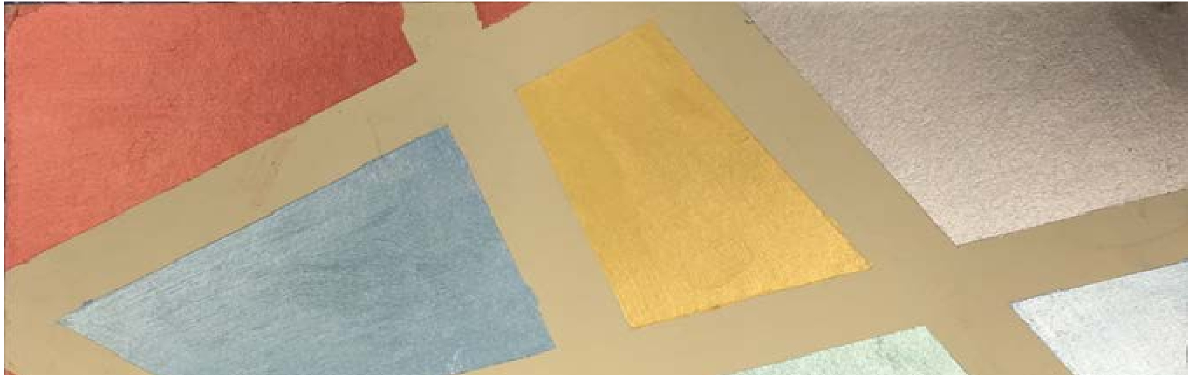

Welcome to the May 2024 Mental Capacity Report. Highlights this month include:

(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.

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

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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 <u>not sufficient</u> 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 Wolff 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.[1] 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 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.

[1] 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.

> *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 Ciutești. 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[2]

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

[2] 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).

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 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

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Conferences

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

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

Adrian will be speaking at the following open events:

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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