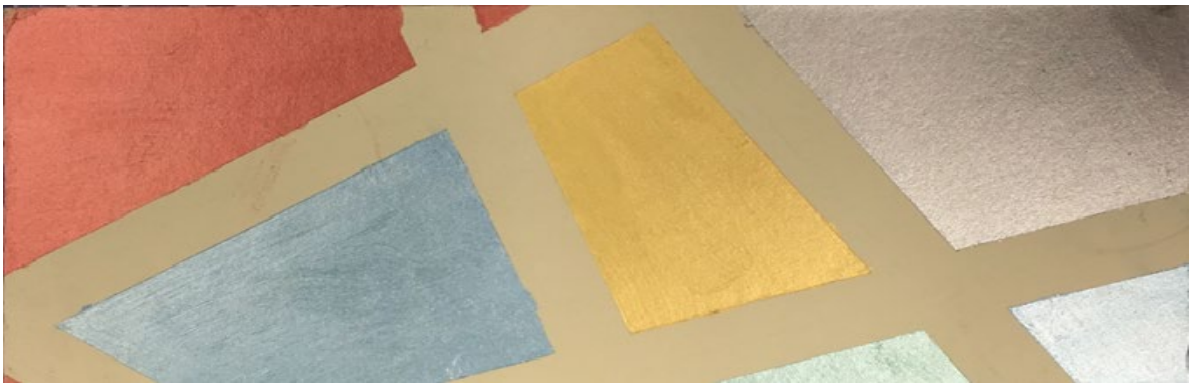

Welcome to the March 2025 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: insight into the proper place of insight, best interests decision-making and good clinical governance, and anorexia and the changing calculus of decision-making;

(2) In the Property and Affairs Report: the Court of Protection's (international) jurisdiction over children;

(3) In the Practice and Procedure Report: fees changes relating to the Court of Protection and the OPG guidance on disclosing visitors' reports;

(4) In the Mental Health Matters Report: the Mental Health Bill progresses and the independent investigation into the care and treatment of Valdo Calocane;

(5) In the Children's Capacity Report: why the report is named as it is, the Court of Appeal confirms that local authorities cannot consent to the confinement of children in care, and guidance for judges writing to children;

(6) In the Wider Context Report: the updated Code of Practice on diagnosing death and restraint in Northern Ireland.

(7) In the Scotland Report: no hard news, but the way ahead for AWI reform becomes clearer, and unhelpful uncertainty about powers of attorney.

The progress of the Terminally Ill Adults (End of Life) Bill can be followed on Alex's resources page here.

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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HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

Capacity, insight and professional cultures

CT v London Borough of Lambeth & Anor [2025] EWCOP 6 (T3) (Theis J)

Mental capacity – assessing capacity

Summary[1]

This case is in many ways the companion piece to *Re Thirumalesh (Dec'd)* [2024] EWCA Civ 896). In that earlier case, the Court of Appeal made clear that the fact that a person appeared not to believe information that they were being told could not be used as a shortcut to reach the conclusion that they lacked capacity to make the relevant decision. In *CT*, Theis J has made clear that the same applies in relation to insight. At first instance, HHJ Beckley had concluded that

[1] Neil having been involved in the case, he has not contributed to this.

CT

> *25.* […] *cannot use or weigh 'the fact that he has mental impairments and that these lead to specific care needs and impact on his wider decision-making ability' [33], 'his own impulsivity, lack of planning ability and lack of foresight when he is making decisions about his care needs' [34], 'the knowledge of his mental impairments' [35], 'the impact of [CT's] mental impairment [39], that CT is unaware that the impact of his mental impairment 'leads to a lack of foresight when weighing the consequences of refusing treatment' [40] and 'on his impulsivity means he is unable to weigh that impulsivity when making decisions' [40], the inability to weigh the likely outcome of the refusal of care [43] and the impact that 'his mental impairment has on his acceptance of care provision explains the history of admission to and self-discharge from previous placements' [45].*

On appeal, Theis J accepted the submissions of the Official Solicitor in relation to the first ground of her appeal on behalf of CT:

> *53.* […] *that the Judge fell into error when he set the bar too high in considering the relevant information for CT on the facts of this case, in particular that CT's mental impairments are relevant information that he needs to understand and use and weigh.*
>
> *54. The course taken by the Judge conflates the two stage test set out in JB and creates a circular approach that risks leading to the inevitable conclusion that those who have a mental impairment lack capacity. Such an approach undermines the principles and safeguards in the MCA 2005.*
>
> *55. What is required is a careful delineation of the relevant information, relevant to the particular case in question, and then an assessment, in accordance with the statutory framework, whether the individual can understand, retain, use/weigh that relevant information and communicate the decision. It is only when that process concludes that the individual is unable to make a decision within that statutory framework that the court then has to consider whether the inability is 'because of, an impairment of, or a disturbance in the functioning of, the mind or brain'. In the Judge's judgment that important delineation was not present or clear.*

The Official Solicitor also appealed on the basis that:

> *39.* […] *the intention of the MCA 2005, as explained in the JB case, is to focus on the functional assessment in the first instance, without considering the individual's mental impairment. This is an important safeguard for those with mental impairments. The Judge's approach in this case of including in the list of relevant information insight into mental impairment had the effect that he did not conduct the functional test in accordance with the MCA 2005, separately as set out by Lord Stephens in JB. Ms Bicarregui submits the Judge's approach in the judgment had the effect of conflating and blurring the two stage test. There was no effective analysis of the relevant information, the Judge's assessment of whether CT could use or weigh the information or engage with the differences in outcome between the assessments undertaken by the social workers and the clinicians. It is submitted the judge erred in carrying out the functional test with reference to CT's mental impairment and in not resolving the key evidential dispute regarding the functional test with those who had assessed CT's capacity.*

> *40. The focus of the third ground of appeal is that assessments of capacity are time and decision specific. The assessments of the clinicians that CT lacked capacity dated from CT's time in hospital, around the time the proceedings were started. The more recent assessments considered CT had capacity. It is submitted whilst this difference is referred to by the Judge at paragraphs [20] and [22], he does not explain why the more recent assessments should not be preferred.*

Although not necessary for the purposes of the outcome of the appeal, Theis J also accepted that both of these grounds were made out:

> *57. The two stage test in JB is clear. The approach in this case of including insight into his mental impairment had the effect that the Judge did not conduct the functional test in accordance with the requirements of the MCA 2005. By taking that into account the Judge conflated and risked blurring the two distinct tests. This was caused by not taking the structured approach of going through the list of information identified as being relevant, resolving the relevant issues in the written and oral evidence and setting out the Judge's assessment of whether CT can use/weigh the information. In effect, the Judge's conclusion on the first stage was determined by CT's mental impairment and not by resolving the key evidential dispute in respect of the functional test.*
>
> *58. In relation to ground three there was evidence from the social work assessments, in particular the more recent ones, that CT had capacity to take decisions about his residence and care. Whilst the Judge refers to these assessments he did not properly take into account the evidence that pointed towards CT having a better understanding that his physical state had changed progressively and had insight into his increasing frailty. Whilst it is accepted that this experienced Judge had the benefit of hearing the oral evidence it was nevertheless important that he explained why the later assessments fell into error and were not capable of being relied upon.*
>
> *59. It is a striking feature of this case that the evidential divide on capacity was largely between the clinicians and the social workers. The form used by the local authority in their capacity assessment promoted a structured approach to the assessment in accordance with the statutory framework. It identifies the decision, sets out the relevant information the person must understand, retain, use or weigh in regard to the decision, includes what has been done to enhance the capacity of the person to maximise their ability to make the decision for themselves, and then cross checks the person's ability to communicate. It then requests a summary of the options that have been discussed with the person. The form then structures each stage of the requirements in s3 MCA 2005 (understand, retain, use, weigh, communicate). In terms of structure the capacity assessment of Ms G, the allocated social worker, in May 2024 was an excellent example of providing both relevant detail at each stage, with clear reasoning to underpin conclusions. This high standard was replicated in the management scrutiny of that assessment by Ms M, the interim Team Manager. In comparison some of the assessments by the clinicians were in a less structured format. I recognise this may have been due to the particular circumstances at the time, but future assessments will benefit from more closely following the statutory framework in the way Dr M detailed in her witness statement in May 2024. As capacity assessments are time and decision specific, the relevant dates*

when the individual was assessed should always be clearly set out and borne in mind.

Counsel for CT and for Mind (who had intervened in writing) had provided checklists to assist those assessing capacity. "Whilst not wanting to add to the growing industry of checklists," Theis J "recognise[d] they may be useful and have adapted them as follows:

(1) The first three statutory principles in s 1 MCA 2005 must be applied in a non-discriminatory manner to ensure those with mental impairments are not deprived of their equal right to make decisions where they can be supported to do so.

(2) In respect of the third principle regarding unwise decisions, particular care must be taken to avoid the protection imperative and the risk of pathologising disagreements.

(3) As set out in A Local Authority v JB [2021] UKSC 52, whether the person is able to make the decisions must first be addressed. Only if it is proven that one or more of the statutory criteria are not satisfied should the assessor them proceed to consider whether such inability is because of a mental impairment.

(4) Those assessing capacity must vigilantly ensure that the assessment is evidence-based, person-centred, criteria-focussed and non-judgmental, and not made to depend, implicitly or explicitly, upon the identification of a so-called unwise outcome.

(5) Insight is a clinical concept, whereas decision making capacity is a legal concept. Capacity assessors must be aware of the conceptual distinction and that, depending on the evidence, a person may be able to make a particular decision even if they are described as lacking insight into their general condition.

(6) In some cases, a lack of insight may be relevant to, but not determinative of, whether the person has a mental impairment for the purposes of s2 MCA 2005.

(7) When assessing and determining the legal test for mental capacity, all that is required is the application of the statutory words in ss2-3 MCA 2005 without any gloss; having 'insight' into mental impairment is not part of that test.

(8) Relevant information will be different in each case but will include the nature of the decisions, the reason why the decision is needed, and the likely effects of deciding one way or another, or making no decision at all.

(9) The relevant information is to be shared with the individual and the individual should be supported to understand the relevant information. The individual is not required to identify relevant information him/herself.

(10) If a lack of insight is considered to be relevant to the assessment of capacity, the assessor must clearly record what they mean by a lack of insight in this context and how they believe it affects, or does not affect, the person's ability to make the decision as defined by the statutory criteria, for example to use/weigh relevant information.

Comment

For those wanting to think more about the apparent lack of insight of a person into their own situation, and how to translate such a situation into the language of the MCA, this may

help.

Four other observations about this case:

1. Theis J was clearly taken by the structured approach to capacity prompted by the relevant forms used by the local authority. Such a structure is undoubtedly very helpful, but it is vital that it follows the correct ordering of the capacity test – as is sadly still not often the case (a situation not helped by the fact that the Code of Practice directs people incorrectly).

2. The flashpoint in this case was around discharge from hospital (in particular in a situation where one potential option had been discharge to be street homeless). Capacity in the context of homelessness is a notoriously difficult area, not least because it is so often loaded with assumptions about individuals, and also capacity being used as a gatekeeper by organisations with stretched resources: see further here.

3. Capacity in the context of discharge from hospital is frequently a flashpoint because of (1) confusion about what decision is actually in issue (as to which, see here); and (2) because of professional cultural differences between the professions involved, of which distinct traces appear in this case. Frequently in our experience, these can be papered over by people talking about "fluctuating capacity," when the reality is that there is a disagreement about the person's capacity which requires identification and resolution.

4. We would not consider that this judgment should be taken as a general finding that a person's insight into any mental disorders is *irrelevant* to whether a person has decision-making capacity. While insight and capacity are distinct concepts, a person's ability or inability to recognise the impact of a mental impairment or illness may be relevant to their ability to keep themselves safe in a living situation, or problem-solve during times of difficulty. For example, if a person with a brain injury and executive functioning impairments is asserting that their condition does not pose challenges and will be able to look after themselves if they are street homeless, but is unable to use and weigh that they have historically not been able to cope, the person's understanding of the condition and how it impacts them may be not only relevant but central to the issue of whether the person has capacity to decide where to live. The question of what information is and is not relevant will depend on the nature of the decision to be taken, and as per *B v A Local Authority* [2019] EWCA Civ 913, a person's insight is not necessarily in a separate 'silo' to the relevant information to make a particular decision.

Consultation, (rotten) compromises and challenging complacency – Hayden J on the warpath

NHS South East London Integrated Care Board v JP & Ors [2025] EWCOP 4 T3 and [2025] EWCOP 8 (T3) (Hayden J)

Best interests – medical treatment – practice and procedure

Summary[2]

This pair of cases concern governance failures in best interests decision-making in relation to a man, JP, in a Prolonged Disorder of Consciousness. They concern the Royal Hospital for Neuro-disability, and follow other recent decisions of Theis J. For present purposes, it is the second judgment which is of most wider relevance. In it, Hayden J made a number of observations about the operation of s.4(7) MCA 2005, and of the role of ICBs in such cases.

Section 4(7) MCA

One of the issues concerning Hayden J was as to the approach that had been taken to involving JP's family and taking into account their views.

> *18. It is important to say something of the relevance and weight to be afforded to the views of family members, when evaluating best interests. Grief, which does not await death, frequently ambushes families in these challenging circumstances. Sometimes, their own sense of loss can become the prevailing emotion. This is of course entirely normal and natural. Those charged with the task of identifying what P would likely have wanted must be alert to the reality and focus of their enquiry. The views of family members, their own wishes, feelings, religious and cultural beliefs, are, in themselves, of little, if any, relevance. **I emphasise that their views are being sought solely to illuminate the likely wishes and feelings of P**. Their evidence is garnered to assert P's autonomy, not to subjugate it. This case is, as my earlier judgment seeks to demonstrate, a striking example of this point. To some extent, many of the family members here identify as Pentecostalists, certainly many have strong Christian faith. Their views, however, on these difficult ethical issues vary widely. I have placed emphasis on the evidence of those family members who have eschewed their own religious and cultural views and concentrated on the views and beliefs of JP.* (emphasis added)

In the instant case:

> *19. It is clear that the RHN recognised these different views within the family. The immediate family, to use Ms Paterson's helpful term, all held clear views that continuing treatment was entirely contrary to what JP would have found tolerable. For the reasons set out in the earlier judgment, those views were expressed cogently and were supported by substantial and choate evidence. Those family members, believing that their father was beyond any experience of his surroundings, eventually drifted away from the hospital and turned, as they had to, to their own lives and young families. VP (JP's daughter) told me, expressly, that she stopped attending the hospital with any frequency because her father was "no longer there". The wider family, perhaps in part driven by moral and religious obligation, as well as love, continued to attend. I suspect, and I say this without any criticism at all, that their views became heard most clearly and consistently. I have found that those views were not JP's.*
>
> *20. With no apology for further repetition, because the point needs to be crystal clear, the objective of the discussions with family members is **not** to ascertain their views and beliefs but to ascertain if what they have*

[2] Note, Arianna and Katie both having been involved in these cases, they have not contributed to this.

> *to say can illuminate P's wishes and beliefs. There has been some discussion as to the need to be sensitive to "the family's views". This referred to JP's sisters' and mother's strict religious beliefs. Of course, I would expect all concerned to be respectful and polite, and I have no doubt they were. However, delaying decision-making for JP in consequence of a heightened sensitivity to the religious views of some of his family would be to neglect him and to lose focus on the central question of what is in JP's best interests. The incapacitous individual, with no awareness of the outside world, is uniquely vulnerable and requires vigilantly to be protected.*
>
> *21. It was clear from Dr Hanrahan's evidence that he was convinced from the beginning, and particularly after his conversation with JP's partner, that JP would not have wished to languish as he now has done. There was strong and convincing evidence as to what JP would have wanted from the outset. I have struggled to understand why there was not a timely application to the Court. I have not discovered any satisfactory explanation. Dr Hanrahan did not seek to proffer one. It is important to say that when there is disagreement within a family as to where P's best interests lie, that is a signal to bring the matter to Court. It most certainly is not a reason to spend months or, as here, years in hand-wringing procrastination. Moreover, the divide in the family really lay between those who had drilled deeply into the beliefs and codes by which JP led his life, and those who advanced doctrinal objections. Keeping JP at the front of the process and applying the best interests test in the manner required, has, on a proper analysis, indicated throughout, that the evidence of the former is qualitatively strongest. A failure to act when confronted by a family disagreement is to elevate that dispute above the best interests of the patient. It is also necessary to say that where the focus is, as it must be, on what P would most likely have wanted, and where there is a reliable foundation (as here) to establish what those views are, it is not helpful or in P's best interests to spend months tracking down family members whose addresses are difficult to find. The exercise is a proportional one, predicated on the quality of the available evidence and the undesirability of delay.* (emphasis in the original)

The systemic problem

It is important to note that Hayden J had his attention drawn to the Parliamentary Office of Science and Technology POSTNote (July 2022) identifying that, as at that point, there were *"between 4,000 and 16,000 patients in VS in nursing homes in England and Wales, with three times as many in MCS and an unknown number of people with PDOC care in other settings."* In light of the very modest number of applications relating to PDOC patients, the Official Solicitor inferred that *"*"*there may well be significant numbers of PDOC patients in nursing homes across England and Wales in respect of whom a full consideration of their best interests has not taken place and that the delays seen in this case may well be far from unique to the RHN*." Further, Hayden J endorsed the observations that

> *that the relatively early discharge of PDOC patients from both an acute hospital or a brain rehabilitation service to a General Practitioner or nurse led community-based service may be a significant feature. As Ms Paterson says, the reality is that P is moved from an environment in which they have been reviewed regularly by a clinician with specialist knowledge (e.g. neurology or neuro-rehabilitation) to an environment in which medical reviews are performed by a General Practitioner review most*

frequently generated by symptoms or medical problems separate from the prolonged disorder of consciousness.

The role of ICBs

Hayden J was, as had been Theis J in the previous cases, very concerned about the apparently passive stance of the ICB, which was responsible for commissioning the care being delivered to JP.

31. In analysing the delay that has occurred, the ICB acknowledges that JP's case should have been identified and referred to the Court of Protection sooner. They have apologised for their part in that delay. It is important that I record their response:

"Avoiding delays of this nature in the future

6. The ICB recognises that as a commissioner of care, it must give active consideration to whether the 'care package includes an effective system being in place for best interest decisions to be made in these difficult cases so that drift and delay is avoided,' as stated in XR. NHS CHC reviews are conducted on at least annual basis per the national framework, and the ICB did review [JP] annually during this period save for one year during the pandemic. The ICB has reflected on the lessons in [JP]'s sad case, and recognises the need to be proactive in exploring if there are other patients within the South East London population living in similar circumstances. The ICB will, as a priority, work with system partners across to identify and review patients on a case-by-case basis to determine whether care of this nature is agreed to be in the patient's best interests, or agreed not to be in the patient's best interests, or whether there is a need for the Court of Protection to determine any relevant dispute. The ICB is conscious that this would be needed both for patients in a hospital setting and for those patients who may be residing in nursing homes or in the community.

7. Since its formation in July 2022, the ICB has worked on developing the governance, escalation and oversight mechanisms for complex and high-risk patients that the ICB funds care for. This includes any patient where there is an element of safeguarding concern or mental capacity that should be considered. There is currently a suite of refreshed policies and procedures (most likely the Clinical Quality Assurance and Safety framework and protocols) going through the ICB internal governance processes to ensure greater alignment and standardisation across the ICB.

8. The ICB is aware that some of its system partners have already taken proactive action in relation to the identification and review of any patient who may lack capacity based on profound brain injury and prolonged disorders of consciousness. The ICB will continue to collaborate and assure that this work has been

undertaken using a consistent approach across South East London.

9. *Following the escalation of [JP]'s case to the ICB's Chief Nursing Officer we will also be undertaking An After Action Review to identify areas of improvement and gaps in policy, procedure and approach across the system and the wider regional health economy that will need to be addressed.*

10. *The ICB anticipates that relevant training based on its findings will be delivered to all partners across the South East London System."*

I have re-read these passages several times. I should very much have preferred plain language, an unambiguous recognition of the extent of the delay, and acknowledgment of the avoidable pain caused to the family by it. I am prepared, however, to take the assurance that "there is currently a suite of refreshed policies and procedures (most likely the Clinical Quality Assurance and Safety framework and protocols) going through the ICB internal governance processes to ensure greater alignment and standardisation across the ICB" as an expression of a real determination to ensure that the ICB will not in future be a "passive bystander", to use Theis J's apposite phrase. The obligation is to be a proactive participant in promoting the patient's best interests. I note, as has the Official Solicitor, that the review of the ICB's working practices would appear to be at a relatively early stage. For all the reasons set out, and which I am bound to say strike me as obvious, this review requires to be given priority. What has occurred with JP is entirely unacceptable.

32. Ms Paterson submits that in deferring their obligations to the RHN, the ICB may have leant too heavily on the status of the RHN as an internationally recognised centre for neuro-rehabilitation. I have some sympathy with that but, to use the famous aphorism of human fallibility, 'even Homer sometimes nods'. The checks and balances required to ensure that these crucially important decisions are taken effectively and timeously are predicated on robust collaborative relationships. The law relating to decisions to discontinue the provision of artificial nutrition and hydration in PDOC cases is now well settled. Neither is there any lack of clarity in ascertaining what procedural steps need to be taken by the parties, collectively to ensure that an application is ready for a hearing when one is required.

Recognising when cases need to go court

Hayden J, finally, reiterated the need to recognise when cases need to go court.

33. Ms Paterson has also highlighted what she describes as the RHN's drift "into a well-meant attempt to mediate the family dispute about [JP]'s best interests, which resulted in yet further delay". She makes the following submission:

"The Official Solicitor suggests that a clear signal needs to be sent through the judgment that there is no onus on either ICBs or healthcare providers to broker an agreement between family members, even if that would be desirable. The terms of section 4(6) of the Mental Capacity Act 2005 only place

> *an obligation on a decision-maker to take "reasonable" steps to "ascertain" P's wishes and feelings; and, s4(7), to "take into account, if it is practicable and appropriate to consult them, the views of anyone engaged in caring for the person or interested in his welfare". In light of this, in the present case, it would have been better to file an application, once the immediate family had been consulted and the family tree obtained from [TP]. That said, the need for an application definitely crystallised once either the RHN and/or the ICB had been met with the absence of a response from a family member(s) as there was then "a lack of agreement as to a proposed cause of action" in relation to "the provision of life-sustaining treatment."*

34. I would endorse this submission. There is no onus on the ICB or healthcare providers to broker an agreement between family members. Ms Paterson moots that it might be desirable if there were. On that point, I take a stronger view. That approach risks occluding the nature of the enquiry, which as I have been at pains to identify, is directed towards understanding what P's wishes and feelings might have been in these circumstances. It is difficult to see how a disagreement amongst those consulted is capable of mediation. The question is ultimately a binary one: would P have been likely to prefer to remain artificially nourished and hydrated or would he have preferred it to be discontinued in circumstances where treatment was ascertainably futile. Mediation in these circumstances risks conflating the family's views of best interests with the authentic views of P himself.

35. Perhaps the loudest signal emerging from this troubling raft of cases is a failure to understand the crucial significance of issuing proceedings promptly. The Official Solicitor suggests that it is better for an application to be filed early, with an accompanying report by a General Practitioner and, if necessary, stayed for a short period while a second opinion from a Consultant in Neuro-rehabilitation is obtained. The reasoning underpinning this is to ensure the Court is seized of P's best interests as early as possible. Equally importantly, P's voice will be given the priority it requires by the provision of representation that this would confer. This, it is said, ensures that "in effect, the court proceedings and the ICB's and/or the healthcare providers' compliance with the guidelines can be progressed in tandem, but P's best interests remain at the forefront of any "time-tabling"." I find this an attractive submission, but I would not wish to be quite as prescriptive. It seems to me that the spirit of this could or ought easily to facilitate a timely application with both the General Practitioner report and one from a Consultant in Neuro-rehabilitation.

Comment

The systemic problems identified by Hayden J in relation to people in PDOC outside facilities such as the RHN are very challenging. The RHN has been the subject of repeated criticism before the Court of Protection because it has recognised its previous failings in best interests decision-making and brought cases to court in consequence (and hence Hayden J was at pains to seek to emphasise that, despite these failings, the actual care being delivered by the staff there is of very high quality). What is much more

concerning, arguably, are all the cases in facilities where no-one has even recognised that there may be an issue. Hence the importance of ICBs recognising their strategic responsibilities for securing good governance as regards best interests decision-making.

Hayden J's observations on s.4(7) are striking, and go beyond Lady Hale's observations in *Aintree* (at paragraph 39):

> *The most that can be said, therefore, is that in considering the best interests of this particular patient at this particular time, decision-makers must look at his welfare in the widest sense, not just medical but social and psychological; they must consider the nature of the medical treatment in question, what it involves and its prospects of success; they must consider what the outcome of that treatment for the patient is likely to be; they must try and put themselves in the place of the individual patient and ask what his attitude to the treatment is or would be likely to be; and they must consult others who are looking after him or interested in his welfare,* ***in particular for their view of what his attitude would be.*** (emphasis added)

Whilst it is undoubtedly correct that the primary purpose of consulting with family (and – very often just as, if not more, important friends) is to understand what the person themselves might have wanted, it is arguably to go too far to say that their views of what the right outcome is are irrelevant. For better or worse, the best interests jurisdiction of the Court of Protection remains a jurisdiction where the decision is ultimately intended to be a subjectively-informed 'objective' one, rather than one of a pure exercise in substituted judgment – that must mean that it is legitimate to take account of the family's views as part of considering all the relevant circumstances (as is required by s.4(2)).

Finally, in relation to the (very) vexed question of when to go to court, it is undoubtedly the case that treating bodies should not pursue what might well be seen as a rotten compromise[3] for the sake of satisfying others at the expense of P, and, as Cobb J has previously identified, the perfect can be the enemy of the good in terms of preparing material for consideration by the court. But it is perhaps important that Hayden J did not descend to prescription in the way invited to by the Official Solicitor, as that could equally well lead to situations where the court simply does not have the material before it to make the relevant decision, and the clinicians have become so embroiled in the court process that they are not able to do the work that is required of them under the PDOC guidelines. Arguably of much greater importance is that clinicians recognise at an early stage that they are in a situation which may need to go court, so that they can start the twin-tracking of working with the relevant lawyers to prepare the application, whilst at the same time continuing the necessary diagnostic and prognostic testing.

Anorexia, the Court of Protection and the changing calculus of decision-making

St George's University Hospitals NHS Foundation Trust & Anor v LV [2025] EWCOP 9 (T3) (Morgan J)

Best interests – medical treatment – practice and procedure

Summary

When and under what circumstances it is

[3] A phrase for which we thank Jordan Parsons, who is doing some very interesting thinking in this area.

legitimate not to treat those with anorexia is a very contentious topic, and is under particular scrutiny at the moment in the context of the Terminally Ill Adults (End of Life) Bill, with very heated arguments as to whether anorexia does, or does not, fall within the scope of the Bill. In the context of the Bill Committee's debates, there has been much discussion of whether and under what circumstances the Court of Protection will endorse compulsory feeding.

This is the most recent case to be determined concerning such issues. As Morgan J described the position of a 20 year old woman, LV:

> 3. *LV is currently an inpatient on a ward in an eating disorder unit of a university teaching hospital. She has been a patient on that ward for more than 2 years since January 2023. Prior to that she had been an inpatient on a different ward in the same hospital since August 2022. That date coincides with her reaching the age of 18. Before that she had been an inpatient since February 2022 on the Paediatric intensive care unit at another hospital, also a centre of excellence in the South London area. So it is that as the case comes before me LV has been an inpatient in hospital wards of one sort or another for the last 3 years. That is the environment in which this intelligent, academically ambitious young woman has spent the last months of her childhood and the early years of her adulthood. She is detained under section 3 of the Mental Health Act 1983.*
>
> *4. LV has been diagnosed with Anorexia Nervosa; Autism Spectrum Disorder; Severe Depression; and Anxiety. Whilst there are interrelating consequences and presentations arising from those conditions, it is those which arise from the anorexia which lead to the application I have to determine. LV is now extremely unwell. She is presently being fed twice a day using a Naso Gastric Tube. She has to be restrained for this. The process requires seven staff members. Since December of last year, this process has been largely ineffective in providing her with nutrition since she has developed the ability, at will, to regurgitate feed whilst it is being delivered and to purge by vomiting most, nearly all, of the remainder after delivery. In that time she has lost a further 15% of her body weight. Her body mass index is slightly over 11. The likelihood is that, absent effective intervention, she will die soon. It is difficult to predict when that may be, but the evidence before me is that a timescale of days or weeks is what is contemplated rather than one of months.*

On an urgent application, the two Trusts sought orders providing for LV to be admitted to an ICU for a period of feeding under sedation. The Official Solicitor, on LV's behalf, ultimately agreed.

Morgan J was satisfied on the evidence before her that LV lacked the capacity to make decisions about the treatment and to conduct the proceedings:

> *51.* […] *In combination both the anorexic cognition and the effects of starvation on her brain are such that LV is affected by an impairment of her mind. Dr A (with whom Dr Kern in her second opinion agrees) in his report dated 21st February gave the following opinion: "I assessed P's capacity on 18 February 2025 and concluded that she lacks capacity to: Make a decision between the options for life-saving treatment, as she was not able to weigh the information for the decision that needed to be made, based on the merits of the options. His view was unchanged in his oral evidence and is not challenged." I have read carefully the basis on which he arrives at that conclusion and accept it.*

The question was therefore as to what was in LV's best interests. As Morgan J noted:

> *56. The proposed course of action is most unusual and there is good reason why it is regarded as an option of last resort. There are the risks which have been outlined in the medical evidence. Those risks include starkly that she may die as a result of the treatment contemplated. A long period of deep sedation or anaesthesia is not a benign experience. The well documented phenomenon of ICU delirium is prominent amongst the risks not to be taken lightly. It is a reasonable inference to draw that for someone with an established history of serious psychiatric illness it may, if experienced, add to the mental health burdens which LV already struggles to bear. There is so much that is unknown: perhaps, so the intensivist tells me, she will not remember very much about the process when awoken. Amnesia is not an uncommon sequela in part attributable to the medication – but one cannot know. Perhaps she will remember all or much of it. If she does, the possible risks psychologically from the experience of having been treated and fed against her will have been highlighted by Dr A . In a sense most troublingly of all it may be that she goes through this risky, invasive and perhaps frightening process in which all control is taken from her - a person for whom control is of enormous importance - and at the end it all, it may be for nothing. It may still be that she cannot break the cycle and move on to the next therapeutic stage and start to recover.*
>
> *57. I have thought long and hard about all of those risks and detriments as I weigh the balance. The point about the balance however is to look at what it is that falls on the other side. Here when I look at the other side, at what lies in the balance against all that is risky; all that which in other circumstances would be an intolerable affront to her autonomy, what I contemplate is her imminent death. At the moment twice a day, LV is subject to what, in other times and contexts, was called 'force-feeding'. The means by which it is achieved, for all the empathetic approach and skill of the staff, is not so very far removed from the images which that phrase conjures up. Yet for all the pain distress and indignity of it (during all of which she is emotionally and physically present) it is achieving nothing. LV is starving to death. An exchange between Ms Paterson and Dr C encapsulated the situation when exploring on behalf of the Official Solicitor the imminence and likelihood of death.*
>
> > *'Is she at risk of collapse by heart attack and death if she walks from one end of the ward to the other briskly '*
> > *'yes'.*
> >
> > *'Could that happen this afternoon'*
> >
> > *'yes'*
> >
> > *Is that a remote or appreciable risk ?*
> >
> > *I'm not sure I can answer that*
>
> *58. I am satisfied that it is, in all the circumstances of this most unusual and troubling case, in LV's best interests to undergo the proposed course of treatment. I make it clear that influential to the decision which I reach on this has been my careful consideration albeit that she lacks capacity, as to how I should factor in her own wishes and how to regard the well documented occasions on which she has said she would like to die. I am acutely conscious that I lack the assistance I would ordinarily have from the Official Solicitor's visit to LV. It is right that LV should be able to have an explanation of*

> *how what she has said has factored into but not determined my conclusions on best interests. Setting as I have those expression of her wishes in the context of all the other evidence, including her own other words and behaviour, I have concluded that the wider picture informs me that her wishes or feelings, forming as they do a part of my decision making, are more nuanced and less consistent than might appear the case at first glance and before detailed consideration.*

Finally, at paragraph 59, Morgan J agreed with the submission made by the Official Solicitor that:

> *given the highly unusual circumstances of this case and the time critical way in which it has been necessary to make decisions in the short period between the issue of proceedings and the conclusion of this hearing, the matter should come back for further review hearing.*

Comment

Over and above the challenges of this very difficult individual case, it is important to draw out a number of features of wider importance.

The first is that both Trusts involved clearly took the view that this was not a situation which could be encompassed within the four walls of the MHA 1983. Many treatment options relating to anorexia – including, for instance, nasogastric feeding under restraint – can, and often are, deployed entirely appropriately under Part 4 MHA. In other words, the fact of the coming into force of the MCA 2005 has not transferred the treatment of anorexia from the MHA 1983 to the MCA 2005. Further, a patient such as LV, who would be on s.17 leave to the ICU in the acute trust, would still notionally be subject to the provisions of Part 4 MHA 1983. An argument could be made that the treatment plan fell within the definition of medical treatment for the (manifestation) of mental disorder, such that it could be delivered under Part 4 MHA 1983. But we would suggest that this precisely the sort of situation in which, even if this could be the case, it was entirely right for the treating Trusts to come to court to ask whether it should be the case. They could have come to the High Court for a declaration under Part 8 CPR as to the lawfulness of their proposed course of action (by analogy, see *Re RC*, where that course of action was taken to confirm that non treatment was lawful). But it is arguably much better that they came to the Court of Protection, as a court equipped to undertake the substantive, inquisitorial, consideration of the position.[4]

The second is that this is a case in which the court was being asked, and was prepared to, endorse very 'high end' steps in relation to a person with anorexia. There appears to be something of an urban myth building up that the Court of Protection will both never take such steps, and indeed actively takes the view that such steps should not be taken. This is simply untrue. What the Court of Protection is doing is deciding upon courses of action proposed by treating clinicians in individual cases – it is therefore important to ask why clinicians take the view that they do in those cases as to whether they want to pursue particular courses of action. This line of thought is developed in these slides, which also set out the cases decided by the Court of Protection prior to *LV*.

The third point arises out of the second. Morgan J in the case before her was at pains to identify

[4] Some complex issues do arise in such situations, not addressed in this judgment, about the operation of s.28 MCA 2005. They may need to fall for consideration in due course.

that the situation had to be kept under review, and provided expressly for this. In other cases, the decision appears to be a final one. In many such cases, the clinicians have come to court for decisions that either continuation or escalation of treatment is not in the person's best interests. It is vitally important to understand that if and when the court makes such a decision, it is not concluding that the clinicians must stop thinking at that point. In particular, there may well be situations in which the person's circumstances change – at that point, the clinicians must consider whether they should bring the matter back to court. In many cases, careful drafting of the relief sought can make clear that the court is not closing the door on treatment if the person wishes it, but rather making clear that it does not have to be imposed upon them against their will: for a very clear example of such a case, see the decision of Cobb J *in A NHS Foundation Trust v Ms X* [2014] EWCOP 35. But even where the relief drafted in a way which appears more definitive, a failure to reconsider where the person's circumstances change would be both legally and ethically indefensible: if the person's situation changes, so must the calculus of their best interests.

PROPERTY AND AFFAIRS

Does the Court of Protection have jurisdiction over children? Answer yes – up to a point (even when they have moved abroad)

Irwin Mitchell Trust Corporation Ltd v KS & Ors [2025] EWCOP 7 (T2) (Senior Judge Hilder)

Mental capacity – assessing capacity

Summary

In this case, Senior Judge Hilder had to grapple with a question that had not been the subject of a previous reported decision: what can the Court of Protection do in respect of a child, whose property and affairs (including assets in England & Wales) are subject to deputyship, but who is no longer habitually resident in England & Wales? The Official Solicitor argued that the court no longer had jurisdiction to determine the deputy's request for authorities in respect of expenditure from her funds. The deputy sought to argue that it did, either by virtue of the operation of s.47 MCA 2005 (importing the powers, rights and privileges of the High Court), or on a pragmatic basis.

Senior Judge Hilder found her own route to maintaining the court's jurisdiction, drawing on the provisions of the 1996 Hague Convention (the counterpart for children) to the 2000 Hague Convention on the International Protection of Adults, sometimes known as Hague 34.

> *It is accepted that the appointment of the Deputy for KS amounts to a protective measure for the purposes of Hague 34. It is also accepted that the jurisdiction issue is not a best interests decision. It is clear, however, that whether or not the Court of Protection retains jurisdiction over KS's property in England will have a very significant impact on the ability of KS and her parents to live the life they choose.*

46. The pragmatic argument in favour of the Court of Protection retaining jurisdiction is attractive on the facts of this case, but pragmatism is not a proper basis for deciding an issue about jurisdiction. Other facts may point a different way.

47. The s47 argument: I agree with Mostyn J at paragraph 27 of R(SM) v Court of Protection that "there is no opacity in the language of s47(1)." The words are indeed "completely clear": the statutory conferment on the Court of Protection of "the same powers, rights, privileges and authority as the High Court" is "in connection with its jurisdiction".

48. I acknowledge that Mostyn J, having noted the difference in the heading of this section as between the Act ("General powers...") and that which had earlier been proposed by the Law Commission's draft Bill ("Supplementary powers..."), observed that the enacted version's reference to 'powers' is not specified as was the Bill and "nor were they confined merely to matters incidental to the court's jurisdiction." However, I do not understand him to have been suggesting that s47 somehow extended the Court of Protection jurisdiction to encompass everything that the High Court does or could do, in particular "inherent power and authority to make orders concerning the property in England and Wales of people lacking capacity (including children who are likely to lack capacity when they reach majority)". The inclusion of the words "in connection with its jurisdiction" has a limiting purpose.

49. Hague 34: it seems to me that the greatest assistance in understanding how s18(3) and Schedule 3 of the Mental Capacity Act 2005 fit together in

respect of KS is derived from Article 14 of Hague 34 and the associated commentary in the Handbook and the Lagarde Report. Article 14 is explicit in providing that measures remain in force according to their terms, even if the basis of their jurisdiction has been eliminated by a change of circumstances. The supporting documents both address specifically the very situation which has occurred in this matter, namely a change of habitual residence from a Contracting State to a non-Contracting State:

a. *paragraph 4.11 of the Handbook spells out that "nothing ...stands in the way of retention of jurisdiction by the authorities of the Contracting State under their non-Convention Rules."*

b. *paragraph 42 of the Lagarde Report echoes that position: "nothing stands in the way of retention of jurisdiction, under the national law of procedure, by the authority of the Contracting State of the first habitual residence which has been seised of the matter."*

50. Nothing in Mr. Dew's written or oral submissions persuades me that Article 14 is not in fact the starting point for considering KS's position.

51. The question then becomes what is the jurisdiction of England and Wales which is retained? KS is not in the same position as children generally. She is in the sub-group of children who are likely to continue to lack capacity to manage their property and affairs once they attain majority. For that sub-group, when it comes to management of their property and affairs in England and Wales, Parliament has created a jurisdiction which is outside the Family Law Act 1986 and the Family Court. Accordingly, after careful consideration, it seems to me that the answer is embedded in the question - "retention" refers to continued possession, use or control of something which was held before. What existed before KS's habitual residence changed to India was not (as Mr. Dew sees it) either the jurisdiction of the Family Court or of the High Court. It was the jurisdiction of the Court of Protection under s18(3) of the Mental Capacity Act 2005.

52. This conclusion is reinforced when checked against the apparent purpose of Article 14. As set out at 8.2 of the Handbook, the aim is "providing a degree of security and continuity for children and their families. Families need not fear that a move to another jurisdiction will, in and of itself, alter the arrangements that have been made.... Article 14 also guards against "gaps" in the protection of children resulting from factual changes in their circumstances." This aim is just as relevant for children being moved (for it is rarely, if ever, their decision to move) to a non-Contracting State as it is for moves between Contracting States. And it is just as relevant for the sub-group of children who are likely to lack capacity to manage their property and affairs when they attain majority.

53. There is however a caveat in Article 14 - "so long as the authorities which have jurisdiction under the Convention have not modified, replaced or terminated such measures." The explanatory documents are less clear in their consideration of a move to a non-Contracting State but paragraph 43 of the Lagarde Report (in the paragraph next following such specific consideration) suggests that it is not distinguished from a move between Contracting States. It also acknowledges risk in an approach which

encompasses potentially competing jurisdictions:

> *"This change of jurisdiction of the authorities in cases of a change of the child's habitual residence runs the risk that the authority which has newly acquired jurisdiction might very quickly take a measure which will annihilate that which was previously taken ..... Certainly, the measure taken in the State of the former habitual residence ought to be recognised in the State of the new habitual residence ...and remain in force there so long as it has not been modified or replaced"*

54. The evidence before me at present is that "India will likely recognise that England has jurisdiction over assets located within its territory" [F29], albeit that this is clearly distinguished from any implication that India will also recognise IMTC in its role as Deputy. On the other hand, there are two potential routes to seeking recognition set out in the evidence, as well as a clear statement that "there is no strict legal requirement for Indian courts to approve the continuation of the deputyship in England unless a question of KS's guardianship, control over KS's assets or a related issue is to be adjudicated upon in an Indian court." [F32] No such prospect is presently apparent.

55. I am concerned that the position taken by KS's Litigation Friend as to jurisdiction of this court would cause unworkable difficulties. It is the deputyship appointment, as distinct from the exercise of it, which is the protective measure. Being, as accepted, an appointment which continues (until termination either by the Court or the death of the protected person), how is a deputy to know the limits of their authority when habitual residence changes? Sometimes, and in this case, such a change is not a matter of a clear fixed date - at least until hindsight is available. In contrast, my conclusion (that the Court of Protection retains jurisdiction) gives clarity consistent with the aim of Article 14 of Hague 34, without offending against the position of KS's new state of habitual residence (according to the evidence before me).

56. As to "the connecting factor" for jurisdiction of the Court of Protection in respect of the property of persons under the age of 16 who are likely still to lack capacity to make relevant decisions when they reach the age of 18, it is unnecessary for me to seek to formulate any generality beyond KS's own circumstances. The Court of Protection undoubtedly had jurisdiction over KS's property in England and Wales when the Deputy was appointed; and it retains that jurisdiction after KS's habitual residence has changed to India, at least until a contrary step is taken in the new state of habitual residence.

57. I acknowledge that the conclusion may not be the same if, for example, a child had never been habitually resident in England but was awarded damages in England in respect of injuries sustained whilst on a brief holiday here. That situation will need to be considered further if/when it arises.

Comment

This case is a helpful reminder that, whilst the Court of Protection has no welfare jurisdiction over those under 16, it can, however, exercise its jurisdiction in relation to the property and affairs of a person under 16 if the court considers it likely that P will still lack capacity to make decisions in respect of the relevant matters when

they reach 18.[5]

In KS's case, it is unsurprising that Senior Judge Hilder wished to find a route to maintaining the court's jurisdiction, as otherwise her property and affairs would remain in limbo. It is of note that in reaching her destination, Senior Judge Hilder implicitly (and we would suggest correctly) identified that Schedule 3 was a red herring. Schedule 3 cloaks the Court of Protection with jurisdiction in cases with an international element where it does not already have jurisdiction (see para 7(1), providing for the court to discharge its functions "insofar as it cannot otherwise do so"). Here, the court had appointed a deputy to manage KS's property and affairs, in England & Wales, at a point when she was habitually resident in England & Wales, and was therefore discharging functions under ss.16 and 18(3). Schedule 3 therefore simply did not enter into it, nor did the carve-out in Schedule 3 for children falling within the scope of Hague 34.

Arguably, one might think that the real question before Senior Judge Hilder was not really whether Court of Protection retained a jurisdiction to authorise the deputy to take relevant steps. As HHJ Burrows had identified in *Re P (Property & Affairs Deputyship: Jurisdiction)* [2024] EWCOP 77 (T2) (a case decided between the hearing and the date of the judgment in KS's case), the very fact that the Court of Protection has made a deputyship order means that it must retain a jurisdiction to vary or revoke the order. Rather, the real question before Senior Judge Hilder was whether it was appropriate for the Court of Protection to seek to continue to exercise that jurisdiction in relation to KS's property and affairs. Until and unless an alternative method was identified – for instance some form of Indian authority which could be recognised and enforced in England & Wales – it might be thought to be entirely obvious that it was right that the court should continue to exercise its jurisdiction.

Short note: there is no upper age limit to the Court of Protection's jurisdiction

The case of *VX v KX & Ors* [2024] EWCOP 78 (T2) is a reminder that, just as there is no lower age limit, there is no upper age limit to the Court of Protection's jurisdiction. It concerned a 100-year old woman, and whether powers of attorney for health and welfare and property and affairs in favour of various combinations of her children should be revoked. The precise details of the decision are not of wider relevance, but, as with the decision in *AECO* discussed below, it provides a useful snapshot of the work carried out day-in, day-out by the Court of Protection.

Short note: removing the deputy

Re AECO [2025] EWCOP 5 (T2) is of note as a snapshot of the routine work of the Court of Protection which does not normally feature in reported judgments. It concerns the removal of a property and affairs deputy at the instigation of the Public Guardian. The failings of AECO's mother in discharging her functions as deputy led HHJ Cronin to the clear conclusion that it was in her best interests for her mother to be removed. There was, however, no doubt (and it was agreed) that AECO needed to have a deputy to manage her property and affairs. As HHJ Cronin noted at paragraph 16:

> *The court will always prefer to have a family member as deputy where there is a family member who is able and willing to take on that responsibility. JO expressed her concerns about being*

[5] MCA 2005 s18(3), although this does not include making a will on behalf of the person, something which can only be done in relation to a person aged 18 or over (MCA 2005 s18(2)).

> *able to work with the interim deputy, but in my judgment the interim deputy is an experienced Court of Protection Deputy who will have the skills to manage the case in AECO's interests and what is required of JO is that she cooperates rather than collaborates with the deputy. It would not be sensible to appoint a further professional deputy because that would incur significant duplication of work. In this case, there is no other candidate but a professional and so I confirm the appointment of Jenny Pierce as deputy for property and affairs on a final basis.*

Property and Affairs Court User Group minutes

The minutes of the January meeting of the CoP Property and Affairs Court Use Group have now been published. Amongst the highlights are an interesting set of exchanges around local authorities relying upon appointeeship to collect a person's private / occupational pension. SJ Hilder made clear that the DWP appointee scheme applies only to state benefits, and that it confers no lawful authority in respect of any other funds. She also confirmed that, as pensions are not usually one-off payments, it is unlikely a one-off order would be appropriate.

A solicitor also asked:

> *When making an application for a deputy to be appointed to manage the property and financial affairs for P. If we have the information available to us, we provide the relevant DOLS paperwork and ask for authority to be provided to sell and or for trustee powers. However, we are not receiving the orders to include this authority and it seems to just be missed. Do you have any thoughts as to why this may be happening?*

Senior Judge Hilder confirmed that:

> *if the DOLS information has been provided and authority to sell is not included, it is most likely that a positive decision has been taken not to include that authority. Encourages decision-makers to set out that decision in a separate order with explanatory recitals, and a statement of the right to apply for reconsideration.*

SJ Hilder made clear that, in any application for a statutory will, the original will and copies must be bound, not stapled, to comply with Probate Rules.

The endless theme of the length of time for which a COP3 remains valid came up again. In answer to the question of how an appropriate person can confirm that a COP3 remains valid, SJ Hilder advised that a capacity assessment cannot be added to, but a COP24 by an appropriate person confirming no change may be filed alongside. She further confirmed that

> *the appropriate person should be obvious from the circumstances of the case – including diagnosis of P, and the involvement with P by the person offering confirmation. For a stable condition, the confirmation of no change could come from a family member or care provider or an appropriately qualified and involved professional, including a deputy.*

PRACTICE AND PROCEDURE

Fees changes in the Court of Protection

From 1 April 2025, and subject to Parliamentary approval, with amendments to the Court of Protection Fees Order 2007 and the Civil Proceeding Fees Order 2008 respectively, fees relating to the Court of Protection will change as set out below.

Application fee: £421 (was £408)

Appeal fee: £265 (was £257)

Hearing fee: £259 (was £494)

On the filing of a request for detailed assessment for Court of Protection costs: £99 (was £96)

Appeal against a Court of Protection costs assessment decision: £79 (was £77)

Request to set aside a default Court of Protection costs certificate: £74 (was £72)

Short note: capacity and contempt

Issues of litigation capacity and contempt arose recently before the Court of Appeal in *Macpherson v Sunderland City Council* (in which a further judgment of Theis J is awaited). They also arose for consideration in *Derbyshire City Council v Grundy* [2025] EWCOP 1 (T1), a decision concerning committal to prison for contempt arising out of proceedings before the Court of Protection. In that case, DJ Davies had to consider whether the defendant had capacity to understand the terms of the injunctions that he had breached, the terms of the suspended sentence order he had breached, as well as capacity to conduct the contempt proceedings. The judgment provides a useful example of the level of detail required both as regards the assessment by relevant professionals and, we would suggest, the court in reaching a determination as to such issues. DJ Davies found that the defendant did have the requisite capacity. The second reported case in the sequence [2025] EWCOP 2 (T1), in which DJ Davies undertook the sentencing exercise, involving the (relatively unusual) sentence of immediate imprisonment.

Court of Protection visitors and the release of their reports

The Office of the Public Guardian (OPG) has published an online guidance document, *Court of Protection visitors and the release of their reports*. After explaining the purpose and operation of Court of Protection visitors and special visitors, the Guidance states that '*publication of visit reports is generally not permitted by the Office of the Public Guardian (OPG)*' and approval should be sought from the OPG before publication. Visitor reports are generally given to the court and given to the parties and under COPR 5.9, '*someone who is not a party to the case can apply to the court for a copy of a report, though the court may only provide an edited version…Reports produced for the court can only be released with its permission.*' Visitor reports may be filed in Court of Protection proceedings; the OPG may consider protecting the identity of people who supplied information to the visitor if disclosure would lead to physical or psychological harm.

Under Regulation 44(5) of the Lasting Powers of Attorney, Enduring Powers of Attorney and Public Guardian Regulations 2007, the OPG may release a copy of a visit report to '*anyone interviewed while preparing the report, inviting them to comment on it.*' A report may also be released to another visitor '*who is visiting people in the same case.*' Deputies who have been subject to an assurance visit may request a copy of the visit report.

The Guidance further states that the OPG may release a copy of the report to '*people or organisations included in a Public Guardian*

application to the court or supplied to the police or a local authority during an investigation' as well as to health bodies and care providers. The rationale for releasing a report to local authorities, health bodies and care providers is given as the power (under s.58(2) MCA) given to the OPG to cooperate in the discharge of its functions *'with any other person who has functions in relation to the care or treatment of P'.*

There is no explanation given as to the basis upon which reports can be provided to the police. We would sound a very strong note of caution about taking this step without formal authorisation, at least if the report has been prepared for Court of Protection proceedings. We would, in particular, note that Keehan J refused permission to the police to see psychological reports prepared for purposes of proceedings before the Court in *Re AB (Court of Protection: Police Disclosure)* [2019] EWCOP 66.

People who have been the subject of reports (or their attorneys or deputies on their behalf) may make a subject access request for the reports.

The Guidance gives circumstances when a report may not be released:

> *The Public Guardian can choose not to release a report if it contains information that:*
>
> - *might go against a third party's data protection rights*
> - *was told to the visitor in confidence by a third party*
> - *could be harmful to anyone named in the report*
>
> *The Public Guardian can also release a report with parts removed, or redacted. For example, to protect the identity of someone making an allegation of abuse.*

The Guidance sets out a process for requesting a copy of a report.

Citation of judgments: Tier 1 and Tier 2 judges

The President of the Family Division has issued the following guidance: Citation of Authorities: Judgments of Circuit Judges and District Judges. In essence, it making clear that there is to be a crack down on the citation of citation of judgments from Circuit and District Judges, absent specific circumstances. The 'new principles' that it sets down are that:

> *5.* […] *judgments at Circuit and District Judge level should not be cited unless they contain an express statement that the judge intends that the judgment should be citable (i.e. relied upon in the future in respect of that legal issue). Judgments that do not contain such an express statement will not be citable. These judgments can and should be published in the usual way to promote transparency but will not be capable of being referred to as primary authority. 2 6. It is not expected that the practice of including a statement as described above will become common. It will not apply to judgments where the judge has applied existing law and/or which provide examples of how the law operates in practice. An express statement that a judgment is intended to be citable should be reserved only for (probably very rare) cases where new ground is being broken. A judge who is considering including such a statement within a published judgment should only do so with the approval of the appropriate leadership judge (identified below).*

Although it may not immediately appear that it applies to the Court of Protection, closer inspection reveals that it does.

> *7. A question arises in respect of past judgments which contain no such statement but were intended to address novel points of law. There are some*

decisions in the Financial Remedies Court in particular, and several in the Court of Protection, which fall into this category, dealing for the most part with points that tend not to arise in cases heard at High Court Judge level.

8. In such a case, the judge should seek approval from their Leadership Judge [the Vice-President of the Court of Protection] *to publish a statement which retrospectively approves citation of the judgment.*

MENTAL HEALTH MATTERS

Mental Health Bill

The Mental Health Bill has had its last day at Committee stage in the House of Lords. This stage allows peers to scrutinise the detail of a Bill, but traditionally no votes are taken. Tim Spencer-Lane has given an excellent summary of the last day on 24 February, as follows.

Implementation/funding

There were calls for a costed plan for community care to support the Bill's reforms and a statutory backstop for implementing the Bill. In response, Baroness Merron set out the Government's implementation plan.

Mental health commissioner

Peers called for the creation of a statutory mental health commissioner to provide "sustained leadership for mental health" and to drive forward the reforms. Baroness Merron repeated that a commissioner would duplicate existing functions such as those of CQC.

Specialist eating disorder units

There were calls for the adequate supply of eating disorder units. Baroness Merron committed to working with NHSE to improve access to eating disorder services.

Community support

Peers called for sufficient high quality community services as alternatives to detention. Baroness Merron felt existing duties under the NHS Act addressed these matters.

'Breathing space' (debt respite scheme) scheme

Peers wanted the scheme to be extended to Part 3 patients and a proactive duty to offer the scheme. Baroness Merron said the revised Code would include a 'requirement' for referrals and the scheme would be kept under review.

Inappropriate placements of children

There were calls for limits on the placement of children on adult mental health wards and notifications of out-of-area placements. Baroness Merron said that the revised Code would address these issues.

Use of force

Peers pointed to the inappropriate use of restraint for children in psychiatric hospitals and limits on the use of long-term segregation. Baroness Merron confirmed that CQC has been commissioned to develop a viable and proportionate reporting mechanism.

HRA

Peers highlighted a gap in human rights protection identified in the 'Sammut' case, calling for private care providers to be deemed public authorities under the Human Rights Act. Baroness Merron confirmed the Government is "actively considering" this matter.

Mentally disordered offenders

Peers wanted a review of the impact of the reforms on mentally disordered offenders in prisons, and the Valdo Calocane case. The MoJ minister (Lord Timpson) argued there was already robust scrutiny for offender health.

Duty to promote well-being

There were calls for a prevention duty to reduce the likelihood of detention.

Baroness Merron argued this was duplicative of existing duties and pointed to the prevention concordat.

Valdo Calocane

Peers raised this case and a duty on services to maintain contact with people with a mental disorder and to publish full versions of independent reports. Baroness Merron confirmed there will be a judge led statutory inquiry.

Scrutiny of power to make consequential provisions

Baroness Marron said DHSC will respond ahead of report stage

The new Mental Health Bill print is now up on the Parliament website. This reflects changes made in Committee by Government amendment, plus various technical corrections. Clause numbers have changed for clauses after 31. Alex has yet to have the chance to update his unofficial version of the MHA Bill available on his MH Bill resources page, but will do so as soon as possible.

Valdo Calocane

As noted above, there will be a judge-led statutory inquiry into this case. In the meantime, the independent investigation into the care and treatment provided to Valdo Calocane commissioned by NHS England has been published.[6] Key findings include that:

- Calocane's risk "was not fully understood, managed, documented or communicated";
- There were missed opportunities to take more assertive action towards Calocane's care;
- The voice of Calocane's family "was not effectively considered to support the dynamic evaluation of risk" during his treatment;
- Other patients under the care of the same trust, some of whom had been discharged, had also perpetrated acts of "serious violence" across 15 incidents between 2019 and 2023;
- Calocane had no contact with mental health services or his GP for about nine months prior to the killings (and his discharge had taken place without any face-to-face contact).

In the context of the Mental Health Bill, two features stand out:

- The emphasis on capacity on the part of both those engaged with Calocane, and on the part of the report authors, who conclude that:

  VC's ability to fully understand the implications of his mental health condition were limited by his lack of insight. This may have meant he lacked full capacity to make decisions in relation to his care and treatment and engagement, particularly in the community. There does not appear to be a systemised approach to assessing patient capacity based on presentations across care settings and relied upon in the context of voluntary treatment within the community. Therefore, the question of capacity does not appear to inform all assessments of risk across the different

[6] Social media commentary has (rightly) identified that there were some quite strange statements in the report about the MHA, including that an emergency application can be made under s.4 by a nearing relative or an AMHP (with no reference to any medical recommendations) and for s.135 warrants to be executed by social workers alone. Those strange statements might rather undermine confidence in the legal literacy of those preparing the report.

care settings.[7]

- That the investigation heard how clinicians, when deciding not to put Calocane on a CTO, were influenced by the comments within the Draft Mental Health Bill (2022), relating to the desire for a reduction in use of CTOs and its disproportionate use for black people. The investigation also noted the tension described within the CQC (2022) report between families' beliefs in the value of CTOs and challenges around their use as perceived overly restrictive by clinicians and patients. As the investigation report notes:

Whilst Trust staff reported that they considered race in relation to the use of restrictive practice, there is nothing in the notes to suggest that this important factor was discussed as an MDT. Such a discussion enables clinicians involved to have an open conversation to help to ensure that their decision-making is based on clinical presentation and need and is not influenced by other factors.

[7] Page 146; on insight and capacity, see the *CT* case discussed in the Health, Welfare and Deprivation of Liberty report. We note that "full capacity" is not a concept contained in the Mental Capacity Act 2005.

CHILDREN'S CAPACITY

What's in a name?

The surgeon Robert Wheeler emailed upon receipt of our first Children's Capacity report in February to question its title, to query whether it should be called the Children's Capability Report:

> *since for the under 16s clinicians rely on the child's presumption of incompetence being rebutted if they have sufficient maturity and intelligence whilst adhering to the presumption of capacity (unless demonstrably absent) thereafter.*

We are always very grateful for feedback, and Robert's point is entirely correct – but one reason for calling it the Children's Capacity Report is to remind readers that children, ultimately, do not enjoy **legal** capacity on the same basis as adults, by virtue of the fact that they remain children.

Re J – appeal allowed

The Court of Appeal, comprising Sir Andrew McFarlane, Lady Justice King and Lord Justice Singh, confirmed at the hearing of the appeal on 5 February 2025 that Lieven J was wrong in *Re J: Local Authority consent to Deprivation of Liberty* [2024] EWHC 1690 (Fam) to conclude that a local authority could provide the required consent in the exercise of its corporate parental responsibility.

Although the court's reasoning is to follow, this is an important clarification, taking immediate effect, that the direction taken by Lieven J was wrong and must not be followed.

President of the Family Division publishes guidance on writing to children

Sir Andrew McFarlane has published guidance, developed with the Family Justice Young People's Board, for judges writing to children to explain their judgments. As he notes in his foreword:

> *The publication of this toolkit for judges writing to children is a most welcome event. The benefit of judges communicating with the child at the centre of proceedings has long been recognised, yet few of us have ever written to a child to explain our decision in their case. There is an understandable judicial reluctance in this regard, partly because of the realisation that the letter will be important and there is a fear of saying the 'wrong thing'. In addition, judges may be worried that it will take a good deal of time to get the letter 'right', coupled with the well-known inertia that comes from staring at a blank page, without a template or previous experience to guide the writer.*
>
> *As is made plain throughout by direct quotation from children, a child is entitled to be given an accurate and informative account of what was decided, and why, from the judge who made the decision. This will be important for the young person in understanding that their wishes and feelings have been taken into account by the court, and in supporting them to accept or make sense of the decision as they move forward with their life thereafter.*
>
> *This very readable 'toolkit' does a great deal to break down the factors that may have inhibited judges in the past. To get past 'blank page' inertia, the content of a typical letter is built up, sentence by sentence, with suggestions, explanations and examples, and the whole is rounded off with worked up examples.*
>
> *I am very grateful to all who have been involved in developing this most valuable resource, but I would particularly like to thank the young*

> *people who have contributed. Their endorsement of what is said here should give judges solid confidence that, if they follow these guidelines, they are likely to produce a message that will be of real and lasting value to the young person who has been the centre of their concern.*
>
> *My hope is that, like many things, once judges have used this toolkit and have written to children in a few cases, doing so will rapidly become the norm and no longer a task to be avoided. I would urge all judges to read this guide and to use it from now on in their cases. The publication of the toolkit has the potential to change the culture and to make the sending of a short letter from the judge the norm in all substantive cases; I earnestly hope that it does indeed do so.*

Whilst we would never fall into the trap of suggesting that those before the Court of Protection are to be equated with children, we would urge judges involved in Court of Protection cases to consider writing more often to P to explain what they have done,[8] and why – and to draw upon this toolkit where appropriate.

Deprivation of liberty, children, care orders, and overlooked caselaw: a tangle for the Court of Appeal

West Sussex County Council v AB & Anor [2025] EWCA Civ 132 (Court of Appeal (Sir Andrew McFarlane, King and Zacaroli LJJ))

Article 5 – deprivation of liberty – children and young persons

Summary

This case concerned a 17 year old woman with complex needs. As Sir Andrew McFarlane, giving the judgment of the Court of Appeal identified:

> *1.*[…] *Despite the impressive care and commitment of her mother ['AB'], it is accepted that she is, and has been for some time, beyond parental control. Since July 2023, the local authority has had authority under a series of deprivation of liberty orders ['DOLs orders'] to protect her and others from harm by restricting CD's liberty. In November 2023, the local authority applied for a care order under Children Act 1989, s 31 ['CA 1989'] and, from that time, CD was the subject of an interim care order.*
>
> *2. An unusual feature of the case is that, despite the substantial challenges presented to those seeking to care for and support CD, and partly because no alternative placement could be found, she has been accommodated in her mother's home for the past 11 months. AB works full time and, in any event, additional carers are required for CD. As a result care is provided in AB's home by a rota of professional carers, with at least two carers being on duty at any one time 24 hours per day.*

In June 2024, a deputy High Court judge placed CD in the care of the local authority under a final care order. The local authority and AB appealed:

> *3.* […] *The appellants assert that, in circumstances where CD's entire care package is authorised and regulated within the DOLs order, and where the authority and other agencies have statutory duties to provide the care that CD needs, a care order was neither*

[8] See, for an example of good judicial practice here, *Re RK (Capacity; Contact; Inherent Jurisdiction*) [2023] EWCOP 37.

necessary nor proportionate.

The children's guardian opposed the appeal.

Sir Andrew McFarlane was at pains to make clear that:

> *4.* […] *the appeal is mounted solely on grounds of proportionality, based on the specific facts of this unusual case and the approach of the judge in his judgment. No discrete matter of law arises for determination. It is not unusual for a DOLs order to be combined with a care order, and there is no legal impediment to doing so. I would also stress that, whilst CD is accommodated at home, the circumstances of this case are separate and distinct from those that are normally encountered when a child is placed at home under a care order and which were the subject of this court's decision in Re JW (Child at home under Care Order) [2023] EWCA Civ 944. In the Re JW cohort of cases, a child in care is placed at home often with minimal monitoring or interaction with the social services. The contrast with the present case, where at least two carers are permanently present in the family home, is stark. Nothing that is said with respect to the approach to the specific circumstances of the present case can have any direct relevance to the more ordinary 'care order at home' cases being considered in Re JW.*

Sir Andrew McFarlane was transparent about the change of mind that he had undergone:

> *29. Prior to the commencement of the appeal hearing, I was of the view that the order of this most experienced Family judge, whose profound concern for the future well-being of a most vulnerable young person was fully justified, and should be upheld. In the event, I was persuaded that the appeal should be allowed for the following reasons*
>
> *30. Firstly, as is accepted by all parties to the appeal, the judge was in error as a matter of law in justifying the imposition of a care order as a means of obliging or galvanizing the local authority into delivering the agreed care plan. As paragraph 37 of Re JW repeats, it has long been held that a care order should not be used solely to encourage a local authority to do that which it is already statutorily obliged to do.*
>
> *31. The judge was obviously justified in seeking to maximise the prospects for the multi-faceted and multi-agency care plan to be delivered in full to meet the needs of this most vulnerable young person in the coming year. But, as a matter of law, where the authority has, and accepts that it has, a statutory duty to deliver the care plan, the making of a care order does not impose any additional requirement upon it. It is a fundamental principle that, once a full care order is made, the court does not have jurisdiction to review the operation of a care plan (A v Liverpool City Council [House of Lords] [1982] AC 363) or require a local authority to adhere to key elements in any care plan (Re S and Re W (Care Order: Implementation of Care Plan) [2002] UKHL 10 – the 'starred care plan' case). Thus, should it wish to, a local authority may, on the day following the making of a care order, amend or fundamentally alter the care plan that has been approved by the court, subject only to the risk of an application to discharge the care order or judicial review proceedings.*
>
> *32. Additionally, as Hale J (as she then was) held in Oxfordshire County Council v L [1998] 1 FLR 70, whilst it was open to a court to make an order other than that for which a local authority has applied, there must be 'cogent and strong reasons' for doing so. In the present*

case the reasons given for justifying the making of a care order, against the wishes of the local authority, cannot be couched in such terms.

33. Finally, on this point, and in contrast to most care cases, the court does have a continuing role in monitoring the delivery of the care plan for CD through the ongoing DOLs process. This was an important element in the balance to be struck on the issue of whether or not to make a care order, yet it was not referred to in the judgment.

34. In relation to the second area of the case identified by the judge as supporting the making of a care order, namely the potential for AB to change her position and move away from cooperating fully with the care plan, there was some evidence justifying the judge's concern. But, as the evidence underlying the submissions made to this court on behalf of the local authority demonstrates, such falling off as there had been in the past was comparatively minor and, in any event, had to be set against the very substantial body of evidence of established and sustained support from AB over a significant period. Although there must always be a risk of AB, or any parent, withdrawing cooperation, when set against the evidence as a whole, this was not a likely outcome and not one which, on its own, justified the imposition of a care order.

35. The judge rightly pointed to CD's imminent 17th birthday, with the consequence that, if there were no continuing care order in place, no care order may thereafter be made with respect to her [CA 1989, s 31(3)]. The judge had 'significant concern' that the local authority would, in the event of AB withdrawing from cooperation with the care plan, look to protect CD by issuing fresh care proceedings yet be unable to do so post-17. That level of concern did not, however, justify the making of a care order in case there should be a falling away in AB's support. Firstly, because, as I have already held, this was not a likely eventuality. Secondly, the local authority's proposal to issue fresh care proceedings was, with respect, misplaced. It would not be necessary to apply for a fresh care order where, as here, there were ongoing High Court proceedings supporting the DOLs order. In the event of a change in AB's support, any dispute, or variation of the care plan, could and should be dealt with within the DOLs process or any subsequent Court of Protection proceedings. Where a local authority is authorised by the High Court under a DOLs order to deliver care to a young person in a particular manner, there will be few circumstances where their position would be enhanced by any additional power that would come from having parental responsibility and the ability to control AB's exercise of parental responsibility under a care order.

36. A further factor bearing on the choice between making a care order or not arises from the concern that both AB and the professionals had as to the impact on CD's behaviour were she to discover, or be told, that she was, once again, a child in care. This was not an insignificant factor in the welfare balance, given CD's vulnerability and the very volatile nature of her behaviour. It was, to my eyes, striking that for some 8 months during which CD had been the subject of an interim care order, the professionals and her mother had agreed that she should not be told that that was the case. It is no small thing for a 16 year old not to be told information of that nature, and the degree of professional and maternal concern about CD's likely reaction can be gauged from their decision not to do so. Against that background, it is hard to understand the judge's characterisation of that

> *degree of professional concern as 'conjecture'. This was a factor which, as Ms Hancock submitted, was of significance and to which insufficient consideration was given.*
>
> *37. Drawing matters together, and whilst fully understanding the judge's focus on doing all that he could to ensure the delivery of all aspects of this complex care package to support CD, I have concluded that the making of a care order was not justified. If My Lady and My Lord agree, the consequence is that the appeal must be allowed and the care order set aside.* (emphasis added)

In a postscript to the judgment, Sir Andrew McFarlane noted that:

> *38. At a stage when our draft judgments were shortly to be circulated to counsel, the court became aware for the first time of a relevant decision by Lieven J: Re JR (Deprivation of Liberty: Care Order: Principles of Care) [2024] EWHC 564 (Fam); [2024] 2 FLR 856.*

In that case, Lieven J had been invited to continue a longstanding DoL authorisation with respect to a 16 year old boy who was placed in a therapeutic placement. For the previous 3 years, JR had been accommodated by the local authority with the agreement of his adopted parents under s.20 CA 1989, s 20. Whilst the local authority had issued an application for a care order in October 2023, no interim care order had been made. By the time of the final hearing before Lieven J, the local authority (with the support of JR's parents) sought leave to withdraw the care order application. Having heard full argument, Lieven J refused the application to withdraw and made a final care order on the basis that it was necessary and proportionate to do so.

Sir Andrew McFarlane was concerned that Counsel had been unaware of the decision at any point, either at first instance, or before the Court of Appeal, and noted at paragraph 42:

> *In all cases, but particularly in a case such as this where detailed submissions of law are to be made, it is the responsibility of specialist counsel to use due diligence in their research for any relevant decisions. Courts are entitled to rely upon counsel in this regard, and it is disappointing that in the present case there seems to have been failure across the board to notice the Re JR decision.*

Luckily, perhaps:

> *43.* […] *Having now considered the position, my view is that the analysis that I have undertaken in this judgment remains the appropriate one on the facts of this case. I also consider that Lieven J's analysis and decision in Re JR were justified and correct on the facts of that case. The level of parental divergence, from time to time, from the local authority's plans in Re JR was of a wholly different order to the altogether more modest disagreement in the present case. In addition, as Lieven J's judgment makes plain, the degree to which the local authority could be relied upon to afford priority to implementing the care plan was questionable, whereas in the present case that was not a significant issue. Re JR is an example of a case where a care order was justified alongside a DOLs authorisation, whereas, for the reasons that I have given, it was not justified in the case of CD.*

Comment

This case is an important reminder that it is entirely possible for a child to be deprived of liberty in their own home. It is also perhaps not surprising that Sir Andrew McFarlane made a

point of identifying that an order made under the inherent jurisdiction authorising deprivation of liberty means that the court "*has a continuing role in monitoring the delivery of* [a] *care plan*." The week prior, he had sat on the Court of Appeal allowing the appeal against the decision of Lieven J in *Re J: Local Authority consent to Deprivation of Liberty* [2024] EWHC 1690 (Fam), a notable feature of the hearing being the concern of all three members of the court at the implications of confinements being 'carved out' of Article 5 and the ongoing checks and balances it requires.

The point about the lack of knowledge of relevant cases is one that repeatedly occurs in the area of deprivation of liberty, and we do regularly come back to the trenchant (extra-judicial) observations of Sir James Munby in 2018:

> *that these cases lie at the intersection of three different bodies of domestic law – mental health law, mental capacity law and family law – where judicial decision-making is spread over a variety of courts and tribunals which, by and large, are served by different sections of the legal professions too few of whom are familiar with all three bodies of law. The existence of these institutional and professional silos has bedevilled this area of the law at least since the earliest days of the Bournewood litigation. One day, someone will write a critical, analytical history of all this – and it will not, I fear, present an altogether reassuring picture.*

THE WIDER CONTEXT

Diagnosing death

The Academy of Medical Royal Colleges has updated its Code of Practice for the diagnosis of death. It also includes, as Appendix 2, the Royal College of Paediatrics and Child Health 2025 update on the diagnosis of death using neurological criteria in infants, children, and adolescents. Paragraph 6.69 is of particular importance, given the small but increasing trend in cases where families challenge the use of the diagnosis of death by neurological criteria.

> *Managing requests to prevent the application of neurological criteria or to continue somatic support after death has been confirmed*
>
> *In rare circumstances, the patient's family may, for a variety of reasons, request that:*
>
> *a. neurological criteria to diagnose and confirm death should not be used, despite the clinical suspicion that the patient has died, or*
>
> *b. if death has been diagnosed and confirmed using neurological criteria, that somatic support, such as mechanical ventilation and other intensive care treatments, be continued. Section 7 outlines principles of communication which may be helpful in supporting families, and others who care for the welfare of the person, through the diagnosis and confirmation of death, and preempt such disagreement.*
>
> *We recommend approaching the patient's family in the usual way that treatment disagreements are managed in intensive care. That is, with respect and compassion, honesty and transparency, listening and seeking to understand, with patience and allowing more time for explanation within the areas of disagreement, and by providing cultural and religious support and second opinions if acceptable to the family. Offering the patient's family the opportunity to see radiological imaging, with appropriate clinical explanation, and to witness the clinical testing of brainstem reflexes and the apnoea test, even repeating the tests for a third time, may also help family acceptance and understanding.*
>
> *Legal advice should be sought urgently if agreement cannot be reached in a reasonable amount of time and at most within a few days.*

It is of importance that nowhere here (or in the section relating to children) is the guidance framed on the basis that the consent is being sought from family members. There is a lurking issue which needs to be resolved by the courts in due course as to whether carrying out the tests required to diagnose death by neurological criteria are governed by the MCA 2005 (in the case of adults at all). The better view is that it is not – the tests should not be being carried out absent a reasonable clinical view that the patient is, in fact, dead. Upon death, a patient can, by definition, have no best interests.

It is also, further, of importance that the Code highlights the need for early legal advice to be sought, rather than to allow the situation to continue in an unresolved fashion.

Restraint in Northern Ireland

The moves towards implementing parts of s.9 MCA (NI) 2016 (the equivalent of s.6) MCA 2005 continues apace. The Department of Health in Northern Ireland has recently published its analysis of the responses received to its consultation on the commencement of the provisions. In headline terms, there was support for provisions to be implemented, which is

unsurprising, because Northern Ireland is currently in the very uncomfortable position of having statutory provisions for deprivation of liberty, but nothing to cover either best interests decision-making more broadly, or to identify when and how restraint in support of such decision-making is legitimate. Commencing s.9 would help with the second, but not the first (which will remain governed by the common law doctrine of necessity). Consultees also made clear that there was a need for further work to be done to develop the accompanying code of practice.

Research corner

Readers may be interested to learn about the 3rd summer school to be held by the Centre for Investigating Contemporary Social Ills (CICSI) together with the School of Philosophical, Historical and Interdisciplinary Studies at the University of Essex. Day 1 will be focused on change of ending coercion in mental health settings; Day 2 will look at effecting wider social change, and will hear about possibilities of lobbying, activism, bringing social patterns of distress into view in therapy sessions, and paying attention to values and ways of living. For more details, and to book, see here.

SCOTLAND

AWI reform: no hard news, but the road ahead becomes clearer

Month by month, we have continued to track progress towards introduction in the Parliament of the promised Adults with Incapacity (Scotland) (Amendment) Bill. It is understood that Scottish Government adheres to its commitment to introduce the Bill before the summer recess commences on 28th June 2025. It is predicted that it will be introduced some time in June, with an aspiration rather than a prediction that it could perhaps be introduced in May. One imagines that it might be necessary for Stage 1 to be initiated and completed as soon as reasonably possible, to give maximum time for remaining procedure, with the ultimate deadline for completion of Stage 3 before the recess ahead of the 2026 elections, when otherwise the Bill will be lost, as we have already emphasised in our reporting.

We are not yet in a position to report further on the likely content of the Bill, nor upon widespread fears that, even after such long and unjustified delays on the part of Scottish Government, some essential and urgent reforms may be omitted and consigned to sometime–never further work.

We can however report a significant change of gear and change of mood, with the arrival of Amy Stuart upon her appointment as Scottish Government's Head of Unit, Mental Health and Incapacity Law. We commented in the February Report about the formidable task that faces her, on a near-impossible timescale. Hitherto, progress towards implementing reforms, most requirements well formulated many years ago, has languished while Scottish Government failed to keep its undertaking to continue in parallel with the Scott Review the urgent work of AWI reform, and to remedy its long-standing breach of its obligations to provide lawful procedures to end widespread practices of unlawful deprivations of liberty of elderly and disabled persons. Instead of moving matters promptly forward on the urgent reforms, once the Scott Report had been submitted well over two years ago now, we have had an endless process of lengthy consultations during which Scottish Government seems to have been trying to create an impression of progress by repeating the work entrusted to the Scott Review, without producing a single formulation of intended content of immediately necessary law reforms. The key change is that Ms Stuart has moved forward from consultation to collaboration: a real and significant change in approach, not simply word-play. That can be attributed to the background of her career experience and achievements to date.

It is significant that after graduating in forensic chemistry, her first job was with the Office of the Public Guardian, early in the career of Sandra McDonald as Public Guardian. That experience pointed her firmly in the direction of public service, a focus that she has retained throughout her continuous employment with Scottish Government since 2007, with responses ranging across the economy, investment in innovation, work with Scottish Enterprise, topics of developing skills and employability including for very vulnerable people, implementing major system change, work with parliamentary committees, and most recently before this latest appointment, responsibility for addressing cladding issues and successfully driving through an expedited Bill on that topic.

She readily acknowledges her lack of experience in AWI law, practice and procedures, and is addressing that with the significant shift from consultation to collaboration. She is in a process of actively initiating collaboration of those best placed to assist her to deliver. After so long, that change of mood is to be welcomed. How much

can be done in the almost absurdly short time available may be questioned, but one has confidence that it is likely to be the most that can be done. Collaboration has to be two-way, but the signs so far are positive that those with the expertise and experience to provide the substance so far missing from endless processes are welcoming the opportunity to do so at last. There has of course been discussion of the need for a major campaign for delivery of law reform, along the lines of the Alliance of some 90 relevant organisations and stakeholders that campaigned in the 1990s for delivery, by the then brand-new Scottish Parliament, of the Adults with Incapacity (Scotland) Act 2000, a campaign which achieved cross-party support for this being the first legislation in a major policy area of the Parliament. However, this is not the time to try to ride two horses at once. One trusts that collaboration will be given every opportunity to succeed, with campaigning as a fallback if necessary.

The Alliance campaign was a response to the failure of the UK Parliament to enact outstanding necessary law reform for Scotland. Hence the key provision in section 28(1) of the Scotland Act 1998: "*Subject to section 29 [defining the legislative competence of the Parliament], the Parliament may make laws, to be known as Acts of the Scottish Parliament*". It took five years from the Scottish Law Commission 1995 Report containing a draft of what is now substantially our 2000 Act, to "enactment". It has now taken more than twice that time from the 2014 Scottish Law Commission Report offering legislation on deprivation of liberty. It would be quite absurd if failure by the Scottish Parliament to perform the primary role for which it was created should necessitate a similar campaign to that of almost 30 years ago. One trusts that all parties in the Scottish Parliament will actively support necessary legislation prior to the elections in 2026 and, in the unfortunate event that there should be any overspill, will make the same commitment to act to meet the needs of our most vulnerable citizens prior to the first elections in 1999.

As we move towards drafting of the Bill, one must add a further concern that it be competently drafted. It should be possible to take that for granted, but one cannot. A relevant example of causes for concern can be found in the Debt Recovery (Mental Health Moratorium) (Scotland) Regulations 2025, as laid before the Parliament. There is, for example, a peculiar definition of "legal representative" in Regulation 2. The current drafting is unclear to the point of being meaningless, and appears to be the work of either a non-lawyer, or a lawyer without basic knowledge and understanding of the 2000 Act. Giving that role to "any guardian" would be contrary to the 2000 Act, in that no guardian would be entitled to act as such except within the powers that have been conferred upon the guardian. Section 64(3) provides that a guardian can act as a person's legal representative "in relation to any matter within the scope of the power conferred by the guardianship order". The wording becomes plainly incompetent rather than inaccurate when it provides that: "'legal representative' means any … power of attorney". A power of attorney is a document, not a person, and cannot do anything in the role of attorney. Appointees under an intervention order are not mentioned at all. The lack of any effective inclusion of attorneys, and of any mention at all of appointees under intervention orders, points to likely challenge on grounds of discrimination, the comparator being an adult who has a guardian with relevant powers. Suitable wording for the definition would be: "Any appointee holding relevant powers under a guardianship order, intervention order or power of attorney". Also, incorporation of "foreign equivalents" in the definition is

incomplete and should follow the method used in section 1(7) of the 2000 Act, and elsewhere in the 2000 Act.

Poor drafting also creates uncertainty, and the risk of avoidable dispute, by the wording of Regulation 5(2)(f)(i). Does the word "they" mean the individual, or the legal representative, or both? The legal representative, if properly defined, would not be able to act unless the individual was incapable of acting in the matter. It seems that there need to be two separate provisions here. Firstly, the individual applies on the basis that the individual can competently do so. In that case, is it considered adequate for an individual to self-assess the individual's competence to make the application, including the individual's understanding? It would be contrary to human rights requirements to presume incapacity because of diagnosis of a mental disorder, but it is doubtful whether it would be appropriate to assume capacity in the particular circumstances in which an application for a moratorium should be made. If the legal representative makes the application, then there would need to be at least an assertion, and possibly evidence, that the individual cannot competently do that. Would it really be necessary for the legal representative to demonstrate the representative's understanding, or would that be an unreasonable and potentially unlawful hurdle?

There also appears to be a drafting error in Regulation 15(1) in that the mental health criteria are defined as alternatives, so it would appear that the wording should be that none of the mental health criteria continues to be met.

Adrian D Ward

Still not Coming Home

Many readers will be familiar with the inability of the UK Government to meet its commitments, dating as far back as the Winterbourne View scandal of 2011, to reducing the number of autistic people and people with learning disabilities inappropriately in hospital settings. A similar story has played out in Scotland, and has been highlighted by two important new reports from the Scottish Human Rights Commission and the Mental Welfare Commission.

In 2016 the Mental Welfare Commission published '*No Through Road*', a report of a visit to all 18 hospital units in Scotland for people with a learning disability. It found that a third of in-patients were experiencing long waits for discharge. In 2018, the Scottish Government published '*Coming Home*', an independent report by Dr Anne Macdonald into out of area placements and delayed discharges. This found that 705 people with learning disabilities had been placed out of their home area, 453 of which were not by choice. 67 people were classed as delayed discharge, of whom 22% had been in hospital for more than ten years. In 2019 the MWC published a further visit report, covering people with autism and complex care needs. Almost half of the people whose care the Commission reviewed were classed as having a delayed discharge.

The Scottish Government established a working group who made interim recommendations in 2020 and published the *'Coming Home implementation plan'* in 2022. This included a Mission Statement that 'By March 2024 we expect to have seen out-of-area residential placements and inappropriate hospital stays greatly reduced.'

Sadly that ambition appears to have been unrealised. In January 2025, the MWC published a further report, *'Hospital is not home'.* This reviewed the cases of 55 people who had been living in hospital for over 10 years. They found that

- Information about whether people were considered to be ready for discharge was hard to find
- Some people had been deemed clinically well enough to leave hospital 10 years previously
- Some patients were not even identified as requiring discharge planning.

In short, 'the right to live independently and to be included in the community is not being realised for a small but significant group of people.'

Also in January, the SHRC published *'Tick Tock: A Human Rights Assessment of Progress from Institutionalisation to Independent Living in Scotland'*. This found 'evidence of direct violations of Article 19 of the United Nations Convention on the Rights of Persons with Disabilities, and also serious concerns about potential violations of the European Convention on Human Rights obligations enshrined in the Human Rights Act 1998, such as Article 5, the right to liberty, and Article 8, the right to respect for private and family life.' The SHRC found that £12.5 million of a £20 million Change Fund remained unspent, going into the final year of the fund. Perhaps even worse, some of the money had been spent on making improvements to the institutions from which people should have been moving.

More positively, the SHRC also published a *Toolkit on Measuring Change on Ending Institutionalisation in Scotland*. This draws on indicators developed by the European Union Fundamental Rights Agency, and was developed in collaboration with families and supporters of people experiencing institutionalisation. It sets out in a clear and straightforward way what human rights are in play, and provides a set of Structure, Process and Outcome Indicators which can be used to assess a State's commitment to ending institutionalisation. Although designed for the Scottish context, its approach is one that is widely applicable.

After so many false dawns, we can only hope that these latest initiatives finally lead to tangible and sustainable progress in ending institutionalisation for autistic people and people with learning disabilities.

Colin McKay

Prescription for uncertainty

Disruption of the powers of attorney regime, and its place in the overall scheme of our adults with incapacity law and practice, is threatened by the last-minute collapse of an appeal to the Inner House from the decision of Lord Braid in *MBM Trustee Company Limited v William Moultrie*, [2024] CSOH 14. Do practitioners now require to ensure that all prospective continuing attorneys are warned of the potential consequences of that case, and do granters require to be advised to take account of it? The pursuer's position was that more than five years after the death of a granter, a continuing attorney could be required to produce a full and proper, duly vouched, accounting of his intromissions as attorney.

The case at first instance was decided, so far as it was then decided, on the question of whether any obligations of continuing attorneys to account for their actions after they have ceased acting as such, in this case by reason of the death of the granter, are or are not extinguished by quinquennial prescription under section 6 (and other related provisions) of the Prescription and Limitation (Scotland) Act 1973 ("1973 Act"). For the operation of the continuing powers of attorney regime, that question require a clear yes/no answer. Lord Braid decided to "deal briefly" with what he treated as "*the subsidiary point as to the form an accounting must take*". Though for the purposes of this case that was a

subsidiary point, it is of major significance for every continuing attorney. Do they all need to keep full and detailed records – taking us back to the pre-2000 days encapsulated in the famous comment "We can't buy her an ice cream cone without obtaining a receipt"? The answers tendered by the pursuer to those two questions mean that 19 years after the death of the granter a continuing attorney could be asked to produce a full and detailed accounting of intromissions over what might well have been a lengthy period ending so long ago. What needs to be produced, by way of an accounting, equally requires clear and precise specification – not just a "full" or "proper" accounting, because those adjectives can only be applied to a clearly defined standard. Otherwise they create meaningless circularities. Unfortunately, the answer at first instance to both questions was, in effect, "Maybe, depending on examination of relevant facts". On the crucial question of whether suitable and conscientious potential continuing attorneys might be deterred from accepting office by the risk – of which they would have to be advised – of finding themselves in that position, that was the worst possible outcome. It gives rise to an immediate public policy question of whether the appropriate operation of the powers of attorney scheme, and – for example – resultant increase in guardianships, requires to be properly addressed. It would seem necessary that Scottish Government be asked to do so in forthcoming amending legislation: probably an unwelcome request, given the major workload for government in addressing in the legislation already pressing and urgent matters, but the potential consequences of not addressing it would seem likely to be more unwelcome.

Two points should be noted. Firstly, although the pursuer's action was served three months and three days after quinquennial prescription, if applicable, would have operated, the pursuer did not seek to rely on section 6(4) of the 1973 Act under which quinquennial prescription is extended by any period during which "the creditor was induced to refrain from making a relevant claim" by fraud, or by error induced by words or conduct. That raises the policy question of whether a properly advised claimant would be likely to need more than five years to make a "relevant claim"; counterbalanced by whether a former attorney should escape liability to answer challenges of alleged wrongful conduct by reason of operation of quinquennial prescription.

Secondly, the defender had not refused to produce any form of accounting at all. The defender had submitted what was described as an "expert report … which had been properly and professionally instructed and vouched the defender's transactions whilst an attorney", but not a year-by-year account as the pursuer suggested was necessary.

The debate before Lord Braid, and in consequence his decision, focused principally upon the question of whether an attorney is a "trustee" for the purpose of the list of imprescriptible obligations in Schedule 1 to the 1973 Act, the relevant sub-paragraph of which reads as follows:

"(e) any obligation of a trustee-

(i) to produce accounts of the trustee's intromissions with any property of the trust;

(ii) to make reparation or restitution in respect of any fraudulent breach of trust to which the trustee was a party or was privy;

(iii) to make forthcoming to any person entitled thereto any trust property, or the proceeds of any such property, in the possession of the trustee, or to make good the value of any such property previously received by the

trustee and appropriated to his own use;"

That links back to section 15 of the 1973 Act, which, so far as material, provides as follows:

"'trustee' includes any person holding property in a fiduciary capacity for another and, without prejudice to that generality, includes a trustee within the meaning of the Trusts (Scotland) Act 1921; and 'trust' shall be construed accordingly."

Thus the question became whether the attorney in this case was a trustee (for the purposes of the 1973 Act) "holding property in a fiduciary capacity for another". It is clear from the Adults with Incapacity (Scotland) Act 2000 ("2000 Act") that a continuing attorney acts "in a fiduciary capacity" for the granter; but does an attorney "hold" property for the granter? On the basis of the submissions before him, Lord Braid concluded that the attorney in this case may or may not have been holding any property of the granter, and that this was "*ultimately a question of fact in any given case*". He also held that the required form of account depended upon whether the attorney was "a trustee holding property for the granter". Ominously, he stated that "*Had I held that the defender did hold funds or property, I would then have found that the expert report was not a proper accounting*". It appears that he was not addressed on potential arguments that such an outcome would be inconsistent with relevant provisions of both the 2000 Act, the relevant code of practice, and indeed the original intentions of the legislation in this regard. However, a settlement agreed between the parties, upon undisclosed terms, apparently agreed on the eve of the hearing before the First Division, leaves us deprived, even in whatever might have been the particular circumstances of this case, of a clear, and no doubt clearly explained, yes/no answer. Standing the outcome and comments narrated above, such an answer is now urgently needed.

For the purposes of this Report, readers must be asked to read the Opinion of Lord Braid, incorporating his account of the submissions of the parties and of other relevant factors that were considered, in reaching those "maybe" answers. What does require comment for the purposes of this Report is the dearth of reference to the 2000 Act and Scotland's wider regime of measures relating to the exercise of legal capacity (in the terminology of the UN Convention on the Rights of Persons with Disabilities ("CRPD") – "measures"), apart from reference to provisions of section 81 of the 2000 Act, and quite baffling reference to the management of funds provisions of Part 3 of that Act; baffling as to what could be their relevance, and even more baffling because of the lack of reference to comparison between the provisions of Part 2 on powers of attorney and the provisions of Part 6 on intervention and guardianship orders. That contrast is probably explained by a practitioner somewhere to a client contemplating granting a power of attorney on most, if not all, working days.

At least four routes other than appointing a continuing attorney are available to anyone seeking to be assured of the greater protections of guardianship, or alternatively of trusteeship. The first is simply not to grant a power of attorney, so that a guardian will if necessary be appointed. It is an alternative often discussed, but – in my experience – only rarely adopted. We do not know how many adults deliberately refrain from having that discussion with a solicitor because they do not have someone whom they might have confidently appointed to be attorney, or if they had consciously opted for the guardianship (or management of funds) regime if that should ever become necessary. I personally while practising have acted upon instructions to implement the second and third possibilities, namely an application for guardianship under section 57(1) by any person

"including the adult himself"; and creating a trust for administration under which funds or assets are explicitly transferred to be "held" by trustees – normally to "put the brakes on" at times when an adult fears that funds may upon impulse be dissipated in ways which the adult might subsequently regret. That last-mentioned option was probably used more frequently prior to the 2000 Act, but would appear to remain competent. The fourth alternative is a variant of the first, namely, to nominate in advance the person whom the adult would wish to be appointed guardian should a guardian become necessary. That is explicitly recognised in Recommendation 14 of Council of Europe Ministerial Recommendation (2009)11 on principles concerning continuing powers of attorney and advance directives for incapacity, expected in due course to lead to statutory regimes (including in Scotland) for advance directives or "advance choices", but amounting to clear statements of wishes, possibly couched as instructions, which would require judicial development, absent legislation, as to the extent to which they might be binding rather than persuasive – though unless there were clear reasons for questioning the choice, it would be difficult to see how failing to follow such a nomination would comply with the section 1 principles of the 2000 Act.

What is clear is that options indubitably providing the protections of guardianship or of trusteeship are available as alternatives to granting a power of attorney. That leads to the key question of what are the obligations of a continuing attorney under the 2000 Act, which requires consideration *inter alia* of obligations placed upon financial guardians but not upon continuing attorneys, with the clear implication that the Parliament did not intend that equivalent obligations should be placed upon attorneys. Firstly, it should be noted that an attorney (under section 21 of the 2000 Act), an appointee under an intervention order (section 54) and a guardian (section 65) are all required to keep records of the exercise of their powers. The significant differences for continuing attorneys relate to any requirements to maintain, and to produce, accounts. The following is not necessarily an exclusive list, by reference to provisions of the 2000 Act, of relevant provisions.

Section 3(3): A sheriff may give directions, which presumably would include directions from that point onwards to keep accounts in such form as might be specified.

Section 3(2)(b): A sheriff may order that reports be lodged, but there is no mention of accounts.

Section 20(2)(a): A sheriff may place a continuing attorney under the supervision of the Public Guardian, emphasising that a continuing attorney is not otherwise subject to such supervision.

Section 20(2)(b): A sheriff may ordain a continuing attorney to submit for audit by the Public Guardian "accounts in respect of any period specified in the order". This is the one provision that indicates an obligation to have kept the records necessary to produce such accounts, but that needs to be read in relation to relevant provisions of the Code of Practice for continuing and welfare attorneys, subtitled "Guidance for people who grant powers of attorney, or people who are appointed as attorneys under the Adults with Incapacity (Scotland) Act 2000", and in particular Chapter 4 of that Code, providing "specific guidance on exercising continuing powers of attorney". It is relevant that Chapter 4 at various points uses "It would be good practice to …" rather than "You must …". However, the formulation "You should …" is used in paragraph 4.35: "*You should keep all receipts for purchases of £100 or more, on behalf of the person and any guarantees or insurance policies in respect of purchases so that you can*

exercise the person's rights as purchaser to have property repaired or replaced". In a typical case, many transactions will be below the £100 threshold. For example, a typical week's grocery shopping for a single adult is unlikely to exceed that threshold. That would not appear to support assertions of an obligation upon attorneys to produce detailed and fully vouched accounts. Under the heading "Possible court proceedings in the event of a complaint", paragraph 4.64 reads:

"If you are ordered to be under the supervision of the Public Guardian you should regard it as a help rather than a threat. As a first step you should have a meeting with the Public Guardian, show her your file, ask for what she wants you to record in your file from now on, and agree a deadline for the submission of the account of your activities to date. …"

This re-emphasises what is apparent on a plain reading of section 20. Any obligation upon a continuing attorney to produce accounts under the 2000 Act is an obligation to produce them to the Public Guardian, of part of a process in which the starting-point of the Public Guardian is to provide assistance to achieve the better operation of the role of attorney. It is not an obligation to submit accounts to the satisfaction of any other party, who might well be a party in conflict with the attorney.

Section 17 provides that an attorney is not obliged "*to do anything which would otherwise be within the powers of the attorney if doing it would, in relation to its value or utility, be unduly burdensome or expensive*". In appropriate cases, that could apply to questions whether a guardian should keep records and maintain accounts to the level of detail that might satisfy demands such as those of the pursuer in this case.

While the whole Part 6 regime relating to guardianship and intervention orders is a relevant comparator to show the enhanced levels of accounting and supervision applicable under Part 6, compared to the requirements upon powers of attorney, some particular provisions are worth noting in that context.

Section 62(6) provides for management by, and the respective liabilities and responsibilities of, two or more joint guardians. There are no equivalent provisions in relation to attorneys. Such provisions may be stipulated in the power of attorney document, but otherwise it must be assumed that the Parliament did not consider that an equivalent level of regulation was necessary. There are likewise potential issues where substitutes take over.

Section 64(12) puts financial guardians under the regime in Schedule 2. This includes the obligation under paragraph 7(2) of that Schedule to submit accounts for audit, and also – significantly – the discretion of the Public Guardian under paragraph 7(4)(b) to dispense with submission of accounts. The lack of equivalent provision for attorneys could be taken as indicating that attorneys may exercise their own discretion in that matter, subject to compliance with section 82 (see below), unless they have already been specifically ordered under section 20 to prepare and submit accounts. On the question whether a continuing attorney is a trustee for the purposes of the 1973 Act, section 67(2)(a) is significant. The guardian is authorised to take possession of, manage and deal with any moveable or immoveable estate (wherever situated) of the adult. This directly engages the fundamental difference between ownership and possession, most recently emphasised in the article "Understanding ownership and possession in Scottish law: distinguishing chalk from cheese", T Odusanya, 2025, SLT (News) 29 (published clearly after Lord Braid's decision, but prior to the date on which the appeal would have been heard). If the Parliament had intended that assets subject to a

power of attorney should vest in a guardian, it would have said so. Instead, it authorised the guardian to take possession. It is reasonable to assume that the same would have applied to attorneys, particularly if that were to apply to attorneys but not to guardians. Deeds of Trust as third party measures, and Trusts for Administration, typically "pay, convey and make over" specified assets to the trustees appointed, and would contain an obligation to grant a disposition of any heritable property to the trustees, to be held – of course – by them *qua* trustees. As regards trusts as third party measures, see long-standing styles still substantially in use such as those offered by Ashton and Ward in "Mental Handicap and the Law", Sweet & Maxwell, 1992. I am not aware that any continuing power of attorney has had similar effect of transferring ownership in trust to an attorney. It must be expected that if such a radical intention had applied to the continuing powers of attorney regime established under the 2000 Act, the Act would have said so. Further complications can arise from actings of the granter at any time following appointment of an attorney. Attorneys can be, and often are, asked by the granter to act regardless of technical capacity or incapacity of the granter, as an assistance for the granter, typically when the granter wishes someone else to take over the burden of aspects of management of some or all of the granter's affairs. Notably, continuing attorneys are obliged under section 1(5) to encourage the granter to exercise and develop relevant skills; and the granting or operation of continuing powers is not subject to the explicit provision in section 67(1) incapacitating an adult from acting within the scope of the authority of a guardian, except where the adult has been authorised to act by the guardian under section 64(1)(e). Such incapacitation would have to be explicit, and reasonable, in order not to violate relevant provisions of the European Convention on Human Rights and CRPD. No equivalent explicit provision applies to attorneys, although there is vagueness in the Act in that welfare attorneys are prohibited from acting except in matters where the granter is incapable or reasonably believed by the guardian to be incapable. That, however, takes us beyond the scope of this Report, for which the relevant point relates to the potential complications for accounting purposes of situations where the granter may be acting in parallel with the attorney.

Section 72(1) enables a financial guardian who has ceased acting to obtain a discharge from the Public Guardian. The Parliament did not provide such a procedure for continuing attorneys, presumably because it was not considered necessary. This points towards the accounting and liability obligations of continuing attorneys being strictly limited to explicit provisions of the 2000 Act.

Section 81 obliges all financial managers to repay funds used in breach of their financial duty or outwith their authority. That is neutral in the sense that it does apply to continuing attorneys as much as any other managers, but significant in that the 2000 Act does not place any obligation upon them to provide accounts. Accounting obligations (if any) are set out Part by Part in the Act, and vary from Part to Part.

Also significant by reason of their uniformity of application are the limitation of liability provisions of section 82. A continuing attorney, among all other persons acting under Parts 2, 3, 4 and 6 (but not Part 5) of the 2000 Act incurs no liability "for any breach of any duty of care or fiduciary duty owed to the adult" if the attorney (in the case of attorneys) has "*(a) acted reasonably and in good faith and in accordance with the general principles set out in section 1; or (b) failed to act and the failure was reasonable and in good faith and in accordance with the said principles*". It does not appear that such a

limitation could be treated as disapplied in the event of complaint by the executors of a deceased granter of a power of attorney against the attorney who acted.

It is relevant to go back to Report No 151 presented to Parliament in September 1995 by the Scottish Law Commission entitled "Report on Incapable Adults", to which was annexed a draft Bill which to a large extent was adopted to form the 2000 Act, and which in particular was so adopted for most (if not all) of the provisions of the 2000 Act referred to above. On the "fiduciary duties in relation to adults", paragraphs 2.74 – 2.79 of that Report are relevant. For example, paragraph 2.77 considers situations where an appointee and an adult live together in the adult's house. Often, such appointees will have given up substantial aspects of their own lives to become resident carers. The Commission expressed the view that it would be unreasonable to expect fully detailed, vouched, accounts from an appointee doing so much for a close adult voluntarily, as well as providing at no charge what would otherwise be a costly management service. Of course, that all assumes that there is no question of the appointee acting unreasonably or dishonestly for personal advantage or gain, but that situation is addressed by sections 81 and 82 of the 2000 Act.

What we have lost by the appeal due to be heard on 17th February 2025 not proceeding is examination and determination by the Inner House of the extent to which continuing powers of attorney are a distinct species *sui generis*, created by the 2000 Act, and the extent if any to which they are a sub-species of general powers of attorney. Put briefly, one would suggest that application of any general provisions should be subject to any explicit relevant provisions of the 2000 Act, such as those referred to above, but it would be surprising if executors were not to have the same rights as the granter would have had upon regaining relevant capacity. Those also now need to be defined.

Generally, settlement of the appeal against Lord Braid's decision has deprived us of the opportunity for debate before, and consideration and determination by, the Inner House of the alternative approach focused on proper interpretation of the 2000 Act. One might suggest that such an alternative route might be preferable as providing greater certainty in the context of the realities of operating continuing powers of attorney. It has to be questioned whether the route that emerged from the hearing at first instance might have made sense in theory only, but has left too much uncertainty in matters in which all concerned are entitled to greater certainty, not predicated upon lengthy proceedings and hearings of evidence to produce different answers in different cases. It is for others to consider whether the outcome of following that route might lead to absurdity as defined by Lord President Carloway towards the end (at [30] - [32]) of his Opinion in *Faculty of Advocates and Judicial Appointments Board for Scotland, Special Case*, 2025 SLT 171.

Quid juris if the granter strictly limits in the power of attorney document the obligations and liabilities of the attorney after ceasing to act, as to duration, extent of any accounting obligations, and so on?

Adrian D Ward

Psychiatric care and treatment of children and young people: lessons from Syke House

On 10th February 2025, BBC Scotland broadcast a documentary in its Disclosure series *Kids on the Psychiatric Ward*, currently available on BBCiPlayer, featuring the experiences of six young women who had been admitted to Skye House, a specialist NHS psychiatric unit for adolescents in Glasgow, between 2017 and

2024 [9] . These were six of 28 young people interviewed by the documentary makers. It raises and reinforces serious issues that need to be timeously and fully addressed[10].

The BBC documentary does not make for easy watching. It is impossible to remain unaffected by the accounts of the young women, who were impressive in their testimony. Their description of episodes involving nurses' conduct and behaviour around the arguably disproportionate use of restraint, forced medication and use of medication, physical handling, use of language towards and mocking of patients, patients being made to clean up vomit and blood after restraint and forced intervention sessions, and sometimes questionable accuracy of clinical notes following episodes of forced interventions is deeply troubling. Equally troubling were the accounts of a lack of supervision of young people on the unit, leading to what may well have been avoidable self-harm incidents and acute episodes, and fear of making complaints or even telling their parents in case this resulted in recriminations from staff.

Whilst Dr Scott Davidson, medical director of NHS Greater Glasgow and Clyde, was interviewed for the documentary and the health board has issued a statement that an investigation will take place, the documentary makers were unable to obtain the views of staff on the unit itself or the Scottish Government. The Mental Welfare Commission's 2023 visit report for Skye House [11] commented with concern about the over-reliance on agency staff, particularly in nursing, at the unit and how they had been told that the unfamiliarity and instability, and sometimes approaches, of agency staff might adversely impact on the quality of care, although the incidents mentioned by the young women in the documentary or similar ones were not mentioned. This may arguably be owing to the reluctance of the young people to make complaints but obviously warrants consideration.

One assumes, indeed hopes, that these incidents and behaviour are isolated and confined to a minority of staff. Several of the young women interviewed acknowledged that not all staff behaved in this way. Some also accepted that at the time they did need professional support, and that their own behaviour was occasionally challenging. However, they also pointed out that they were unwell and suggested that such traumatising experiences might have been avoided or reduced had earlier and more understanding approaches been adopted. The considerable pressure that mental health nurses are under should not be underestimated either, for example in terms of challenging behaviours they are required to navigate and resourcing constraints. However, irrespective of the number of patients involved, it is never alright to subject a person of any age to cruel, inhuman or degrading treatment or punishment. This is not only a moral imperative. It is also an absolute human right[12].

We have human rights-based mental health legislation: how did this therefore happen?

One has to ask how this sort of thing happens.

[9] Mark Daly and Jax Sinclair, 'Teenagers mocked by nurses at psychiatric unit', BBC News Alba, 10 February 2025
https://www.bbc.co.uk/news/articles/cx2kg2djkk2o

[10] Full disclosure: I was involved in the documentary, to the extent of providing some legal and human rights information to and being interviewed for it. The views expressed in this article, however, are entirely my own.

[11] Mental Welfare Commission for Scotland (2023), *Report on announced visit to Skye House, date of visit 28 March 2023*

[12] For example, Article 3 European Convention on Human Rights, Article 15 Convention on the Rights of Persons with Disabilities, Article 27 Convention on the Rights of the Child.

Further, it appears that this may not be entirely confined to one psychiatric unit, or to adolescent care and treatment alone. How was the line crossed in terms of respect for human rights, notably respect for dignity and autonomy, and proportionality?

The Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA) (which applies to people of all ages) after all sets out human rights informed principles and criteria [13] governing decisions about, and implementation of, compulsion under the Act. These are there to safeguard an individual's liberty, autonomy and dignity when faced with the prospect of detention and/or non-consensual psychiatric treatment [14] . They, together with related guidance and codes of practice, provide safeguards against inappropriate and disproportionate use of coercion and medication, including the use of force, in administering care and treatment[15].

The MHA principles and criteria are predominantly informed by the European Convention on Human Rights (ECHR). Practitioners must also take the Convention on the Rights of Persons with Disabilities (CRPD) and Convention on the Rights of the Child (CRC) into account. CRC rights are now legally enforceable (since July 2024) in Scotland[16] and the Scottish Government has also said that legislation will be introduced making CRPD rights legally enforceable. However, whilst the CRC and CRPD were not legally enforceable in 2017-2024 (the period covered by the documentary) they should have nevertheless been considered alongside ECHR rights, and ECHR rights interpreted according to these, insofar as the national law permits.

Children and young persons' rights

The MHA essentially requires that any detention and compulsory intervention must be necessary and proportionate, provide a benefit that is not otherwise available and be the least restrictive option under the circumstances. There must also be a significant risk to the child or young person's health, welfare or safety or the safety of another person. In other words, it must be a very last resort, and other options should be thoroughly explored first unless there is genuine risk to life and health. Any detention must be in the most appropriate setting[17] and must end as soon as the therapeutic benefit provided by it has been achieved. The child or young person's wishes and feelings must be taken into account (of course, capacity assessed according to the effects of the child's condition and age) and they must be supported to do this. Any intervention must best secure their welfare as a child.

It is often said that we lose our rights when admitted under compulsion to a psychiatric unit, but that is not the case. The rights to liberty and autonomy may be limited but an element of possessing human rights is that any restriction must be lawful, necessary and proportionate (and also non-discriminatory). Moreover, even where our liberty and other aspects of our autonomy may be legitimately limited upon

[13] See, for example, sections 1 and 2, and sections 36, 44 and 64 Mental Health (Care and Treatment) (Scotland) Act 2003.
[14] For example, Articles 3, 5, 8 and 14 ECHR; Articles 3, 12, 19, 23 and 25 CRC; Articles 7, 12, 15, 16, 17, 19, and 25 CRPD.
[15] See, for example, amongst others, Mental Welfare Commission for Scotland (1) (2017) *Human Rights in Mental Health Services*; (2) (2021) *Rights, Risks, and Limits to Freedom*; (3) (2024) *Carers, Consent and Confidentiality*; (4) (2024) *Consent to Treatment*. They have been around for some time; these are the latest editions.
[16] United Nations Convention on the Rights of the Child (Incorporation) (Scotland) Act 2024.

[17] See *Rooman v Belgium* (18052/11), ECHR Judgment of 31 January 2019 for a recent interpretation of this.

being admitted to a psychiatric unit (either voluntarily or involuntarily) this does not remove our right to be free from cruel, inhuman or degrading treatment or punishment. Recent Strasbourg Article 3 ECHR jurisprudence [18], reflecting increasing international human rights bodies' concern over psychiatric compulsion and institutional care, indicates that even stricter scrutiny of psychiatric care and treatment practices is now required, especially where coercion is involved, and there is more recognition that what is considered to respect our dignity is personal to the individual concerned.

Parents' rights

The MHA also requires that regard should be had to the views of a patient's family and their named person. This does not mean that parents, for example, are automatically entitled to know everything about their child's care and treatment but it does not mean that important information about their child should not be considered.

Moreover, where a parent, as is normally the case, is their child's named person, the MHA allows them to be notified and involved in discussions about care options and decisions about compulsion, including receiving relevant information and being able to make applications or appeals to the Mental Health Tribunal.

What needs to be done?

The young people and their families require answers and, where appropriate and necessary, apologies and redress. We all need to know that steps will be taken that ensure that this does not happen again. Staff and managers also need to know that there will be mechanisms to guide and support their work so incidents such as this do not occur. All such actions and measures must be in accordance with relevant legislation and be human rights based.

In relation to the prohibition of inhuman or degrading treatment or punishment, for example, the recent European Court of Human Rights *Clipea and Grosu v Moldova* ruling [19] makes it clear that Article 3 ECHR creates both negative obligations and positive obligations on the part of public authorities. This means an obligation not to treat an adult or child in an inhuman or degrading manner. It also means an obligation to adopt a regulatory framework to prevent violations and take operational measures where there is an imminent risk of violation, and to prosecute both state and private actor perpetrators of violations, with the Court emphasising that these positive obligations apply to both voluntary and involuntary patients albeit with stricter scrutiny in the case of involuntary patients.

We are aware that mental health professionals, including mental health nurses, are under considerable pressure, not least because of resourcing limitations, which must clearly impact on day-to-day practice. I understand that around 1% or less of the budget allocated to NHS Scotland by the Scottish Government is for children and young people's mental health, and we are told that post-Covid-19 mental ill-health is increasing for this age group. We must acknowledge that, like all humans, they will have breaking points which will be tested when dealing with what can amount to patients' challenging behaviour. However, as previously stated, whatever the circumstances, there can be no excuse whatsoever for cruel, inhuman or degrading treatment or punishment or failing to respect the other rights of patients in institutional or community, and particularly in therapeutic, settings involving children and young people.

[18] *Clipea and Grosu v Moldova* (39468/17), ECHR judgment of 19 Novembre 2024.

[19] Ibid.

Individual staff members who have exhibited such behaviours must be held to account under disciplinary processes and professional standards, and, where such behaviours amount to offences, under the criminal law.

Importantly, it is necessary to also consider the wider institutional environment and cultures which may allow for these things to happen. There are many factors here that any investigation and steps taken to remedy the flaws in the system need to address in this highly complex area of mental healthcare.

Resourcing is an obvious consideration but so is recruitment, and better and greater assurance of training, particularly around the use of restraint and focusing on up-to-date human rights interpretation of the law. More effective accountability, leadership and monitoring (there is no official inspection process around children and young persons' psychiatric units in Scotland at present, and it must be remembered that the Mental Welfare Commission's role is to monitor not or regulate) is also important. Crucially, there needs to be accessible processes whereby patients and their families, and other staff, can request and be supported to request specific support and raise to concerns and make complaints without fear of reprisal (whistleblowing arrangements at present do not seem to work), and where staff who are struggling or unclear about aspects of their practice can, without judgment and impact on their career, seek support.

It would also be highly advisable that any steps to review and address these issues – and this needs to happen urgently – take place across all Scottish health boards, not simply confined to Greater Glasgow and Clyde.

Initial next steps

As already mentioned, NHS Greater Glasgow and Clyde have stated that an investigation will take place. On 19th February, the Scottish Minister for Social Care, Mental Wellbeing and Sport, Maree Todd, announced to the Scottish Parliament that extra inspections are to be carried out at children and young persons' psychiatric units in Scotland. She has asked Healthcare Improvement Scotland and the Mental Welfare Commission for Scotland to carry out a series of joint visits to all adolescent in-patient units in Scotland and the national child in-patient unit.[20] She also stated:

> *"The care and treatment of young people as described in the programme are completely and wholly unacceptable. When our most vulnerable and unwell young people come forward and ask for help for their mental health, we owe them the highest standard of care and compassion. The accounts that were given by those brave young people and their families were truly harrowing. We must do everything that we can to ensure that patients are treated with the care and respect that they deserve."*[21]

The Children and Young People's Commissioner, Scottish Human Rights Commission, The Promise Scotland, and Equality and Human Rights Commission have sent a joint letter[22] dated 14th February 2025 to various Scottish Cabinet Secretaries and Ministers calling on the Scottish Government to commit to establishing a unified statutory framework which will regulate

[20] Scottish Parliament, Official Report: Meeting of the Parliament (draft), Session 6, Wednesday 19 February 2025. https://www.parliament.scot/chamber-and-committees/official-report/search-what-was-said-in-parliament/meeting-of-parliament-19-02-2025?meeting=16261&iob=138891#orscontributions_M5669E393P730C2658199

[21] Ibid.

[22] See, for example, https://www.scottishhumanrights.com/publications/ for a copy of this letter dated 14th February 2025.

the use of restraint and seclusion on children across all state care and education settings. As the Scottish Mental Health Law Review (Scott Review) also did, this importantly recognises that the wellbeing of children and young people cannot be viewed or addressed in terms of service and support silos. It also expressed concern over a lack of action so far on this by the Scottish Government, and highlighted that the current piecemeal approach places vulnerable children at risk of harm (as well as undermining Scotland's commitment to the protection of children's rights!).

The BBC Skye House documentary was specifically mentioned in the letter as well as concern over the slow pace of implementation of the Scott Review recommendations. It also calls on the Scottish Government to undertake various steps towards this including establishing a short-life legal working group to develop a model which could be applied across the different pieces of legislation, accelerate work on the legislative elements of the Scottish Government response to the Scott Review (involving both the Adults with Incapacity (Scotland) Act 2000 and MHA).

Chapter 12 of the Scott Review's final report makes a number of human rights-based recommendations for the improvement of psychiatric care and treatment of children and young persons. In relation to restraint, the Review recommended (Recommendation 9.8) a detailed review of the treatment safeguards, with specific consideration given to independent authorisation of restraint and seclusion, except in emergencies, and a possible right of appeal. Amongst other recommendations which apply equally to adults and children, the final report (Chapter 11) also contains recommendations for better scrutiny and monitoring of mental health services. These all form a good starting point to frame any health board investigations and the development of the requested unified statutory framework to regulate the use of restraint and seclusion on children and young people.

These are all steps in the right direction, and time will tell how effective they are. However, there is no room for complacency in ensuring redress for the young women involved in the BBC documentary and others who may have had similar experiences, and ensuring it does not happen again.

Jill Stavert

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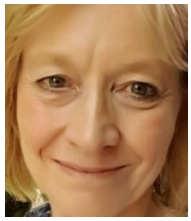

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Conferences

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

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

Advertising conferences and training events

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

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

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