her mobile phone on a foreign network) and ensure she has an adaptor so her mobile phone can be charged.*
> *9. What are the flight details? When contacting travel providers and airlines, clearly state any needs and any assistance that AG may require.*
> *10. What are the Visa requirements?*
> *11. What vaccinations are needed before travel?*
> *12. What medication is needed? Ensure there is enough medication for the trip and possible delays.*
> *13. Check that any prescribed medication can be taken abroad (some medication contains ingredients that are illegal in some countries).*
> *14. How will the trip be funded?*
> *15. How much money is needed to cover all costs?*
> *16. Who will provide assistance to AG with finances when abroad (as necessary)?*
> *17. What travel insurance is needed? Check that it covers the places that AG will visit, the duration of the visit and any planned activities.*
> *18. Is AG's passport valid?*
> *19. Check whether the emergency contact details on the back of the passport have been completed.*
> *20. Is there an extra form of photo ID that can be checked?*
> *21. Consider any advice that has been provided by the Foreign, Commonwealth & Development Office (FCDO) regarding travel to the area chosen (and any safety and security issues raised).*
> *22. Provide contact details for the nearest British embassy, high commission or consulate, or the FCDO in the UK.*
> *23. Consider what to do if AG goes missing abroad, including detail of how to report it to the police and how the FCDO can assist.*
> *24. Whether independent travel training can be given to AG before the proposed*

> *trip to maximum her independence and autonomy.*
> *25. Ascertain the wishes of AG and all those who should be consulted regarding the trip.*

Whilst Theis J endorsed the case plan put forward by the local authority, on the basis that AG lacked capacity to make decisions about her care (but not about residence or contact), she did not accept that AG was deprived of her liberty, either objectively or subjectively. In this, the local authority's case was somewhat hampered by the fact that it had only a relatively few months previously declined to grant a standard authorisation in respect of a care home where she was then resident, on the basis that the mental capacity requirement was not satisfied. She considered that, in the event that AG did express a wish to move from the placement "*there is a clear statutory framework to deal with that situation through a combination of the statutory responsibilities of the local authority under the Care Act 2014 and the statutory protection provided by ss 5 and 6 MCA, and, in an emergency situation, section 4B MCA*" (paragraph 145, being clear – see paragraph 114 – that s.4B provided authority whilst a decision was being sought from the court).

Theis J acceded to the Official Solicitor's invitation to invoke the inherent jurisdiction on a time-limited basis with the aim of supporting AG being free from external pressure to facilitate her unencumbered decision-making. At paragraph 148, Theis J identified that:

> *In the unusual circumstances of this case I am satisfied that the inherent jurisdiction should be invoked in the way outlined by Ms Sutton. I am satisfied that a combination of the order regulating contact between AG and her parents, supported by the framework to manage any changes in a way that supports any consequent decision will best enable AG to retain her capacity about making decisions about contact, and, indirectly, residence. The order will only be in place for a limited period until December 2024. I am satisfied, bearing in mind the history of this matter that without that structure being in place it is very likely AG will be unable to manage the consequences of any pressure on her to spend increasing time with her parents which, in turn, will impact on her ability to make capacitous decisions.*

PRACTICE AND PROCEDURE

Welfare deputies: discharge and placing limits on their powers

CL v Swansea Bay University Health Board & Ors [2024] EWCOP 22 (Theis J)

Deputies – welfare matters

Summary

This judgment concerned an appeal to a decision of a circuit judge to discharge CL's mother as her personal welfare deputy. The first instance decision of HHJ Porter-Bryant, dated 6 December 2023 (*Swansea Bay University Health Board v P & Ors* [2023] EWCOP 67) has only recently been published. We set out details of that judgment as the context for the appeal to Theis J.

The matter related to LL, who was 22 years with a number of diagnoses including significant learning disability, atypical autism, attention deficit hyperactivity disorder, hypermobility/low muscle tone, bowel problems, neuralgia and hydrocephalus with 2.5 shunts in place for 5 arachnoid cysts in the brain. He was assessed as requiring 2:1 care. CL was LL's mother and was appointed as his personal welfare deputy in 2019. At paragraph 8, the judgment sets out that "[t]*he deputyship order identified that CL may make decisions on LL's behalf in relation to:*

> *a. where he should live;*
>
> *b. with whom he should live;*
>
> *c. decisions on day-to-day care, including diet and dress;*
>
> *d. consenting to routine medical or dental examination and treatment on his behalf;*
>
> *e. making arrangements for the provision of care services;*
>
> *f. whether he should take part in particular leisure or social activities; and*
>
> *g. complaints about his care or treatment.*

The order also specified the restrictions in s.20(2), (5), and (7) MCA, making clear at paragraph 9 that CL did not have the authority to:

> *(i) to prohibit any person from having contact with him;*
>
> *(ii) to direct a person responsible for his health care to allow a different person to take over that responsibility; …*
>
> *(v) to refuse consent to the carrying out or continuation of life sustaining treatment in relation to him; and*
>
> *(vi) to do an act that is intended to restrain him otherwise than in accordance with the conditions specified in the Act.*

LL appears to have been eligible for NHS Continuing Healthcare, as the Health Board was responsible for funding his care and support. LL had lived with CL until July 2021, but the judgment records how difficulties were encountered in finding a care agency to provide this support. LL was moved to a care home and an application was made in July 2021 to the Court of Protection to authorise the move. The care home was intended as a temporary placement, although no other placement had been found and the proceedings were therefore continuing.

The Health Board made an application to revoke the deputyship order in October 20222. The application was founded on a range of

allegations about CL's behaviour, including, inappropriately managing his finances and claiming benefits on his behalf, taking and posting inappropriate photos online, 'continually' challenging professionals involved with LL's care, intimidating and threatening staff, obstructing the delivery of care, making excessive and unjustified complaints, among other allegations.

The court process was protracted by repeated directions made about whether the matter would be subject to a fact-finding hearing in respect of LL's residence, which was ultimately not warranted. In October 2023, the court concluded that it would consider the application to revoke the deputyship on the basis of written submissions, without making findings of fact. A fact-finding had been planned on contact issues, but was ultimately not required after the parties agreed a protocol contact.

CL resisted the revocation of the deputyship application, but argued that *"if the court was minded to grant it consideration should be given to varying the deputyship order so certain elements were retained, in particular the authority to consent to routine medical or dental examination and treatment on behalf of LL"* (paragraph 18)

First instance judgment

Much of the argument in the case related to the provisions of ss.16(7)-(8) MCA, which state:

> *(7)An order of the court may be varied or discharged by a subsequent order.*
>
> *(8)The court may, in particular, revoke the appointment of a deputy or vary the powers conferred on him if it is satisfied that the deputy—*
>
> > *(a)has behaved, or is behaving, in a way that contravenes the authority conferred on him by the court or is not in P's best interests, or*
> >
> > *(b)proposes to behave in a way that would contravene that authority or would not be in P's best interests.*

In the first instance judgment, HHJ Porter-Bryant proceeded on the basis that the deputyship could be discharged under s.16(7) MCA. HHJ Porter-Brywant was not persuaded by CL's submissions that there was a distinction between making an 'appointment' of a deputy under s.16 MCA and making an 'order' under s.16 MCA, *"and if there is a distinction, it is a "distinction without a difference"* (paragraph 31). He concluded *"that the question for the court is whether it is in P's best interests for the deputyship to continue, either in its current form or in an alternative form."*

HHJ Porter-Bryant concluded that it was not in LL's best interests for the deputyship to continue, and it should be discharged in its entirety; this decision was made despite the court not having made findings on the allegations made against CL. The first-instance judgment concluded that:

> *74.* […] *it is appropriate to discharge the deputyship in its entirety. Many of the decisions in respect of which authority is provided under the deputyship are now matters that are firmly before the Court of Protection or are otherwise matters in respect of which C is no longer the decision-maker, in particular residence, with whom P should live, the day-to-day diet and dress, leisure and social activities, provision of care, services and future care. To retain a deputyship in respect of those matters would be disproportionate and unnecessary and would represent an unjustifiable intrusion into P's life and decision-making. Such an order would be*

contrary to the principles of section 16(4) and the guidance thereto and the principles echoed through the case law.

75. Likewise in respect of medical treatment, the circumstances are now such that the current deputyship seems to me to amount to a request for a deputyship to enable C to continue to be informed. That is provided for by the section 4(7) duty. Indeed, should any party be unaware or mistaken as to the extent of their duty under 4(7), it is now fortified by the protocols that I have proved.

76. Further, the current deputyship and proposed variation in those circumstances would, in my judgment, run contrary to the guidance provided by Keehan J in YH v Kent County Council & Ors [2021] EWCOP 43. The relevant paragraph is helpfully set out at paragraph 41 of the Health Board's position statement, where Keehan J said that YH's position in that case was one where, in effect, the applicant seeks the deputyship so that she has a label, a status and so that she would be listened to and consulted. That, in the view of Keehan J, was not an appropriate basis upon which to found an application for deputyship […]

81. […] *best interests requires consideration of all the circumstances, an assessment of matters including the extent to which an order or decision intrudes into P's life. I accept the Health Board's assessment of the actual circumstances surrounding the provision of P's needs in relation to P. The fact that this order is not limited in time is one factor that the court can consider. The order provides for decision making to be vested in C when she is not in a position to make those decisions. That is a factor that the court can weigh. The effect that an order or the continuation of the deputyship would not enhance the collaborative approach required in this case with clinicians and indeed might, at worst, be detrimental to it, are relevant factors to the section 4 assessment.*

82. In arriving at the conclusion that it is in P's best interests for this deputyship to be discharged, I have had regard, as Mr McKendrick encourages me to do, to the fact there is no analysis of wishes and feelings in this case, with wishes and feelings, of course, being an important factor. But, in my judgment, the submission by the Health Board and the litigation friend is a sound one in this regard: wishes and feelings on a conceptually complex matter such as this deputyship is difficult, if not impossible. One cannot extrapolate from the love that P has for his mother that he would wish for her to be deputy.

83. […] *ultimately I conclude that the deputyship should be discharged since the overwhelming majority of the matters in respect of which C has authority under the deputyship are matters in respect of which she is not the decision maker, and those matters that remain are such that the role that is proposed by C under the deputyship falls foul of the guidance given in, in particular, YH v Kent by Keehan J and represent an order that is not the least restrictive that the court can make or decision the court can arrive at in this case.'*

The appeal

CL advanced three grounds of appeal, arguing that:

1. the court erred in law by relying on s 16(7) MCA to discharge the deputyship order;
2. the court erred in its approach to the discharge of the deputyship, failing to recognise the difference between

granting a deputyship and discharging a validly appointed one;

3. the court failed to carry out a detailed and comprehensive best interests analysis in respect of the evidence available as to the best interests in respect of the discharge of the deputyship order.

In relation to the first ground, CL argued that "*the Judge was wrong to discharge the deputyship order purely as a question of LL's best interests, without the need to apply the s16(8) test*" (paragraph 37). CL's case that the Parliament had made a 'clear distinction' between an 'order' and an 'appointment' under s.16 MCA, and that "*although there might be situations when a deputyship order may be discharged for reasons other than the deputy's conduct, where the application both initially and at the hearing was predicated on CL's conduct this could not be ignored, as Parliament had set out the test for removal in such circumstances and however agile the court is, it must follow the statutory language*" (paragraph 39). It was submitted that there was a "*comprehensive and robust scheme to regulate deputies and protect P,*" and specifically that "*the powers conferred on the deputy should be limited in scope and duration as is reasonably practicable (s16(4)(b))*" (paragraph 42). Further, "*this heightened test in s16(4)(b) underscores his submissions that Parliament did not intend the revocation of the appointment to be limited to best interests due to this additional test on appointment, supported by the provisions in s20(6) that a deputy does not have authority to act contrary to P's best interests*" (paragraph 42). CL argued that "*the language in the MCA makes it clear Parliament has made a deliberate distinction between appointment (as a deputy) and orders more generally* […] *that distinction is made in other parts of the MCA, for example in s19 with the repeated references to 'appointment', s58(1) uses the term 'appointed' in respect of deputies and s16 (7) uses the term 'discharge an order' whilst s16(8) uses the different term to 'revoke' an appointment*" (paragraph 45). CL submitted that the test for revocation was not met where "*no breach of the complex duties and statutory scheme applied by the MCA and the Code of Practice were established and the Public Guardian had raised no concerns*" (paragraph 49).

CL argued the second and third grounds together. She argued that "*the best interest evaluation was wrong for two reasons: (i) the Judge conflated the decision to revoke with whether it was in LL's best interests for CL to be his welfare deputy, and (ii) he failed to carry out a detailed evaluation of the s4 factors and did not have proper evidence before him from the Health Board to carry out that evaluation*" (paragraph 50). It was argued that the first-instance judge erred in "*failing to have regard to the detailed statutory framework in the MCA that governed the deputyship, this was particularly so where no breach of these duties had been established*" (paragraph 52), and the court had insufficient evidence to undertake a best interests analysis, including insufficient evidence on CL's wishes and feelings.

The Health Board resisted the appeal, supported by the litigation friend, for reasons which were accepted by Theis J in its judgment.

Appeal judgment

Theis J granted permission to appeal but dismissed all three grounds of appeal.

On Ground 1, Theis J found that the first-instance judge had analysed the interpretation of ss.16(7)-(8) and given a conclusion at paragraphs 45-60 of the first-instance judgment. Theis J found (on the concession of CL in oral argument) "*that an appointment of a deputy is set out in an order and that an ability to vary the deputyship order was retained in s16(7) but not to discharge that order,*

as that could only be done under s16(8)" (paragraph 81(a)). Theis J agreed with the first-instance judge that any distinction between an appointment and an order was a distinction without a difference.

Theis J accepted the Health Board's "*submission that s16(7) should properly be interpreted as a general, broadly-worded power, which empowers the court to vary or discharge any order that it makes pursuant to any of its powers under s.16, whether under 16(2)(a), s.16(2)(b), or s.16(5). As Mr Patel convincingly submits this sensible interpretation of the word "order" encompasses all actions that the court can take under s.16(2), (5) or (6): orders, decisions, appointments, directions, "conferring powers" and "imposing duties". Any of these actions by the court under s16 are made "pursuant to an order" and properly fall within the language in s.16(7) MCA 2005 as being an "order of the court" and so can be "varied or discharged" by a subsequent order (as provided for in the section)*" (paragraph 81(2).

Theis J accepted the submissions of the Health Board that the list set out in s.16(8) was "*on a plain reading* […] *not an exhaustive list*" of reasons why a deputyship may be discharged (paragraph 81(3). Theis J considered that CL had placed an overreliance on the MCA scheme to regulate documents, and the outcome of CL's argument "would result in the court being unable to discharge the deputyship order in the circumstances listed by Mr Patel, when P's best interests demands such an order is made. To accept Mr McKendrick's submissions would wholly undermine the purpose of the MCA. The justification given by Mr McKendrick of any perceived unfairness for the deputy does not stand up to scrutiny in circumstances where the deputy can fully engage and participate in the process that results in any decision" (paragraph 81(4).

In relation to Ground 2, Theis J was satisfied that the first instance judge had recognised the difference between granting and appointing a deputyship, looking to the coverage of this issue in the judgment, and the focus the judge had placed on discharge. Theis J considered that the first-instance court's treatment of this issue had been clear.

In relation to Ground 3, Theis J considered that the best interests analysis had been sufficiently detailed and considered all relevant matters, noting the context "*that this is a discretionary decision reached by the Judge who has been the allocated Judge dealing with this case for some considerable time*" (paragraph 84). Theis J also considered that the judge had considered LL's wishes, "*but rather concluded that in the context of his long standing involvement with the case this was not a matter where LL's wishes and feelings would assist him. A conclusion he was entitled to reach"* (paragraph 86(2))

Comment

The conclusion of the Theis J appears unsurprising: it is difficult to see that s.16(8) imposes any mandatory limitations on s.16(7) and even more difficult to see that there should be any bar to a judge of the Court of Protection discharging the appointment of a deputy where the court feels that appointment is contrary to P's best interests. We would note the court's reliance on the judgment of Keehan J in *YH* that a deputyship must be for purposes greater than the deputy's wish to have an official status or concerns that he or she will not be listened to in best interests decisions.

We would, however, note a point in this case which arose in argument, but did not factor into the decision – the provisions of s.16(4) MCA, which states in relevant part:

> *(4)When deciding whether it is in P's best interests to appoint a deputy, the court must have regard (in addition to the matters mentioned in section 4) to the principles that—…*
>
> *(b)the powers conferred on a deputy should be as limited in scope and duration as is reasonably practicable in the circumstances.*

Welfare deputyships are by some considerable margin the less common form of deputyship, and continue to be relatively rare. However, we would note that typically, when both property and affairs and welfare deputyship orders are made, they are made for indefinite duration. We would query this practice, and suggest that welfare deputyships should not typically be made for an indefinite duration, and should be subject to provision for review.

We understand from information disclosed by the Court of Protection that applications for welfare deputyships are very commonly made when a person lacking capacity is about to or recently has turned 18 (as appears to have happened in this case): the person's family may wish to retain a formal status as decision-makers as parental responsibility comes to an end. The transition from childhood to adulthood may often come along with many other transitions in terms of education, health and social services, and may be a challenging one for the person and their family. The family's deputyship at that time may assist that process to have clear lines of decision-making, and in a great many cases, may be very much supported by the young person (as was the case in *Lawson, Mottram and Hopton* [2019] EWCOP 22).

However, from our experience, we have also seen many cases where the person's views and relationship with their family change as they become older, leave the family home, and develop other interests and relationships. P's wish to have their parent make all decisions for them at 18 may not persist when P is 30 and has lived away from their parents for many years. Further, if the person stops living in the family home, there may be many day-to-day decisions which the welfare deputy is not in a practical decision to make, and conflict may potentially arise between the deputy and those are with P every day and are charged with his or her care.

We would consider that it would be prudent for there to be further consideration of the application of s.16(4)(b) in the appointment of welfare deputies. If an application is being made because P is a young person aging out of children's service, an appointment of 4-5 years with provision for review may be a 'reasonably practical' limitation on duration. This would not serve as a renewal of the deputyship if it were still required, but would recognise that P's circumstances may well have changed after the transition to adulthood. It would also recognise that P themselves may find it very difficult to express a wish for a parent to relinquish deputyship, or to practically make such an application; a review would ensure that P had some regular opportunities to put forward their own wishes and feelings about whether a person should hold such significant control over their life.

Short note: Serious medical treatment – the importance of the public record

In 2014, a (relatively) very long time ago, Sir James Munby, then President of the Court of Protection, issued guidance on the publication of judgments. This set a presumption, absent "compelling reasons," for publication of judgments relating to a range of matters, either where the judgment already exists, or the judge has ordered that the judgment be transcribed. The guidance applied to all judgments in the Court of Protection delivered by the Senior

Judge, nominated Circuit Judges and High Court Judges (in other words, not to judgments delivered by District Judges, who hear the majority of cases – to understand more about this, see here).

The cases Sir James had in mind were judgments arising from:

> *(i) any application for an order involving the giving or withholding of serious medical treatment and any other hearing held in public;*
> *(ii) any application for a declaration or order involving a deprivation or possible deprivation of liberty;*
> *(iii) any case where there is a dispute as to who should act as an attorney or a deputy;*
> *(iv) any case where the issues include whether a person should be restrained from acting as an attorney or a deputy or that an appointment should be revoked or his or her powers should be reduced;*
> *(v) any application for an order that an incapacitated adult (P) be moved into or out of a residential establishment or other institution;*
> *(vi) any case where the sale of P's home is in issue;*
> *(vii) any case where a property and affairs application relates to assets (including P's home) of £1 million or more or to damages awarded by a court sitting in public;*
> *(viii) any application for a declaration as to capacity to marry or to consent to sexual relations;*
> *(ix) any application for an order involving a restraint on publication of information relating to the proceedings.*

The guidance has never formally be withdrawn, nor can it properly be said to be honoured in all cases. This makes the judgment of Henke J in *King's College Hospital NHS Foundation Trust v South London and Maudsley NHS Foundation Trust & Anor* [2024] EWCOP 20 refreshing. It is a 'routine' serious medical treatment case, of huge importance to the person concerned (and also to those delivering medical treatment to him), but of no wider importance in terms of the development of the law. However, Henke J nonetheless explained why a judgment nonetheless appears:

> *20. Whilst this matter has ultimately been agreed, I have considered it important to publish this short judgment for two reasons. Firstly, this case has been heard in public subject to a transparency/reporting restrictions order. I consider that where, as here, a case has been listed for a final hearing in public, if it is reasonably practicable, a short judgment should be published so that the public may know, if they wish, what has happened and why it has happened. Secondly, GF should have a record which he can access at his will which sets out why he has had his leg amputated and the steps that were taken to make sure that that amputation was in his best interests. GF did not want to see me as part of the hearing. However, I am conscious that his views on the operation have been sought by the Official Solicitor and those treating him. I have recorded a summary of those views in this judgment, and I have factored those views into my decision making. He should know that and the outcome of this hearing, which after all is about him.*

Short note: closed material and parallel proceedings

As an interesting counterpoint to the publication of the serious medical treatment decision noted immediately above, Henke J has also loyally followed the *Closed Hearings and Closed Material Guidance* ([2023] EWCOP 6) and produced a judgment "to enable disclosure at an appropriate point in the future and to enable the speedy and

proportionate determination of any appeal if this decision is appealed by any party. The story disclosed in *P (Application to Withhold Closed Material: Concurrent Civil Proceedings)* [2024] EWCOP 26 is a sad and difficult one involving a young man who suffered serious injuries (including a brain injury), and whose parents were – on the evidence before the court – both not able to act in his interests in the resulting civil litigation, and also profoundly distrustful of the entirely judicial process.

Indeed, the application before Henke J arose out of failed attempts by the solicitors instructed by the Official Solicitor to engage with P to progress the civil claim on his behalf. In the course of those attempts, the Official Solicitor had become sufficiently concerned by the actions of his parents that, having failed to persuade the local authority to take steps, she brought an application on his behalf in the Court of Protection for declarations and decisions about P's welfare, including contact.

In the course of that separate application, Henke J was asked to withhold material from his parents for a time-limited period and for a specific purpose, namely for P's capacity to be assessed. For the reasons set out with admirable clarity in the judgment, Henke J acceded to the application, although with one important amendment, noting at paragraph 89:

> *Throughout this part of the judgment dealing with closed material, I have written at this stage. Any interference with the rights of any party must be lawful, necessary, and proportionate. This court has a duty to keep the issue of disclosure under review and to only make an order for such duration as is necessary and proportionate on the facts of this case. On the facts as presently before this court, I cannot see any justification for withholding the material from P's parents once the court assessment proposed by the Official Solicitor has been served on P's parents. The duration of the order will thus be until the assessment has been served on P's parents or further order of the court, whichever is the sooner.*

The judgment is also of note because it also featured an application by P's parents to discharge all the previous orders made in the Corut of Protection, on the basis that the personal injury proceedings should be the only proceedings before any court in relation to P. Henke J refused this application, noting at paragraph 78 that:

> *On behalf of the Official Solicitor, it is accepted that there are several issues which will require co-ordination between this Court and the King's Bench Division including the management of any monies P may receive. Further, this Court may, in due course, be required to authorise any care arrangements put in place as a result of the civil proceedings, such as any arrangements depriving P of his liberty. This overlap between the two sets of proceedings is perhaps inevitable given the welfare concerns in relation to P were raised in the personal injury proceedings. However, there are significant and relevant differences between the two proceedings. The personal injury proceedings are about compensation for injuries received. The Court of Protection proceedings were initiated because of safeguarding concerns about P and concerns about his capacity to decide (amongst other matters) where he should live, who he should have contact with, and issues about his care and treatment. Those will be best interest decisions will be matters for this court.*
>
> *79. Based on the papers currently before me, I agree with the Official Solicitor that as this case proceeds, there may be legitimate disputes to be determined in*

> *this court about where P should reside to receive the care he requires and potentially issues about whom he should have contact with. Accordingly, I do not agree with P 's parents' argument that these proceedings should be dismissed, and all previous orders should be discharged. This court has jurisdiction. The proceedings before this court are necessary and have a purpose which cannot be fulfilled by the personal injury proceedings alone. The King's Bench Division will determine the level of P's compensation and his needs in that context. This court will consider his best interests when making any welfare orders that may be required in the future.*

Fees increase in the Court of Protection

With effect from 1 May 2024, the fee for making an application in the Court of Protection rose from £371 to £408, and the appeal fee from £234 to £257.

The Court and Tribunal Fees (Miscellaneous Amendments) Order 2024 also corrects some errors, including in the Court of Protection Fees Order 2007. As the Explanatory Memorandum notes:

> Paragraph 14(3)(b) in Schedule 2 to the Court of Protection Fees Order 2007 deals with the calculation of a party's disposable capital and gross monthly income for the purposes of calculating entitlement to fee remissions. Mistakenly, paragraph 14(3)(b) fails to specify that the gross monthly income of 'P' (the protected party) is to be treated as the gross monthly income of the party, in proceedings brought concerning the property and affairs of a P. This amendment will correct this oversight.

MENTAL HEALTH MATTERS

Deaths in custody – the MHA problem

The Independent Advisory Panel on Deaths in Custody has published an updated report analysing deaths in custody for the period between 2017 and 2021. The report concludes that:

- People in state custody are at a significantly elevated risk of death, both natural and unnatural, compared with the general population. These deaths are often preventable.
- Greater transparency is needed to understand who is dying in closed institutions and why.
- Prisons have the highest number of deaths, with an average of 322 annually during the period analysed.
- Mental health detention had an average of 263 deaths annually in the period analysed, or 1314 per 100,000 people detained. This figure jumped starkly higher to 15,770 when it was adjusted for the fact that the average period of detention was one month.
- Even on the average, unadjusted rate, when rates are considered, the mortality rate of individuals detained under the Mental Health Act is three times higher than prisons and the highest across all places of custody.
- Despite the frequency with which deaths of people detained under the MHA occur, a lack of timely and high-quality data limits learning to prevent further deaths in secure health settings.
- Deaths among men and women were roughly equal in mental health settings when measured relative to the number of male and female detainees.
- The majority of unnatural deaths across all settings – which includes suicides, accidents and homicides – occurs in those under the age of 40.
- For deaths in mental health detention, deaths by 'natural' causes were significantly higher than deaths by 'external' causes, though high numbers of deaths were considered to be 'awaiting classification' pending a coroner's inquest.

The report makes clear recommendations for how data should be kept on deaths in mental health detention.

> *Data on deaths in mental health detention is still not good enough.*
>
> - *Data on deaths in MHA detention remains poor quality in terms of comprehensive and timeliness. As the IAPDC has found for a number of years, we cannot identify the proportion or rate of deaths by race or ethnicity due to the lack of available data.*
> - *The same remains true for identifying rates of death for both men and women within MHA detention: it is currently not possible due to the poor data quality.*
> - *It remains the case that a large number of deaths in MHA detention in each new year are reported as "awaiting classification". This is because those reporting the data wait for coroners' verdicts before*

determining whether a death was self-inflicted or 'nonnatural'.

- *However, this issue does not pose a problem for the other detention settings, such as prisons or police custody, with the relevant bodies using other, provisional methods for reporting apparent self-inflicted deaths before a coroners' verdict to ensure timely and potentially actionable data. This should be changed for data on deaths in MHA detention.*

When (not) to rely upon capacity

Lukes v Kent & Medway NHS & Social Care Partnership Trust & Anor [2024] EWHC 753 (KB) High Court (King's Bench Division) (Julian Knowles J)

Other proceedings – civil

In this case, Julian Knowles J had to consider whether Mr Lukes had a viable claim for damages for personal injury against either the police or a mental health Trust. Mr Lukes had jumped from height in August 2020 onto railway tracks and sustained serious injuries. In the year or so before this incident, and especially in the days leading up to it, there had been concerns about his mental health, and he had been detained twice the year before under the Mental Health Act 1983. He had also been arrested by police officers for assaulting members of his family. Both the police and the Trust sought to shut the claim down at an early stage, in effect on the basis that there could be no proper basis for a claim against them. The police succeeded in essence because they persuaded the judge that there could be no argument that they had failed to fulfil their duty of care by ensuring that Mr Lukes received appropriate clinical attention (see paragraph 149).

The position of the Trust, however, was different. One striking submission made on the Trust's behalf and recorded at paragraph 95 was that the claimant that at no point in August 2020 lacked capacity (to decide what is not set out in the judgment). The Trust also emphasised that Mr Lukes was not cooperative. At paragraph 179, Julian Knowles J observed that:

> *179. I next turn to the complaint that Mr Parish [a community psychiatric nurse] wrongly determined that he was unable to speak with C's mother, or write to his GP, to find out more information about his mental health because of C's lack of consent. The note made by Mr Parish on 12 August 2020 was, 'I am unable to speak with his mother or write to his GP without his consent, which he is clearly not going to give to me.'*
>
> *180. Initially, I was sceptical about this argument, and ventured during the hearing the possible view that whilst C's lack of consent might not have absolutely prevented Mr Parish from speaking to C's mother or GP, the reality is that any conversation would have been a short one of little value. I noted the absence of any clear pleading about what such a conversation could have revealed which would have been of assistance.*
> *Having reflected, however, I consider that there is force in Mr Woolf's submission that if he had spoken to C's mother or GP, Mr Parish could have asked – without breaching confidentiality - about what they had witnessed about C's state of mind over the previous two years and whether there had been in their mind concerns about his risk of self-harm and, if so, why.*

Julian Knowles J found Mr Lukes had a reasonable prospect of showing that the Trust failed properly to ascertain his mental health

history and so failed to carry out a proper screening assessment (paragraph 186). The question, though, was what flowed from that arguable breach.

> *187. […] I acknowledge the strength of the points made by Mr Trusted that: C had capacity; he repeatedly refused to engage with Mr Parish, which he was entitled to do; and that there is little to show that he was psychotic around 12 August 2020, or during the subsequent week when he dealt with Ms Hatfull, or when was assessed in Kings College Hospital in early September 2020 following his accident, and hence there was no basis for him being detained on any view.*
>
> *188. However, the conditions for compulsory detention under the MHA 1983 for either assessment or treatment are not limited to cases of psychosis. Section 2(2) (admission for assessment) provides:*
>
> > *"(2) An application for admission for assessment may be made in respect of a patient on the grounds that -*
> > *(a) he is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and*
> > *(b) he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons."*
>
> *189. Having capacity is also not a bar to being compulsorily detained. In the notes for 8 September 2019 following C's detention there was this from the duty psychiatrist:*
>
> > *"…Capacity Fully capacitous. Diagnosis Drug induced psychosis. Plan he needs antipsychotic medication. No indication for his prescribed citalopram. Not ready for section 17 leave yet prn medication."*
>
> *190. I also cannot ignore the fact that C's detention in September 2019 took place despite C denying that he had 'any problems and reported that he actually feels quite clear in his head'.*
>
> *191. It therefore seems to me that there is a triable issue as to whether a properly conducted screening by Mr Parish would have led to a further mental health assessment – or assessments - and compulsory detention in light of C's presentation, his extensive mental health history, and his MHA 1983 detention a year earlier. Whilst, as Mr Trusted said, it was not possible for Mr Parish himself to have conducted an assessment given C's refusals, there were other options open to him by way of referring the case upward to others who could have assessed C.*

Julian Knowles J also found that there was a triable issue as regards the conduct of a Ms Hatfull, in the single point of access team:

> *192. Turning to the alleged breaches by Ms Hatfull, the gist of these is that she failed to gather a proper history and failed to carry out a proper screening, despite apparent evidence of psychosis being relayed to her colleague Ms Pinduke, and wrongly discharged C. This is evidenced by her erroneous completion of the screening form.*
>
> *193. I also consider that there is a triable issue that there were also breaches of duty by Ms Hatfull. As pleaded in [16] of the PoC, she was arguably wrong to state on the form she completed on 15 August 2020 that C was not known to*

local mental health services or other agencies; that there was no history of mental illness in the family; and that C had never attempted suicide. As to the last, whether what happened in January 2019 was properly an 'attempt' seems less important than the history of suicide threats by C which I outlined earlier. As to this, the box 'Client Risks (protective factors, self-harm, risk to others, risk from others, etc)' was left blank and no reference made to these earlier suicide concerns. Also, given that C had been arrested in the days before for assaulting his father and sister (and was then on bail), and had assaulted his grandfather the previous year, the fact no reference was made to this (as 'risk to others') is surprising. Whilst not said to be a breach of duty, this omission is perhaps indicative of the incomplete way in which Ms Hatfull conducted her assessment of C.

194. Again, I understand D1's case that circumstances were difficult in August 2020 because of COVID; that days earlier he had been fit for a PACE interview; and that he had capacity on 15 August 2020; that there is no evidence around that date he was at imminent risk of self-harm, or suffering from a mental illness, such that an urgent MHA 1983 assessment was then required.

195. However, all these matters seem to me to relate to triable issues. As I have already said, lack of capacity is not of itself a bar to compulsory detention. The risk of suicide was arguably not properly assessed by Ms Hatfull. And whether C was suffering from a mental illness requiring an urgent MHA 1983 assessment on 15 August 2020 is a matter of expert evidence. It is relevant that just four days later on 19 August 2020 he was found to require just such an urgent assessment and was said to be possibly psychotic.

It is very important to emphasise that the judge did not find that the Trust did breach its duty of care towards Mr Lukes – all he said was that Mr Lukes must have the chance to seek to establish his case at trial. However, his clear rejection of the assertion that 'having capacity' is sufficient to alleviate the need to consider detention under the MHA 1983 is very helpful. For those who want to think more about this issue, we recommend this video discussion with Dr Chloe Beale, a champion of critical thinking in this area.

MHA reforms, autism and learning disability

The always useful Parliamentary Office of Science and Technology has published the most recent of its POSTnotes on the proposed reforms of the Mental Health Act 1983, this time summarising the key reforms relevant to and including research evidence and stakeholder views on the impacts on autistic people and people with a learning disability.

THE WIDER CONTEXT

Capacity, autonomy and the limits of the obligation to secure life

R (Parkin) v His Majesty's Assistant Coroner for Inner London (East) [2024] EWHC 744 (Admin) (Administrative Court (Collins Rice J))

Other proceedings – judicial review

Summary

This is an important, but curious, case about the limits of the duties imposed by Article 2 ECHR on public bodies to seek to secure the life of individuals in the community. It concerned the inquest following the death of a Mrs Rosslyn Wolff, who was found dead in her home on 2022, following a domestic fire. A London Fire Brigade investigation team report concluded the most probable cause of the fire was unsafe use or disposal of smoking materials. Mrs Wolff had lived on her own; she was a hoarder, and the London Fire Brigade had multiple referrals for home safety visits over the years, although had managed to bring about the installation of a smoke alarm in 2019. She had come to the attention of the local authority after her son had raised concerns about her self-neglect and poor living conditions, and about her abusive treatment at the hands of another family member (who in turn was known to the local mental health service). An initial multidisciplinary assessment was carried out: no mental health concerns were identified in relation to Mrs Wolff herself, but "'*after much persuasion', she agreed to a care package to support personal hygiene and medication compliance*." She had briefly been detained under the Mental Health Act 1983 on two occasions in 2021, but her symptoms of confusion were then diagnosed as not proceeding from mental ill health but from hyperglycaemia – the result of not maintaining her diabetes medication regime.

In October 2021, a multi-agency risk assessment conference of health and social care professionals reviewed Mrs Wolff's circumstances. They noted no concerns over her mental health or capacity, but noted "ongoing risk presented by her unwise decision making." These included that she had been "adamant in her expression of not wishing to engage in conversations about her environmental circumstances" – which included concerns about the state of her home: poorly looked-after dogs, dog mess, risk of electrical injury, risk of leaking water. It was noted there had been some progress with engagement with her allocated social worker, but this had had to be "*very gentle*" – "*Rosslyn does not respond well to multiple offers of help or professional involvement*." An action plan was agreed, to include continued offers of follow-up and engagement with her social worker, and a fire assessment was to be made of her home by the fire brigade. Attempts by the social worker to visit were unsuccessful between October 2021 and Mrs Wolff's death in January 2022.

The coroner had found that Article 2 ECHR was not engaged:

> *[19] Public bodies such as healthcare foundation trusts and municipal corporations are embodiments of the state for the purposes of recognising the possible application of Article 2 obligations. But the bare fact that such institutions may have interacted with the citizen does not thereby determine whether Article 2 is engaged.*
>
> *[20] The relevant situations must be identified. That entails a consideration of whether there is evidence to suggest that Rosslyn was at the time of her death in state detention or in real and immediate risk to her life. Neither of those situations is shown on the evidence. The evidence is that she lived*

> *in her own home. She had declined additional intervention by the state. Her mental capacity had been assessed and she was deemed to have capacity. She was therefore entitled to exercise choice. She had the right to take unwise or inappropriate decisions. The state does not take on added duties or responsibilities in such circumstances.*
>
> *[21] The evidence does not support the application to engage Article 2. Any shortcomings or failings which might be established can be investigated within a Jamieson inquiry and scrutinised if necessary within a Report to Prevent Future Death, or even a finding of neglect if the evidence proved as much. I therefore reject the application to engage Article 2.*

Mrs Wolff's son challenged this decision by way of judicial review. Collins Rice J disagreed with the coroner as to the risk, finding that that "real and immediate risk of harm" threshold was crossed, given that:

> *46.* […] *I am satisfied that the risk of death, not just the risk of harm, was inherent in the risk of a house fire at Mrs Wolff's home, and the risk of a house fire was real, continuing and present – and recognised as such. There was nothing in her home environment, apart from the smoke alarms, recognisable as capable of limiting the effects of any house fire there to one of non-fatal harm alone. And the smoke alarms proved insufficient by themselves in the event.*

However, this was insufficient, because Collins Rice J was not persuaded that the state had assumed responsibility for Mrs Wolff by the making of the care plan:

> *52. No doubt the public authorities in this case owed professional duties to Mrs Wolff. But it is not every case in which health and social care professionals draw up care plans for individuals, or patients spend time in hospital, that the Art.2 duty arises. Helping and supporting an individual, even in the discharge of legal duties, does not routinely give rise to the operational duty. Something more is needed. And it cannot just be a real and present risk to life because that is necessary but not sufficient for the duty to arise.* (emphasis in original)

Further, in response to the submission that the Supreme Court in *Rabone* had observed that:

> *54.* […] *'in circumstances of sufficient vulnerability, the ECtHR has been prepared to find a breach of the operational duty even where there has been no assumption of control by the state'. And I have reflected further on that. But this point has two important limitations.*
>
> *55. First, the example given in Rabone of 'sufficient vulnerability' is that of a local authority failing to exercise its powers to protect a child at known risk of abuse. In those circumstances, the state's power includes assuming control over the child (taking it into care). The child ultimately lacks autonomy in the matter; the necessary welfare decisions can ultimately be taken on its behalf. That was not Mrs Wolff's situation.*
>
> *56. Second, and relatedly, the qualifier of 'sufficient' vulnerability indicates that not every degree of vulnerability will be relevant. Mrs Wolff was from time to time referred to as vulnerable, and it is plain enough from the evidence that to a degree she was. She was not identified as vulnerable on account of her mental health. She did not, Mr Lay accepts, lack competence to make her own decisions about her lifestyle. She was identified as vulnerable as a victim of past domestic*

abuse (although that is not obviously 'connected to' the fire risk to her life). But her hoarding habit perhaps signals a degree of relevant vulnerability. And, importantly, her irregularity with her diabetes medication had certainly rendered her significantly vulnerable from time to time.

57. That raises the question of whether the degree of vulnerability which would support the inference of a state duty in respect of the risk to her life is made out on the evidence in this case. I have to bear in mind that Mrs Wolff was an adult of confirmed competence and psychiatrically sound mind, even though attempting further mental health assessment appears in her plan. She ran many risks with her health and safety. Aside from smoking, hers were socially atypical risk-taking behaviours. But she was fully informed as to the risks she was running, and targeted help to eliminate or mitigate them had been made available to her over a sustained period of time.

58. I also bear in mind that Baroness Hale JSC in Rabone (at [100]-[101]) underlined that there is no general duty of the state to protect an individual from deliberate self-harm, even where the authorities know or ought to know that it entails a real and immediate risk of death. The authorities are unanimous that the autonomy of properly autonomous individuals must in the end be respected. In my view, the situation is a fortiori in relation to consciously adopted behaviours which pose a risk of self-harm, and to self-neglect. If (and it is an important 'if') these are properly autonomous choices, and there is no state power to intervene and overbear them, then they fall to be respected. Indeed, they may positively demand to be respected, as an aspect of an individual's autonomy protected by Article 8 of the Convention.

59. There is no evidence that Mrs Wolff's choices were other than properly autonomous. She was plainly a risk to herself. There is evidence that she was to a degree vulnerable. But the fact that her behaviours, by general social norms, could be labelled unusual, unattractive, unwise or unreasonable – or even disorderly – is neither itself inconsistent with their being autonomous, nor indicative that her autonomy was materially compromised. I was shown no decided authority in which properly autonomous risk to the self was nevertheless made subject to implied transfer to the state by way of the Art.2 duty. On the contrary, the authorities point to the two being mutually exclusive. (emphasis added)

Collins Rice J considered that she did not have:

the authority of the decided caselaw for the extension of the [Article 2 operational] *duty to the facts of this case. Mr Lay accepts that would not be squarely precedented. On the contrary, in my judgment the caselaw provides firm guidance that to do so would be to cross the proper boundary between personal liberty and state intervention.*

64. The evidence is that Mrs Wolff was a fiercely independent lady of sound mind who did not want well-intentioned health and social work professionals judging or interfering with a lifestyle she was well aware was a risky one. The tragic circumstances of her death, and the natural dismay that this was, on at least some level, an avoidable disaster befalling an unfortunate and perhaps disadvantaged individual, do not mean it was one which it was the duty of the state to prevent.

Even if she was wrong in that, Collins Rice J found, the state had not breached the operational duty that would have arisen:

> *69. The authorities' strategy was therefore necessarily long term, patient and opportunistic, based on nudging Mrs Wolff towards wiser choices, and making the most of such chances as she permitted for intervention. The evidence discloses no reason to expect that the execution of the December plan needed to be prioritised at a pace demanding renewed attempts at engagement over the particular few weeks in question – or that there was reason to believe it would have achieved anything relevant if it had. The fact that Mrs Wolff had given the fire brigade access more than two years previously to fit smoke alarms has to be seen in the context of her more recent sustained pattern of firm and settled reluctance to engage with any sort of state help. Her smoking habits were evidently deeply ingrained and her sofa was flammable. She had not long previously been given the clearest of reasons, and offers of support, for taking her diabetes medication. It is hard indeed in all these circumstances to see, on an evidenced basis, what more the authorities could have been expected to do that they did not do – and what basis they could have had for expecting it to have made a material difference if they had implemented their plan any more quickly.*

Collins Rice J identified, as had the coroner, that:

> *72. that does not necessarily mean that the matters about which Mr Parkin is concerned cannot be addressed by other means. Issues of potential shortcomings or failings leading up to Mrs Wolff's death can be investigated in the context of a traditional inquest and scrutinised if appropriate in a prevention of future deaths report. That can include identification of neglect, if any. So this is not necessarily the end of the road for pursuing his concerns. But as I have explained, my task is the narrow one of reviewing whether the Assistant Coroner was entitled to conclude that this was not an Art.2 case. I have set out my review and explained why, applying the caselaw guidance which binds me, I come to the same conclusion as the Assistant Coroner.*

Comment

As noted at the outset, this is an important decision about the limit of the state's obligations under the ECHR to seek to secure the life of individuals in the community. As Collins Rice J made clear in her conclusion, public bodies may well owe other obligations, for instance in negligence. Collins Rice J was, however, clear as to where she considered the boundaries of Article 2 to lie in the cases of those who are considered to have the capacity to make their own decisions and are exercising that capacity in ways which are risky. In its repeated references to Mrs Wolff's decision-making as autonomous, it makes an interesting case study for the application of the "autonomous decision-making" test proposed by the Scottish Mental Health Law Review.

It is, however, a judgment which is somewhat curious both factually and legally.

The factual curiosity arises from a contemporaneous press report of the pre-inquest hearing, which had caught Alex's eye for the somewhat startling proposition reported as having been put to the coroner that:

> *the law requires a person "must be assumed to have capacity unless it is established that they lack capacity".*

> *In the absence of a capacity test, he said it was right for Havering Council to treat Mrs Wolff as having capacity.*

The second sentence is self-evidently wrong: the question is not whether a capacity "test" has been carried out, but whether "*there is good reason for cause for concern [or] where there is legitimate doubt as to capacity*" (Royal Bank of Scotland v AB [2020] UKEAT 2066 at paragraph 26). That submission was predicated upon a capacity assessment (presumably in respect of management of hoarding risk) not having been carried out. The press report also included a report of evidence given by the head of legal services at the mental health trust to the effect that "[t]*he serious incident investigation report does acknowledge that Rosslyn did not have a formal capacity assessment relating to self-neglect and hoarding*."

We are always cautious about relying upon press reports, and it may well be that there was more going on than meets the eye. But on the face of it, what was set out in the press report stands at curious odds with the conclusion in the judgment of Collins Rice J (on which she placed such weight) to the effect that Mrs Wollf was "*an adult of confirmed competence and psychiatrically sound mind*" (emphasis in original). "Confirmed" competence (or capacity) or (as the coroner had put it) "deemed" capacity is a rather different beast to capacity that has been presumed.

We note, though, that Counsel for Mrs Wolff's son appeared to have conceded that she had capacity in the material domains (see paragraph 56 above), so it may be that Collins Rice J did not have to descend in detail into the question of precisely how the conclusion had been reached by the various public bodies that Mrs Wolff had capacity in those regards.

The judgment is legally curious in that it did not involve any consideration of the inherent jurisdiction, which might be thought to be "*state power to intervene and overbear*" capacitous choices. The absence of such state power was considered to be of relevance by Collins Rice J. The decision of Cobb J in *CD v London Borough of Croydon* [2019] EWHC 2943 (Fam) might be thought to be a decision directly on point, concerning the use of the inherent jurisdiction to secure entry to a man suffering from self-neglect and declining assistance from the local authority. In that case Cobb J ultimately concluded that, in fact, he could make the order on the basis that CD lacked the relevant decision-making capacity, but confirmed that "*CD is also a vulnerable adult within the meaning of the well-known Re: SA test, and that that route is or was an alternative available to the local authority on the particular facts of this case*."

There is no reference in the judgment in Mrs Wolff's case to the inherent jurisdiction, so it is not possible to say whether it was something that was considered and ruled out by the statutory authorities. Views undoubtedly differ amongst both professionals and (more problematically the judiciary) as to whether and how the inherent jurisdiction can be used.[4] But it would perhaps have been useful for Collins Rice J to have squarely before her the fact that at least some High Court judges might well have taken an expansive view of the ability of the state to intervene had they been asked to consider the question of what to do before Mrs Wolff's death.

Finally, we do not know from the judgment precisely how Mrs Wolff's capacity to make

[4] Alex's cue to plug, again, the importance of the Law Commission picking up the work that it left off in the 1990s on this topic: "Vulnerable adults" – a last push – Mental Capacity Law and Policy.

decisions surrounding the management of hoarding risk was assessed, but this provides an opportunity to flag the decision in *A Local Authority v X* [2023] EWCOP 64, discussed in the Health, Welfare and Deprivation of Liberty report. As with the decision of Cobb J in *CD*, the decision in the *X* case also shows the extent to which the courts are prepared to roll up their sleeves when confronted with a dilemma such as that which was facing the statutory authorities in Mrs Wolff's case. And, importantly, to do so at a time when it might make a difference, as opposed to looking backwards through the retrospectoscope.

Short Note: capacity, presumptions and catastrophe

As Lieven J noted in her opening paragraph, *A Council v An NHS Foundation Trust & Ors* [2024] EWHC 874 (Fam) was, even by the standards of the Family Division, a particularly tragic and awful case. It has recently appeared on Bailii, but was decided at the start of 2024. It concerned Z, one of two young twins who had both been born with health issues. He had remained in hospital since birth, when (in terms described cryptically in the judgment), something clearly went wrong such that his tracheostomy tube was dislodged, and he was in major and prolonged cardiac arrest for 15 minutes. There was no prospect of his recovering.

The case came before the court because the local authority was very concerned about the parents' capacity to make decisions about end of life treatment for Z. In the case of Z's father, this was his legal capacity. In the case of Z's mother, this was her mental capacity. Z's parents were both heroin addicts and had a history of fluctuating engagement with the care proceedings that had been brought shortly after his both, and with him in hospital. There was no doubt that the father had mental capacity to make decisions about his son's medical treatment but on the facts of the case,, he did not have parental responsibility and could not therefore formally in law consent to treatment. Whilst Z's mother did have parental responsibility, the local authority had real doubts about her mental capacity. The local authority therefore sought an order for a capacity assessment, an order Lieven J willingly granted. However, unfortunately (but as Lieven J noted) perhaps not wholly surprisingly, Z's mother did not engage with it. As Lieven J noted at paragraph 12.

> *Quite apart from the fact the mother apparently has a history of non-engagement at certain times, it is hardly surprising in the circumstances that the mother has found this situation so overwhelming that she has defaulted to a position of non-engagement.*

At Lieven J's direction, a second opinion was obtained, confirming that Z had no quality of life and no possibility of any meaningful improvement.

Lieven J identified that the first issue in terms of what to do at the substantive hearing of the matter was as to what she should do about the mother's capacity:

> *7* […] *In order for the court to rely on a decision of the mother that Z should be moved to palliative care only, I have to be satisfied that she has capacity and I also have to be satisfied that she gave informed consent. I am very conscious of the fact that the NHS Trust considers that she does have capacity and also relies on the presumption in favour of capacity under section 1(2) of the Mental Capacity Act 2005. I am, however, equally concerned that the case law suggests that, when a court is considering capacity, the more important the decision the more careful*

the court needs to be that the person in question has capacity, as well as being particularly careful that they can give informed consent.

18. The evidence in this case is very limited. I have the LA's deep concern about whether the mother has capacity. I have the Trust saying that they thought she did have capacity in December, but they were not undertaking a formal capacity assessment under the Mental Capacity Act. I am very conscious of the fact that, for the mother to have capacity, she must be able to process the information that is given to her. I am not at all confident that she could process the information and I am equally concerned that she has not considered the information in any detail since December.

19. I consider it to be inappropriate to rely on a presumption of capacity in these circumstances where the decision is as to whether the mother's child is allowed to die. It does not feel to me judicially comfortable to rely on a presumption of capacity in those circumstances where I know that the LA, which has had considerable contact with this mother in the past, has such worries about her capacity. I am going to proceed on the basis that the mother does not have capacity. I am not going to make a finding she does not have capacity because I do not have the evidence, but, I think, I can make a section 16 decision and take an interim view that she does not have capacity. Even if she does have capacity to make the relevant decision, I am even more concerned that she cannot give informed consent, because I have very little evidence as to what information she was given in order to give informed consent within the meaning of the case law.

It therefore fell to Lieven J to determine what was in Z's best interests, and not rely upon parental consent. She did, however, take into account what was known of the views of the mother, and the father's view. She concluded, that, sadly:

> *21.* […] *Sadly, I think there is very little doubt that this is a clear decision. There is a unanimity of clinical view, including a second opinion, that it is in Z's best interests to allow his life to end. The medical evidence is so overwhelming, as to the level of his suffering, as to the lack of hope of any improvement in the quality of his life and, importantly, as to there being no alternative care plan which could improve his quality of life, that, in my view, it is clear it is in Z's best interests for the palliative care plan to be approved and for me, under the inherent jurisdiction, to allow the withdrawal of medical treatment and the provision of end of life care. I give consent for that application to be brought and I allow the application.*

Comment

Of wider relevance beyond the very sad facts of the case itself is Lieven J's careful approach to the presumption of capacity. In contrast to situations such as that noted here, Lieven J was clear (and we suggest clearly right) to take the view that reliance on the presumption would simply be improper in the face of evidence giving rise to real doubt as to whether Z's mother had capacity to make the relevant decisions. It is also of interest, perhaps, to note Lieven J's careful self-direction (at paragraph 17) in relation to the approach to be taken to important decisions – i.e. not that there is a sliding scale in terms of the person's capacity, but there is, rather, a particular importance for the court to test whether the person has it. Whatever may have been the position before the coming into the force of the MCA 2005, where the term 'sliding scale' was used, the statutory scheme of the MCA 2005

does not on its face allow for such a scale; rather, we would suggest that Lieven J's approach represents the proper calibration.

Intellectual disability, psychiatric admissions and Article 3 – the European Court of Human Rights raises the stakes

In *VI v Moldova* [2024] ECHR 251, the European Court of Human Rights considered the placement of a 15 year old orphan with a perceived mild intellectual disability in a psychiatric hospital against his will. He was under the care of the State at the time. At the end of what was supposed to be a three-week placement, he was left there for another four months, with nobody coming to visit or fetch him and being treated with neuroleptics and anti-psychotics. The applicant alleged that his placement and treatment, together with the conditions in the hospital and the conduct of the medical staff and other patients, had amounted to ill-treatment contrary to Article 3 ECHR. He also complained that the investigation into his allegations had been ineffective and alleged that social stigma and discrimination against people with psychosocial disabilities and a lack of alternative care solutions had been to blame.

The court was clear as to how it approached the situation:

> *103. The Court would first observe that the case concerns a child, aged 15 at the time of the events, who had not reached the age of 16 or 18 - the ages at which persons may express consent for medical treatment, as required by domestic law* […]. *His placement in a psychiatric hospital and his psychiatric treatment were therefore subject to the consent of his legal guardian, the mayor of Ciuteşti. For this reason, in view of the applicant's disagreement with the consent allegedly expressed by his legal guardian for his placement in a psychiatric hospital and his psychiatric treatment, the case concerns involuntary placement in a psychiatric hospital and psychiatric treatment* […]. *At the same time, the Court notes that the applicant turned 16 one month before his discharge from the hospital and that the authorities had not assessed the validity of the consent for his placement in the psychiatric hospital and his treatment there.*

The court observed that cases concerning medical interventions, including administration of medication and admission to a psychiatric hospital carried out without the consent of the patient, will generally lend themselves to be examined under Article 8 of the Convention. However, in the present case it considered that the issues of placement in a psychiatric hospital, including subsequent placement in the adults' section and the material conditions there (namely the psychiatric treatment with neuroleptics) and the delayed discharge, combined with the applicant's vulnerability – resulting from such elements as his age, learning disability and the absence of parental care or institutionalisation – were sufficiently serious to fall within the scope of application of Article 3 of the Convention.

The court went on to hold that there was sufficient to conclude that the authorities had failed to carry out an effective investigation into the applicant's allegations of ill-treatment. The inquiry that was undertaken did not factor in the applicant's vulnerability, his age or the disability aspects of his complaints concerning the institutionalised neglect and medical violence committed against him.

The court also found that the existing Moldovan legal framework – which lacks the safeguard of an independent review of involuntary placement

in a psychiatric hospital, involuntary psychiatric treatment, the use of chemical restraint, and other mechanisms to prevent such abuse of intellectually disabled persons in general and of children without parental care in particular – fell short of the requirement inherent in the State's positive obligation to establish and apply effectively a system providing protection to such children against serious breaches of their integrity, contrary to Article 3 of the Convention.

It further found that the applicant had made out his allegations that his placement in a psychiatric hospital and psychiatric treatment lacked any therapeutic necessity, at any point in his time there. It emphasised that it was "*important to point to the national and international standards which provide that an intellectual disability is in itself insufficient ground for placement in a psychiatric hospital, psychiatric treatment and the deficient practice, in particular in the Republic of Moldova, of placing persons with psychosocial disabilities in metal health institutions in the absence of any therapeutic purpose*" (paragraph 136). The court was also troubled at the absence of any consideration of the applicant's views. In the absence of safeguards against an unlimited hospital stay, the applicant had been made to stay there for a further four months despite there being no medical need for him to be there. The court held that all of these aspects together with his transfer to the adult's section, his being subjected to what amounted to chemical restraint, and the material conditions there, constituted violations of Article 3 ECHR.

Importantly, the court also went on to consider the position by reference to Article 14 read together with Article 3. It noted that:

> *173. Turning to the circumstances of the present case, the Court observes that various authorities - the school administration, the Nisporeni doctor, the legal guardian, the child protection authority and the hospital doctors - all with statutory duties of care towards the applicant, unanimously agreed to his placement in a psychiatric hospital and psychiatric treatment in the absence of any therapeutic purpose, as already found above by the Court. Administrative and medical admission documents consistently referred to the applicant's intellectual disability as ground for placement in a psychiatric hospital and psychiatric treatment, which attests to the authorities' perception that an intellectual disability was a mental disorder which required treatment. This "defectology" approach is further confirmed by the way the authorities subsequently argued, on the basis of new assessments, that the applicant was "normal" and therefore should not have been subjected to placement in a psychiatric hospital and psychiatric treatment (see paragraph 35 above).*
>
> *174. The Court also notes that the prosecutor agreed with the applicant that his placement in a psychiatric hospital had been related to the absence of alternative care options. However, the investigators never went further to identify the underlying discriminatory reasons for the applicant's placement in a psychiatric hospital. Moreover, the Court observes that the domestic investigations relied significantly on the absence of quantifiable traumatic consequences for the applicant (see paragraphs 38, 48-49 and 117 above), thus failing to properly factor in his vulnerability due to his intellectual disability when interpreting his perception of what he had experienced. The authorities' failure to attempt to correct such inequality through different treatment was also discriminatory.*
>
> *175. In the Court's opinion, the combination of the factors above clearly demonstrates that the authorities'*

> *actions were not simply an isolated failure to protect the applicant's physical integrity and dignity, but in fact perpetuated a discriminatory practice in respect of the applicant as a person and, particularly, as a child with an actual or perceived intellectual disability. The applicant's social status as a child without parental care only exacerbated his vulnerability.* (emphasis added)

It is perhaps worth noting that the applicant did not raise any specific issue under Article 5 ECHR, although, given the tenor of the balance of the judgment, one would expect that, had he done so, the court would have been likely to have found that he was unlawfully deprived of his liberty as well.

Comment

It is important to note that the ECtHR went perhaps further than it has done previously in terms of its observations about the acceptability or otherwise of compulsory placement and treatment. At paragraph 98 it noted that:

> [t]*he legal instruments and reports adopted by the United Nations indicate that forced placement in a psychiatric hospital and psychiatric treatment, especially in respect of persons with existent or perceived intellectual disability, as well as administration of neuroleptics without medical necessity may amount to ill-treatment prohibited under the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment."*

However, and in line with its previous jurisprudence, it did not rule out that compulsory admission or compulsory treatment could, in principle, be acceptable if there was a proper therapeutic basis. Nor, given its framing of the applicant's ability to express his views, can the case necessarily be said to shed any direct light on the approach to be taken where a person lacks the mental capacity (to use the English law term) to make decisions about admission and treatment. Nonetheless, it is relatively easy to see that the time is coming when the court may well determine that compulsory admission and treatment in the face of a person's capacitous refusal is simply not allowed under the ECHR.

Whilst grounded in the factual situation of Moldova, the observations of the European Court are of wider importance, both as regards its clear statement that intellectual disability itself cannot justify detention in a psychiatric hospital, and also as regards the "calling out" of the discrimination against those with actual or perceived intellectual disabilities. Translated to the United Kingdom context, the observations undoubtedly raise the stakes (yet) higher for the legal frameworks which allow for detention in psychiatric hospital on the basis of intellectual disability. And any suggestion that discrimination is something which is only a problem for other countries would be entirely hollow, not least in light of the recent report of the UN CRPD Committee on its follow-up to the inquiry concerning the United Kingdom of Great Britain and Northern Ireland.

Children's participation in decisions about their health

A new guide from the Council of Europe provides practical guidance for health professionals about involving children aged under 18 in decisions about their health, which is also of relevance to legal professionals. In addition to familiar principles such as the need for transparency and respect, the guidance says that the involvement of children is a continuous process of co-production, and that professionals should have training to facilitate meaningful participation by children, and that following their participation, children must be provided with feedback about

how their views have been interpreted and used and how they have influenced any outcomes. There is information and practical advice about how best to carry out conversations with children and their parents, noting that "Research on interactions during paediatric consultations has suggested that children's contribution to the interaction with the doctor tends to be inversely proportionate to the contribution of the parent(s)." Materials from other countries are linked to as examples of good practice – including strategies for reducing the need for physical restraint.

New Zealand capacity legislation reform – next steps

Te Aka Matua o te Ture | the Law Commission of New Zealand has published the Second Issues Paper in its review of the law relating to adult decision-making capacity.

It focuses on the Protection of Personal and Property Rights Act 1988, New Zealand's legislation which provides for (inter alia) court-appointed representatives and enduring powers of attorney. Whilst the whole paper makes very interesting reading, of particular interest to readers outside New Zealand is likely to be the discussion of the concept of decision-making capacity in Chapter 7.

The Law Commission has also published four Key Topic documents. These are short, plain-language summaries of a few of the most important topics in the Second Issues Paper and are available in many accessible formats and in te reo Māori.

IRELAND

Proposed Adult Safeguarding Legislation[5]

On 17 April 2024, the Law Reform Commission published four volumes of a report on a regulatory framework for adult safeguarding. The Law Reform Commission report has recommended that adult safeguarding legislation should be introduced in Ireland. The proposed legislation would apply to adults at risk of harm who may be defined as adults who, by reason of their physical or mental condition, other personal characteristics, or family life circumstances, need support to protect themselves from harm at a particular time.

Guiding Principles

Echoing the approach of the Assisted Decision-Making Act, the proposal would include guiding principles underpinning adult safeguarding legislation, which would propose a rights-based approach. It would also include a presumption of capacity, decision support, informed consent, a respect for autonomy, provision for independent advocacy, respect for personal preferences, a right of explanation, and a right to consultation. It is also recommended that when granting any order, a court adopts the least restrictive method possible to achieve the objective.

A National Safeguarding Body

The proposed adult safeguarding legislation will provide for the establishment of a safeguarding body. This body would be tasked with receiving

[5] Editorial note – the Irish Law Reform Commission report discussed by Emma here makes fascinating reading for readers in England & Wales in terms of an outside perspective on safeguarding in this jurisdiction, given that the Law Reform Commission uses the English & Welsh legislation as a comparator on multiple occasions (and also makes interesting observations about the operation of the inherent jurisdiction to safeguard capacitous but vulnerable adults).

reports of harm and would be given the power to take whatever action it deems necessary to safeguard an at-risk adult where it believes there is a risk to the health, safety, or welfare of an at-risk adult. This may include interventions under the adult safeguarding legislation, reports to professional regulatory bodies, applications under the Assisted Decision-Making Act, and the preparation of a safeguarding plan.

The Law Reform Commission proposes that the adult safeguarding body may be introduced as an independent statutory body or as a statutory body within an existing agency, for example, the HSE. Although it is recommended that the body should, insofar as is practicable, operate independently from the HSE's social care division. It is recommended that an existing regulator or a joint inspection model of multiple existing regulators should have the functions to regulate the social work-led adult safeguarding services provided by the safeguarding body.

Safeguarding Statement and Risk Assessment

The proposed legislation would oblige service providers to undertake and document a risk assessment, and prepare an adult safeguarding statement. This statement would need to specify the policies, procedures, and measures in place to manage the risks. It is proposed that HIQA and the Mental Health Commission would oversee compliance with these measures. A two-stage procedure involving a warning notice and a non-compliance notice would be introduced in relation to failures to comply with these obligations. The process would culminate with a non-compliance notice being served on the service provider, which would be payable to the district court within 21 days. A register of non-compliance would be created.

Independent Advocacy

The Law Reform Commission recommends that the government treat the provision of independent advocacy across all care settings consistently. It's recommended that certain legislation should be amended to facilitate adults' access to independent advocacy services. The proposed legislation would introduce a duty on the safeguarding body to facilitate access to independent advocacy services for adults who are at risk. The duty to facilitate access would be required where the adult may experience significant challenges in understanding, retaining, weighing or using, or communicating information. It's also recommended that the government should consider whether regulation of independent advocates or their services is required, and it is proposed that the safeguarding body would publish a code of practice for independent advocates.

Mandatory Reporting

The Law Reform Commission recommends against the introduction of universal mandatory reporting in the adult safeguarding context. The commission recommends that the scope of offences for which it is an offence to withhold information in relation to a vulnerable person be broadened to include coercion, endangerment, intentional reckless abuse, exposure to risk or serious harm, coercive control, or coercive exploitation. The commission recommends that the list of notifiable incidents under the Health Act be broadened to include financial coercion, patterns of neglect, and psychological emotional abuse. It's also recommended that the number of incidents that is notifiable to the Inspector of Mental Health Services be broadened to include unexpected death, serious injury, unexplained absence, amongst others.

The proposed legislation would include a list of mandated persons who are required to report if they know, believe, or have reasonable grounds

to suspect, based on information that they have received during the course of their employment, that an at-risk adult has been harmed, is being harmed, or is at risk of being harmed, as soon as practicable, that knowledge, belief, or suspicion, to the safeguarding body. Reportable harm in this context would mean the assault, ill-treatment or neglect of a manner that seriously affects or is likely to seriously affect the health, safety, or welfare of a person, sexual abuse, serious loss of, or damage to, property by theft, fraud, deception, or course of exploitation. The commission recommends excluding self-neglect other than where a mandated person has assessed an adult who is reasonably believed to be an adult at risk of harm as lacking capacity or has a belief based on reasonable grounds that the adult who is reasonably believed to be an adult at risk of harm lack capacity.

There are certain circumstances in which a mandated person would not be required to make a report; where the person has capacity, has stated that they don't want the suspected abuse reported, and the mandated person is of the view that they are making that decision of their own free will. The proposed types of mandated person would be the An Garda Síochána, managers of certain centres for older adults, probation officers, and safeguarding officers. A failure to make a report by a mandated person would not result in a criminal sanction. Professional mandated persons would be dealt with in accordance with their code of professional conduct and ethics, while those who are not registered professionals would be addressed by internal disciplinary procedures, notifications to HIQA and the HSE, and notification to the National Vetting Bureau of An Garda Síochána.

Powers of Entry

The commission recommends that the adult safeguarding legislation provide for authorised officers of the safeguarding body to be conferred with the power of entry to, and inspection of, a relevant premises for the purpose of assessing the health, safety, and welfare of an at-risk adult. A relevant premises would have a broad meaning of including any designated centre and a day service and a hospital, hospice, refugee accommodation service, homeless service amongst others. It is noted that the commission recommends that this power of entry and inspection would exclude any part of a relevant premises that is occupied as a dwelling (note: dwelling are dealt with elsewhere). The commission recommends that an authorised officer of the safeguarding body should not be able to enter or inspect any part of a relevant premises that is occupied as a dwelling other than with the consent of the occupier or in accordance with a warrant or other legal power of entry. The proposed legislation would contain a provision that the authorised officer may be accompanied by police where they have been prevented from entering the premises or there is a reasonable belief that they will be.

Warrant for Entry

The commission recommends that the safeguarding body's authorised officer should be able to make an application to the district court for a warrant where the authorised officer has been prevented from entering a relevant premises or has a belief that there is a likelihood that they will be prevented from entering the relevant premises.

Objection by the at-risk adult

The proposed legislation would include an appropriately qualified health professional or social care professional right to conduct a private interview with and a preliminary medical examination of an at-risk adult in a relevant premises. This power would not be exercisable if the at-risk adult objects, and they must have this

right of objection explained to them in advance. The registration would allow the authorised officer to remove documents, records, computers, interview any person working at the premises, or any person in receipt of services at the premises who consented to interview.

Information for the at-risk-adult

The commission recommends that the legislation should provide that a notice in plain English be provided to the at-risk adult to whom access is sought, explaining the nature of the warrant or power being exercised and the process involved. When exercising any power of entry to a relevant premises, the authorised officer should, insofar as is practicable, explain to the schedule the nature and purpose of the power they are authorised to exercise.

Reasonable Force

The district court would be granted the power to issue a warrant allowing for the use of reasonable force if necessary by an authorised officer or member of An Garda Síochána to gain access to a relevant premises.

Offence of Obstruction

The legislation would make it an offence for a staff member, service provider, or other person to refuse to allow entry, obstruct or impede the authorised officer carrying out their functions, or giving information which they know or should know to be false or misleading. Such an offence would be liable on summary conviction to a €5,000 fine or a term of imprisonment not exceeding 12 months, or on conviction on indictment a fine not exceeding €70,000 or imprisonment for a term not exceeding two years or both.

Access to Private Dwellings

It is proposed that the legislation would also provide a new power of access to at-risk adults in places including private dwellings, for the purpose of assessing the health, safety, or welfare of an at-risk adult. The power of access would be exercised on foot of a warrant issued by the district court. An application for a warrant would be capable of being made by either the authorised officer of the safeguarding body or a member of the police. Such a warrant could be sought on the basis of a reasonable belief that an at-risk adult is in place, there is a risk to their health, safety, or welfare, the warrant is necessary to assess the health, safety, and welfare of the adult and access cannot be gained by less intrusive means.

Summary Powers of Access

The commission also recommends that a member of An Garda Síochána would have a summary power of access whereby they can enter a place including a private dwelling without a warrant where they have a reasonable belief that an adult is at risk in that place, there is an immediate risk to the life and limb of the adult at risk, and the risk is so immediate that the place must be accessed so urgently that there is insufficient time to apply for a warrant for access. Where a summary power of access is exercised, An Garda Síochána would have to notify the safeguarding body in writing as to the use of the power. Details of the use of the power also need to be uploaded to the PULSE database.

Removal and Transfer Order

The commission recommends that there be a removal and transfer order that would permit the removal of a person who is reasonably believed to be an at-risk adult to a designated health or social care facility or other suitable place to allow assessment of their health, safety, and welfare, and assessment whether any actions are needed in respect of them, where this cannot be done in

the place where the adult is currently located. This would allow An Garda Síochána, accompanied by an authorised officer of the safeguarding body, together with qualified health or social care professionals to enter a place where an at-risk adult is believed to be including a private dwelling, remove the at-risk adult, and transfer them to that place specified in the court's order.

Either an authorised officer of the safeguarding body or An Garda Síochána must have a belief that there is a serious and immediate risk to the health, safety, or welfare of the at-risk adult. The application for a removal and transfer order would have to be grounded on an affidavit sworn by a health or social care professional. The applicant would have to make reasonable efforts to ascertain the views of the at-risk adult and consider those in deciding whether to make a removal and transfer order application. The evidence as to their views or the attempts to ascertain their views must be provided to the district court, including the use of any support such as speech and language therapist or independent advocacy services. The district court would be obliged to enquire as to what efforts have been made to ascertain the views of the at-risk adult, and in determining any application consider any views expressed by the at-risk adult. However, the legislation is clear that a removal and transfer order may be sought and granted against the views or wishes of an at-risk adult, but this is limited to where there's a reasonable belief that the at-risk adult's objection is not voluntary or that they may lack capacity to make a decision on this ground.

Upon being granted a removal and transfer order An Garda Síochána would be entitled to take all reasonable measures necessary for the removal of the at-risk adult including the use of reasonable force. There's an obligation on the executing person to explain to the at-risk adult the nature and purpose of the order and that upon arrival at the transfer location the at-risk adult may choose to leave and will be facilitated in doing so. If the at-risk adult chooses to leave the transfer location the relevant professionals would be obliged under the legislation to support them in doing so, and the removal and transfer order would be considered discharged. It is not proposed that the legislation would contain any summary power of removal and transfer, and the removal and transfer order would not allow for the detention of the at-risk adult other than during their removal and transfer to the designated centre.

No-Contact Orders

The commission recommends that the Domestic Relations Act 2018 be broadened to include individuals of full age who cohabit with an at-risk adult on a non-contractual basis and a contractual basis where care is being provided to the at-risk adult. The commission also recommends that an adult safeguarding no-contact order should be provided for in the legislation which would prohibit a non-intimate and non-cohabiting third party from engaging in actions such as following, watching, pestering the at-risk person including at the place they reside.

Similar to other provisions the views of the at-risk adult must be sought before applying for a no-contact order. The registration would also mandate that the District Court enquires whether reasonable efforts have been made to ascertain the views of the at-risk adult, and in determining whether to grant any such order have regard to the views of the at-risk adult. It is recommended that the legislation should provide that a no-contact order cannot be made or granted where the at-risk adult objects to the order. An adult safeguarding no-contact order would be made *inter partes*.

The threshold for granting a no-contact order would be that the court is satisfied that there are reasonable grounds for believing that the health, safety, or welfare of the at-risk adult requires it. The maximum period of validity of such an order would be two years. Wilful non-compliance with the terms of a no-contact order would be a criminal offence capable of being tried summarily or on indictment. However, there would be no legal sanction imposed on the at-risk adult if they choose to engage with the person against whom the order is made.

Interim No-Contact Order

The commission recommends that an interim no-contact order or an emergency no-contact order should be provided for. Either party, or the authorised officer of the safeguarding body would be entitled to make an application for an interim adult safeguarding no-contact order. Such an order would be valid for a maximum of eight working days if granted on an *ex parte* basis. Unlike the full order, an interim order may be granted against the wishes of the at-risk adult. The threshold for granting an emergency or interim adult safeguarding no-contact order would be that there are reasonable grounds for believing that there is an immediate risk to the health, safety, or welfare of the adult and a no-contact order is required to address or mitigate that risk, or to assess the voluntariness of the at-risk adult's objection to the making of the contact order and where necessary to facilitate a capacity assessment. If the emergency order is sought in the context of an objection by the at-risk adult, the district court must also be satisfied that there is reasonable ground for believing that the apparent objection of the at-risk adult is not voluntary, or that the at-risk adult lacks the capacity to decide whether to continue to have contact with the intended respondent to the emergency no-contact order.

Financial Abuse

The commission recommends that the Central Bank Reform Act regulations be amended to provide for obligations on regulated financial service providers to prevent and address actual or suspected financial abuse of at-risk customers. Regulated financial service providers would be obliged to ensure that their staff receive regular adult safeguarding awareness training. It is recommended that regulated financial service providers be given the power to temporarily suspend the completion of a financial transaction where there is knowledge or reasonable belief that an at-risk customer is being, has been, or is likely to be subjected to financial abuse. This would involve immunity where that action is taken in good faith to safeguard an at-risk customer. The safeguarding body would be entitled to receive and respond to reports of actual or suspected abuse or neglect of at-risk adults which would include suspected or actual financial abuse.

Adult Safeguarding Reviews

The commission recommends the introduction of adult safeguarding reviews to review serious incidents that reach a high threshold. The aim of such reviews would not be to attribute blame but to identify changes that can be made to improve the quality and safety of services. Such a review would be required when an at-risk adult dies, and abuse or neglect is known or suspected to be a factor in their death, or where an at-risk adult is known or suspected to have experienced or is experiencing serious abuse or neglect, or where an incident or series of incidents suggest that there have been serious and significant failings on behalf of one or more agencies, organisations, or individuals in the care and protection of that at-risk adult.

Regulation of Healthcare Assistants

The commission recommends that healthcare assistants and healthcare support assistants

should be regulated to ensure the protection of the public and other such goals. It's recommended that post-conviction prohibition orders should be introduced to prohibit persons who have been convicted of offences under the adult safeguarding legislation or assisted decision-making legislation, or whose victims were at-risk, from engaging in work or activities where they would have access to or contact with adults.

Criminal Offences

The commission recommends that a broad issue, neglect or ill-treatment defence should be included in the legislation, along with an offence of exposure of a relevant person to the risk of serious harm or sexual abuse. The commission recommends that a new offence of coercive control of a relevant person would be enacted which would apply to a broader range of relationships than in the existing Domestic Violence Act. It would apply to all persons in a familial, caring, or cohabiting relationship with the person. An offence of coercive exploitation should criminalise the actions of a person who, without reasonable excuse, engages in controlling or coercive behaviour in relation to a relevant person for the purpose of obtaining or exercising control over any of the property or financial resources of the person in order to gain a benefit or advantage, whether for themselves or a third party. It would be irrelevant whether there was any actual gain, benefit, or advantage and it will not be a defence to prove that the person had the consent or acquiescence of the relevant person. If found guilty of such an offence, the court may make a publicity order.

Next Steps

Along with the Report, the Law Reform Commission have drafted a proposed Adult Safeguarding Bill 2024. This will now be considered by the Government.

More information and access to all of the reports, summaries, draft Bills, and a short overview can be found here.

Emma Slattery BL

SCOTLAND

Release on licence conditions challenged

AB sought judicial review of the imposition of certain conditions upon his release from prison by the Scottish Ministers. The conditions had been imposed in accordance with the Prisoners and Criminal Proceedings (Scotland) Act 1993 ("the 1993 Act"), section 12, upon the recommendation of the Parole Board for Scotland. The main relevance to this Report are questions about whether provisions of the Mental Health (Care and Treatment) (Scotland) Act 2003 ("the 2003 Act") would have achieved the desired outcome and should have been preferred, and various grounds of challenge with reference to the European Convention on Human Rights, among other factors considered by Lord Lake in his decision issued on 14th March 2024 ([2024] CSOH 30, Case Reference P512/23). The circumstances were described by Lord Lake at the outset of his judgment:

> *"[1] AB was formerly a prisoner in HMP Edinburgh. He was convicted of two charges of rape at common law and two charges of contravention of the Criminal Law (Consolidation) (Scotland) Act 1995, section 6 (lewd, indecent or libidinous conduct to a girl between the ages of 12 and 16). His victims were his daughter and a friend of hers. The offending went on for an extended period. The victims were aged 13 to 15 at the time.*
>
> *"[2] He was sentenced to imprisonment for a term of 16 years but, on appeal, this was reduced to 12 years. In terms of the sentencing regime that applied to him, he was entitled to automatic release on licence on 22 March 2023. …"*

Lord Lake noted it as relevant that AB "continued to deny his guilt throughout his prison sentence and continues to do so. This meant that while he was in prison, he did not engage in work to address the risk of him committing further sexual offences and prior to his release it had not been possible for him to engage in unescorted community testing." Later in the judgment, it was noted that in view of his denial of guilt he had not engaged in any offence-focused work during his sentence, that in consequence there was only limited insight into the triggers and motivations that caused him to offend, and his ability to desist from further offending was untested.

The challenged licence conditions included condition 12, which stated:

> "*Mental health*
>
> *"12. You shall undertake an assessment by community mental health services, and cooperate with services after this, all as directed by your supervising officer;"*

AB's challenges included that the effect of condition 12 was to subject him to compulsory mental health care which should only be done under the provisions of the 2003 Act, and that it was improper to use the provisions of the 1993 Act to seek to achieve the same result, because that denied AB the safeguards contained in the 2003 Act. This, and other findings in the decision, founded on the underlying point that there is a very material difference between the requirement that prisoners released on licence require to be managed to mitigate the risk that they may present to the public at large that they will re-offend, which does not apply to relevant provisions of the 2003 Act. The assessment required by condition 12 was for the purposes of the 1993 Act, and Lord Lake was unable to identify any basis upon which assessment could have been enforced under provisions of the 2003 Act.

Among other conditions, and challenges to them, AB asserted that "park" and "associations" were too imprecise in the following conditions:

> *"17 You shall not enter parks, playgrounds or any other places where children who you know to be, or should have reasonable cause to believe to be under the age of 18 years are likely to be, or might reasonably expect them to be, without the prior approval of your supervising officer and subject to any restrictions that officer may impose, and shall immediately report any unavoidable or inadvertent entry to that officer;*
>
> *"20 You shall:*
>
> *a) immediately inform your supervising officer of any friendships, associations, or intimate or domestic relationships that you enter into, with anyone;"*

Lord Lake considered contrasting decisions about the test of enforceability in the English cases of *Kruse v Johnson* [1898] 2 QB 91 and *Percy v Hall* [1997] QB 924. He followed Lord Pentland in *B v Parole Board for Scotland* 2020 SLT 975 in favouring the latter, in which Simon Brown LJ said:

> *"A provision should only be struck down on the ground of uncertainty in the rare case where it can be given no sensible and practicable meaning in the particular circumstances of the case."*

Lord Lake held that both challenged words were ordinary words with readily understood meanings; and that the issue should not be tested "by hypothetical situations". In reality, it had been submitted for the respondents that if there really was ambiguity, AB could seek clarification from his supervising officer.

Lord Lake quoted various precedents on challenges by reference to Article 5 of ECHR. He concluded that Article 5(4) does not apply to a decision to recall a prisoner on a determinate sentence, therefore it could not apply to imposition of a condition which, if breached, would result in such recall. Article 8 was not breached either on grounds of certainty, as identified above, or proportionality, as it was clear from the evidence that the purpose of the conditions was to manage safely such risk as AB might present to the community. The objective being public protection, Article 8 was not breached.

He also took the view that the conditions imposed did not give rise to a deprivation of liberty, observing that ""The level of freedom the petitioner retains as to how he wishes to conduct his daily life cannot be seen as a deprivation of liberty."

As regards Article 14, AB cited as the comparator group prisoners who had their mental health needs addressed and met under the 2003 Act. While the comparator group need not be identical, Lord Lake held that in AB's situation there was "a very material difference", namely the same difference as identified above between the requirement to manage to mitigate risk of re-offending in the case of prisoners released on licence, which does not apply to the comparator group.

For other grounds of challenge and how they were addressed, see Lord Lake's judgment. He refused the petition.

Adrian D Ward

Executor *qua* attorney – a few steps back?

In the October 2023 Report, we commended the decision by Sheriff Mann in the case of *Gordon Petitioner* 2023 SLT (Sh Ct) 187 putting an end to the strange situation that while a guardian

appointed by a court could take up the office of executor in place of an executor nominate who has lost sufficient capacity to act as such, existing authority up until then had held that an attorney appointed by the executor nominate could not do so. Three cheers to welcome that modernising decision may require to be reduced to one in light of an ensuing decision on 4th January 2024 by Sheriff P Paterson in Petition of Joy Monique Cornforth and Andrew Cornforth, [2024] SC SEL 8.

Having considered Sheriff Mann's decision in *Gordon*, Sheriff Paterson asked to be addressed further on a point that troubled him, namely "*the proposition that an appointment as executor is a personal one and accordingly it is not possible for an executor to delegate the legal duties incumbent on an executor under a POA – Currie 8-32.*" It was not clear to him *"how an adult granting a POA could grant their attorney a power, which they themselves did not possess i.e. the power to delegate the legal duties of an executor to themselves as attorneys."* He was addressed on the point by RAS MacLeod, Advocate, who provided a commentary on the decision in *Gordon* which I commended in the October 2023 Report.

The positive outcome is that Sheriff Paterson was prepared to grant the petition on the basis of each of two considerations. The first was Mr MacLeod's argument that, in the sheriff's words, *"the POA does not amount to a delegation of trust."* The general management powers in the POA conferred on the attorney *"full power for me and in my name"*. Sheriff Paterson was therefore willing to hold that there was no delegation of the duty of executor, but rather that the attorney would simply be acting in the name of the executor. He commented that *"It may be legitimately said that this is stretching a point in that the attorney is acting in the name of someone who does not have capacity. However, as it does not directly offend against the principle of non-delegation of the legal duties I am prepared to grant the petition on this basis."*

The other submission which persuaded Sheriff Paterson was that the deceased's Will allowed for the appointment of substitute executors. This suggested to the sheriff that the intention of the deceased was that there was no *delectus persona* attached to the nomination of the deceased's wife. Therefore there was no bar to the delegation of the duties of executor.

Sheriff Paterson rejected arguments that as the wife had not expeded (the decision has "expended") Confirmation there was no delegation of trust by her *qua* trustee; that the attorney's duties required the attorney to act, given that the wife was the universal legatee of her late husband; and that the power of attorney reflected the wishes of the wife and as such should be respected (the judgment has "reflected"). The first two were rejected on the grounds that if powers could not be delegated after Confirmation, then the sheriff could *"see no a priori reason why the position should be any different prior to confirmation"*; and because the second *"still involves a delegation of duties which crosses a 'red line' according to the authorities."* The sheriff rejected the third because he considered that although section 1 requires adoption of the least restrictive option, that could not mean an option which in the sheriff's view was unavailable.

One does not know from the relatively short judgment what were the full submissions by Mr MacLeod. What can be predicted is that there are likely to be further cases where sheriffs may ask to be addressed before deciding whether to accept or reject a similar application. Resolution of the matter by an Appeal Court would be helpful, provided that all relevant arguments are canvassed, starting with the obvious one that the granter of a power of attorney does not in these

circumstances delegate. The granter empowers the attorney to do certain things, including to apply for Confirmation, just as under Council of Europe CM/Rec. (2009)11, Principle 14, a person may in advance give directions as to choice of guardian, should one be appointed. It would be odd if nominating a guardian who could apply for Confirmation as executor should be competent, but appointing an attorney to make the same application should not be.

It could be argued that this is more than odd. It would violate rights under ECHR and the UN Convention on the Rights of Persons with Disabilities, the first incorporated into Scots law and the second proposed to be so incorporated, and in the meantime applicable through ratification by the UK. Any flavour of revival of the long-discredited view that some degree of impairment of faculties causes a person to be discriminatorily labelled "incapax" and deprived of full status "on an equal basis with others", and disqualified from making effective provision for such a situation, is arguably a violation collectively of Article 8 of ECHR, discriminatory in that regard under Article 14, and a violation of the requirements of Article 12 of the Disability Convention for equal recognition before the law, the retention of "legal capacity on an equal basis with others in all aspects of life", the obligation on states to ensure provision of support that may be required to exercise capacity, and effective safeguarding of respect for the person's will and preferences. This is not a matter of delegation, but of effective safeguarding of the wife's right (not in any way lost through any impairments of capabilities) to use an available mechanism to overcome the consequences of her disability. As was pointed out in the Three Jurisdictions Report support for the exercise of legal capacity may go beyond supporting people to act for themselves, to other forms of support for people who are incapable themselves of acting or deciding in any particular matter, even when all means of support have been provided. In the Three Jurisdictions Report this was formulated in the question: "What measures should be taken to support the exercise of legal capacity, both by supporting persons with disabilities to make decisions themselves wherever possible, and by supporting their ability to exercise their legal agency even in circumstances when they lack the ability to make the requisite decisions themselves?" (Three Jurisdictions Report, pages 13 and 14).

Adrian D Ward

Scotland: a human rights blackspot

It is anticipated that on 10 May 2024 Scots Law Times will publish the first instalment of Adrian's three-part article entitled 'Scotland in 2024: a human rights blackspot'. It illustrates that theme with discussion and commentary on various cases in Scotland, England and Ireland which have been described in the Report in recent months, and current themes of review and discussion including the definition of 'mental disorder' in Scots law, and a suggested interpretation of 'unsound mind' in Article 5.4 of the European Convention, having regard to the versions in both English and French of the Convention, which have equal status."

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

Arianna Kelly: Arianna.kelly@39essex.com

Arianna practices in mental capacity, community care, mental health law and inquests. Arianna acts in a range of Court of Protection matters including welfare, property and affairs, serious medical treatment and in inherent jurisdiction matters. Arianna works extensively in the field of community care. She is a contributor to Court of Protection Practice (LexisNexis). To view a full CV, click here.

Nicola Kohn: nicola.kohn@39essex.com

Nicola appears regularly in the Court of Protection in health and welfare matters. She is frequently instructed by the Official Solicitor as well as by local authorities, CCGs and care homes. She is a contributor to the 5th edition of the *Assessment of Mental Capacity: A Practical Guide for Doctors and Lawyers* (BMA/Law Society 2019). To view full CV click here.

Katie Scott: katie.scott@39essex.com

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

Nyasha Weinberg: Nyasha.Weinberg@39essex.com

Nyasha has a practice across public and private law, has appeared in the Court of Protection and has a particular interest in health and human rights issues. To view a full CV, click here

Simon Edwards: simon.edwards@39essex.com

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

Scotland editors

Adrian Ward: adrian@adward.co.uk

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

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

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

Conferences

Members of the Court of Protection team 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:

1. Adults with Incapacity at the Horizon Hotel, Ayr on 22 May 2024, organised by Ayr Faculty (contact Claire Currie claire@1stlegal.co.uk)
2. Adults with Incapacity Conference in Glasgow on 10 June 2024, organised by Legal Services Agency (contact SusanBell@lsa.org.uk)
3. The World Congress on Adult Support and Care in Buenos Aires (August 27-30, 2024, details here)
4. The European Law Institute Annual Conference in Dublin (10 October, details here).

Advertising conferences and training events

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

Our next edition will be out in June. 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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