39 Essex CHAMBERS

MENTAL CAPACITY REPORT: THE WIDER CONTEXT

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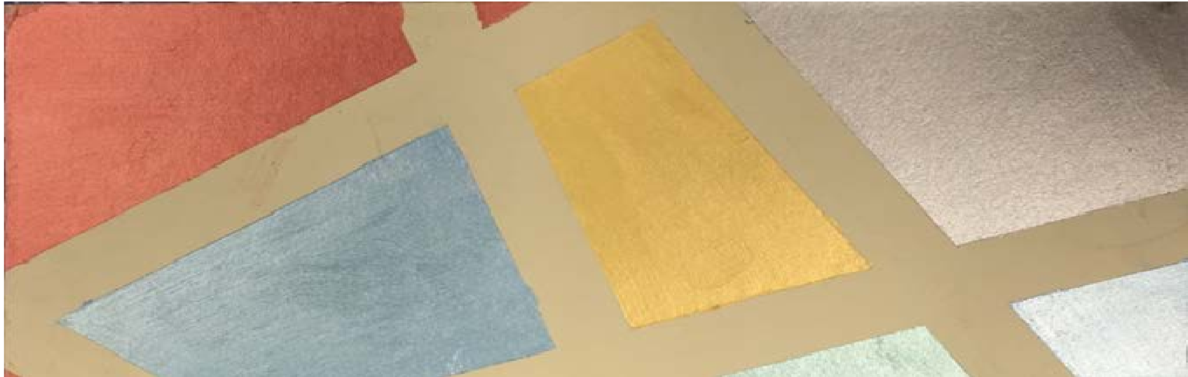

Welcome to the June 2024 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: when no option is a good one, snapshots from the frontline, and are we listening closely enough to the person in the context of deprivation of liberty;

(2) In the Property and Affairs Report: the Powers of Attorney Act 2023 on election hold, contesting costs in probate cases and guidance on viewing LPAs online;

(3) In the Practice and Procedure Report: post-death costs, what does it mean to be an expert in the person, and procedure in brain stem death cases;

(4) In the Mental Health Matters Report: the MHA 1983 under strain in police cells and the hospital setting;

(5) In the Wider Context Report: the inherent jurisdiction – a case, guidance, and a challenge from Ireland; the older child and medical treatment decisions – mental capacity or competence, and Capacity and contempt proceedings – what is the test?

(6) In the Scotland Report: guardianship under examination before the Sheriff Appeal Court and Scottish Government's Mental Health and Capacity Reform Programme.

There are two plugs this month:

(1) For a free digital trial of the newly relaunched Court of Protection Law Reports (now published by Butterworths. For a walkthrough of one of the reports, see here.

(2) For Lucy Series' blog post about mental capacity and voting.

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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The inherent jurisdiction – a case, guidance, and a challenge from Ireland

Two recently published decisions of Cobb J have shone a light on the lesser spotted beast that is the inherent jurisdiction of the High Court to protect adults who are vulnerable[1] but who do not fall within the scope of the Mental Capacity Act 2005. Both decisions in *Wakefield Metropolitan District Council v FH* & Anor relate to the same couple; the first dates from 2021, but was not published until very recently, at the same time as the second decision from 2024.

The couple had been married for some sixty years by the time of the first hearing, which resulted in an oral judgment, now transcribed. The wife, FH, had very extensive care needs, which had been provided by her husband, MH, who himself had his own care needs. Cobb J noted (paragraph 4) that "*one important agreed fact on the information that I have received is that they deeply love each other and want to be together*." However, in the next paragraph, he identified that "[o]*ver a period of time stretching over years, a number of concerns have been raised with the local authority adult social services about the dynamics of the relationship between MH and FH in which it is said that physical and verbal abuse have been a feature. JS [the social worker's] professional view is that FH is subject to coercion and control by MH, who it is said manipulates her.*" FH had been admitted to hospital in circumstances of very considerable distress, having apparently fallen out of bed. Cobb J noted from the audio recording of the Care Line phone call made (it is not clear by whom) that "[w]*hat was striking about MH's response to that situation was that he appeared to show no empathy or care for her in her situation but, on the contrary, demonstrated high levels of verbal abuse of her, both directly to her and at her. It makes, if I may say so, extremely distressing listening*" (paragraph 6). It was those circumstances which led to the urgent application being made under the inherent jurisdiction for an order protecting FH and facilitating her move into a care home.

Cobb J identified that:

> *17. On the evidence that I have read, and I am conscious that of course the evidence that I have read has not been*

[1] This is the term that the High Court uses, as opposed to (for instance) "adults at risk" as per the Care Act 2014 approach.

subject to testing or other live scrutiny, and on the submissions that I have heard from the local authority, from Mr Kennedy on FH's behalf, and from MH himself, I declare myself satisfied that this is a case in which the court could, and indeed should, exercise exceptionally its inherent jurisdiction in respect of FH. The narrative statement of JS, summarising a history of coercion, control and abuse over a number of years, was, I must emphasise, brought vividly and worryingly to life by the content of the audio recording which I heard before the hearing began. That audio recording, in my judgment, revealed an unacceptable and, in some measure, shocking level of intolerance, abuse and lack of empathy and care on the part of MH towards his wife. While the circumstances in which that recording were taken may have been circumstances of very considerable stress and pressure to MH, that does not in my judgment explain or excuse that which I heard, including the language and the offensive names which he called FH during the course of fifteen minutes of fairly unrestrained abuse.

17. In my judgment, FH requires the protection of the court at this stage to ensure that she does not return, at this stage, I emphasise, to the home which she shares with her husband and into his primary care. I am satisfied that the local authority has made out its case for an order which will ensure that FH remains at Dewsbury Hospital until she is fit for discharge, and that upon that stage being reached in her recovery, that she then be transferred to a care home, probably HH Care Home, for the immediate future.

18. I am satisfied that where it is necessary, it is indeed proportionate for modest forms of restraint to be used to ensure that FH is enabled to make that journey and then remain at the care home. I am comforted to know that arrangements will be made for MH regularly to visit FH, subject to him testing negative for Coronavirus through the lateral flow tests, and that short visits will be permitted to enable them to see each other. In the meantime, further assessment can and should be made of her care and support needs so that plans for her return home can be contemplated, evaluated and, as appropriate, implemented.

19. I will authorise Wakefield Metropolitan District Council to convey and place FH at such a care home as I have indicated, because I am satisfied that it is necessary, proportionate and plainly in her best interests. I propose to direct that, within seven days of FH's placement at an appropriate care home, the local authority shall serve a statement updating the court as to MH and FH's views, wishes and feelings, whether she has settled, providing details of the care and support FH is in receipt of, and filing an interim care plan for her future care.

By 2023, further proceedings were on foot. In the March 2024 judgment, Cobb J was at pains to emphasise (paragraph 10) that FH had capacity to make the relevant decisions, and to conduct the proceedings. He also emphasised that he had:

> *in this particular case, at this particular time, […] taken great care to focus on whether there is a need to exercise the inherent jurisdiction, and that if exercising the jurisdiction, I make orders which are both proportionate to the safeguarding issues which lie at the heart of them, and which interfere with the Art.8 rights under the European Convention of Human Rights of FM and of MH only to the limited extent appropriate* (paragraph 11).

Sadly, it appeared that the problems which founded the orders made in 2021 had continued, such that:

> *16. The continuation of the behaviours to which I refer reinforce for me the necessity of protecting FH, so far as this court can do, from the abusive conduct of her husband. In my judgment, a continuation of protective injunctive orders under the court's inherent jurisdiction remains a proportionate response to the risks about which I have read. I have no doubt at all about the love which FH has for MH, and MH for his wife, but MH's aggressive conduct as observed by professionals and care staff, his ungoverned temper at times, his interference with the proper provision of care for FH in the care home, render the making of injunctive orders necessary in FM's best interests. FH rightly accepts that she is a vulnerable person. I can see that for myself and, in this way, the intervention of the court remains utterly justified.*

The parties before the court (but not MH, who had not participated) agreed as to the nature of the orders to be made:

> *18. It is agreed that for as long as supervision and monitoring of MH's relationship with FH is required at Care Home (Y), or elsewhere in the community within resources and/or other facilities provided by the local authority, the funding of those arrangements under the Care Act 2004 will fall properly to the local authority. It has been agreed today that the Trust will accept responsibility for the funding of supervised or supported contact between FH and MH during any time that FH is accessing their medical services. In the meantime, the plan is that the arrangements for MH to see FH will continue with the supervisor being positioned either at the door, or just outside the door of the room where FH is accommodated, but in the line of sight of the supervisor.*
>
> *19. The order that I propose to make prohibits MH from removing FH from her place of residence – currently Care Home (Y) – and that order will continue until or unless I discharge it. MH is further injuncted from removing FH from any of the Trust premises, should FH be relocated to one of the Trust premises in the future. The order will prohibit MH from having direct contact with his wife without third party support, as agreed with the local authority, whilst FH is the Care Home or elsewhere within the community, or as agreed with the Mid Yorkshire Teaching NHS Trust in the event she is resident on Trust premises. Those orders are now to be final orders, although of course it will be open to any party, including MH, to apply to vary or set aside those orders on notice to the others.*

Comment

Given that the inherent jurisdiction can only be used to fill in a statutory gap, it is perhaps of note that both (relatively brief) judgments do not include consideration of any of the relevant statutes that might be in play (this list being drawn from our updated guidance note on the inherent jurisdiction), including s.42 of the Family Law Act 1996 (non-molestation orders which victims, but not public authorities, can seek), the Serious Crime Act 2015 (s.76: which creates a criminal offence of controlling or coercive behaviour where A and B live together and "are members of the same family"), a Domestic Abuse Protection Notice or Order under the Domestic Abuse Act 2021, a Domestic Violence Protection Order under ss.24-33 of the Crime and Security Act 2010, a Stalking Protection Order under the Stalking Protection Act 2019 or other civil remedy such as the Protection from

Harassment Act 1997. As a matter of logic, all these remedies must have been considered and in some way found not to meet the needs of the situation.

In this context, it is also very interesting to read the observations of the Law Reform Commission of Ireland on the use of the inherent jurisdiction – a concept which applies in essentially exactly the same way in Ireland as it does here. In Volume 1 of its recent report on adult safeguarding, it notes that its main advantage is its flexibility (paragraph 1.51), but:

> *1.53.* [t]*he inherent jurisdiction also has significant limitations. While this "safety net" is useful, there is a great need for "precision, clarity and certainty", given the seriousness of the matters at hand. Relying on a statutory framework instead of the inherent jurisdiction would avoid the current "potential for over subjectivity" and ensure greater "transparency, democratic oversight and legal certainty". Unlike the inherent jurisdiction, a statutory framework allows for clear thresholds and safeguards, ensuring that the rights of those who may be subject to an order are appropriately, and consistently, weighed and considered. Only a statutory framework can establish clear standards and thresholds for intervention by reference to which decisions can be assessed and, if necessary, appealed. There is a strong constitutional interest in requiring that potentially very intrusive powers should be conferred, and delimited, by the Oireachtas* [the Irish Parliament]. *The use of the inherent jurisdiction to detain individuals also poses problems in light of Article 5 of the European Convention on Human Rights.*
>
> *1.54. Practically, a statutory framework would also provide greater certainty for relevant professionals in the administration of the care and treatment of persons who are subject to orders currently provided under the inherent jurisdiction. The inherent jurisdiction also necessarily involves recourse to the High Court, which can be a costly and cumbersome process, particularly in comparison to other courts such as the District Court.*

The older child and medical treatment decisions – mental capacity or competence?

Re J (Blood Transfusion: Older Child: Jehovah's Witnesses) [2024] EWHC 1034 (Fam) (Cobb J)

Other proceedings – family (public law)

This was a a characteristically thoughtful judgment from Cobb J, concerning whether authorisation should be given to provide a 17 year old Jehovah's Witness with blood products in a planned operation. In analysing the legal framework, Cobb J was taken to the decision of the Court of Appeal in *E v Northern Care Alliance NHS Foundation Trust and F v Somerset NHS Foundation Trust* [2021] EWCA Civ 1888 ('E and F'). He resisted, however, the submission by the Trust that the decision set out the proposition that there can be a point in cases involving the medical treatment of those under that 18 that "*the discretionary powers on the court to intervene convert into a duty on the court to intervene to preserve the young person's life*" (paragraph 33).

Cobb J noted at paragraph 35 that:

> *I do not interpret the remarks in Re E & F set out in the foregoing paragraphs (§33/34) to mean that where proposed medical intervention carries with it any risk of loss of life, the court is obliged to authorise treatment so as to preserve the young person's life. That would be to negate the lodestar of welfare in the widest sense. Nor do I believe that those remarks are intended to contradict the*

> *earlier remarks about the two transcendent factors in play when considering the welfare of a mature young person (see [50] Re E & F, and §31 above). When considering authorising medical treatment which is opposed by a competent young person (using 'competent' in the context of Gillick above), it is crucial that the court should consider, among other factors, the chronological age and level of maturity of the individual young person, their intelligence and understanding of the issues and risks, the nature of the specific decision to be made, objectively the full set of risks involved both ways (of having or not having the treatment and its consequences), the reasons given by the young person for their decision, and the prospective quality of the life to be lived should the unwanted treatment be successful in preserving the minor's life. As the Court of Appeal made clear in Re E & F it is important that the court identifies:*
>
> > *"… the factors that really matter in the case before it, gives each of them proper weight, and balances them out to make the choice that is right for the individual at the heart of the decision" ([52]).*

Applying the legal framework set out in *E & F* to the facts of the case before him, Cobb J found that, although it was very small, the risk of serious haemorrhaging did exist, and that there was a need for intervention, such that the need to consider authorising the giving of blood could not be avoided.

As to J's welfare, Cobb J made clear he had:

> *44. […] found this to be an extremely finely balanced decision which directly and poignantly engages the "two transcendent factors" referred to in Re E & F, namely the preservation of life and personal autonomy. It is plain that the subject young people in Re E & F felt "aggrieved" ([5]) that their views were overridden, and I am satisfied that J would feel the same. Even though the body of case law to which I have been referred has generally concluded with a decision in favour of treatment, I am conscious that "that is not the invariable outcome" (per Re E & F at [65]). To be faithful to the rich seam of pronouncements in this area I wish to emphasise that judicial 'respect' for the 'views of the mature child' is not a tokenistic mantra; it must be given true meaning, and where appropriate, full effect. To some degree this is demonstrated by the decisions of Moor J in A South East Trust v AGK[2019] EWFC 86 and to the decision of Cohen J in A Teaching Hospitals NHS Trust v DV (A Child) [2021] EWHC 1037 (Fam), where the objections of young people to the administration of blood products held sway. However, the distinguishing feature between those cases and this is that in AGK and DV no significant opposition was offered by the medical profession to the minor's objections.*
>
> *45. J is only a matter of weeks away from being an adult as a matter of law. He has limited – but nonetheless evolving – experience of mature decision-making; he has first-hand experience of the death of someone of whom he was fond. He already shows many attributes of adulthood. I found him to be an impressive young man with clear thoughts and expression. I am satisfied that he knows his own mind, and is aware of the risks to which he is exposing himself in declining blood products in the unlikely event that they would be needed in this operation. J's clear and unequivocal decision in this regard, and his reasoning, are rooted in his faith; I respect his well-recognised right under Article 9 of the ECHR to manifest and observe his religion. The*

Applicants recognise that J's beliefs about blood products are "long held and considered". I accept that if I were to accede to this application and blood products were therefore administered intra-operatively or post-operatively, this would be likely to affect J's sense of self-determination, his fidelity to the tenets of his religion, and the quality of his life going forward. I am satisfied that while blood products may save his life, their administration against his wishes would lead to him experiencing a much reduced quality and enjoyment of that saved life, and he would be 'tormented' by having other blood in his veins.

46. Having weighed all of the matters outlined above, I have concluded that in this case it is in J's best interests for his own decision to refuse the administration of blood or blood products in surgery to prevail, and I propose therefore to refuse the application for the court's authorisation to administer blood products in the event of emergency in the upcoming operation.

47. The order must reflect my conclusions about J's competence to participate in this litigation without a guardian, and to make decisions about the planned medical treatment. I shall declare that it is lawful, being J's decision and in accordance with his best interests, for his treating clinicians not to administer whole blood or primary blood products, even if in the opinion of the treating clinicians the transfusion of blood or blood products may preserve J's life, or prevent severe permanent injury or irreversible physical or mental harm. I shall further provide that if prior to the procedure J consents to having such blood or blood products, such treatment will be provided as long as his clinicians consider this to be clinically indicated.

In a postscript, Cobb J relayed that the surgery did proceed, that it was successful, and the post-operative period has passed without complication.

Comment

For those working with Jehovah's Witnesses, this guidance from the Association of Anaesthetists of Great Britain and Ireland may be of assistance.

Cobb J's statement that the need for judicial respect for the views of a mature child is clear and important. It is also clear and important that this case was framed as one where J was recognised as having the ability to make his own decision, the relevant question being whether it should be overridden. This is very much in line with the decision of Munby J in *NHS Trust v X*, the most detailed post-Human Rights Act 1998 analysis of the position of children who wish to refuse treatment. In *NHS Trust v X*, Sir James Munby also made the important point that (at paragraph 78) consent and refusal are two sides of the same coin of the child's ability to make a decision. That approach is important, because it helps avoid the temptation to deny that the child has the ability to make a decision which the medical professionals do not like. The more respectful approach, we would suggest, is agree that they have that ability, and then focus clearly in on whether there is some countervailing factor of sufficient strength to override it.

One oddity about J's case, though, is that Cobb J framed the question of J's ability to make the decision as a matter of *Gillick* competence.[2] At

[2] To the extent that Cobb J was directing himself by reference to *E & F*, it is worth noting that the question of competence / capacity was not in issue before the Court of Appeal, which also used the two phrases interchangeably (including in relation to a child below 16 – see paragraph 67); that decision cannot therefore be

paragraph 24, Cobb J had no hesitation in concluding that:

> *J is a competent young person with an understanding, maturity, and intelligence which equips him well to make his own decision, and give consent, in relation to the medical treatment issues, in line with the principles discussed in Gillick v West Norfolk and Wisbech Area Health Authority and Another [1986] AC 112 at 171 (Lord Fraser), and 186 (Lord Scarman). I consider that he is capable of appreciating fully the nature and consequences of the treatment which is proposed for him; all of these issues are questions of fact (Gillick at p.189/190). I am equally satisfied that the views which he expressed are authentically his own, free from influence of his parents or others.*

Cobb J does not appear to have been addressed on this point, so it is not clear the extent to which his observations reflect a considered discussion of the matter.

By contrast, Sir James Munby was addressed in detail on this in *NHS Trust v X* at paragraph 77, and set out his views as follows:

> *(1) Until the child reaches the age of 16 the relevant inquiry is as to whether the child is Gillick competent.*
>
> *(2) Once the child reaches the age of 16:*
>
>> *(i) the issue of Gillick competence falls away, and*
>>
>> *(ii) the child is assumed to have legal capacity in accordance with section 8 [Family Law Reform Act 1969], unless*
>>
>> *(iii) the child is shown to lack mental capacity as defined in sections 2(1) and 3(1) of the Mental Capacity Act 2005.*

Sir James Munby's approach has recently been followed by Cusworth J in the context of life-sustaining treatment (see here), and also MacDonald J in the context of gender-affirming treatment (see here). Conversely, it would be possible to read the decision of Judd J in *O v P & Anor* [2024] EWHC 1077 (Fam) (also concerning gender-affirming treatment) as if *Gillick* competence remained the test post-16. However, this was not the central focus of the case,[3] so it is not clear that this can be prayed in aid as a case in the competence camp.

On one view, we are in the unhelpful situation in relation to 16 and 17 year olds where four possibilities present themselves:

- Mental capacity and competence mean different things and some judges are applying the wrong test.
- Mental capacity and competence mean the same thing, in which case interesting (as in difficult) questions apply as to why Parliament uses the two different terms in the same legislation (see for instance the Mental Health Act 1983 provisions relating to treatment in the community, which draw a distinction between competence for

said to represent a definitive determination of the position.

[3] Which was, in effect, on whether the court could or should ever prevent a child (with the requisite ability) from consenting from treatment being offered by a treating doctor (see paragraph 57). As Judd J implicitly recognised, and the Cass Review explicitly sets out in chapter 16, any treatment, whether gender-affirming or otherwise, must be clinically appropriate for it to be on the table (and hence for questions of competence / capacity to be relevant).

children under 16 and mental capacity for those aged 16 or over).

- Mental capacity is the test to apply in some medical treatment situations but not others, in which case the question arises to which test to apply and why.
- Mental capacity is necessary but insufficient, which may feel intuitively true, but again raises questions as to what else is needed and how to tell whether the person has it.

Our wait for the next iteration of the MCA Code continues; that may give an opportunity for clarification, but cannot make the law. Given that there is ever greater focus on the ability of children to make their own decisions, not least in the context of gender affirming treatments, I would hope that we can get (likely appellate) level of the position sooner rather than later. In the meantime, and not just because Alex was in *NHS Trust v X*, he at least would suggest that Sir James Munby's analysis – the most detailed since the MCA 2005 came into force – is the correct one.

Capacity and contempt proceedings – what is the test?

What is the test to decide whether you can defend yourself against a charge that you are in contempt of court? That was the question before the Court of Appeal in *Solicitors Regulation Authority Ltd v Khan & Ors* [2024] EWCA Civ 531.[4] Helpfully, but perhaps not entirely surprisingly, the Court of Appeal has made clear that the test to apply if charge is that you have committed contempt in civil proceedings is that contained in the Mental Capacity Act 2005. Giving the lead judgment of the Court of Appeal, Nugee LJ rejected the proposition that the approach should be that applied in criminal proceedings, ie whether the person is fit to plead and stand trial. He found "entirely persuasive" the argument put forward by the SRA, namely that the test was governed by Part 21 of the CPR, which applied to Part 81 CPR (setting out the procedure for committal proceedings in the civil courts). Part 21 imports the test for capacity set out in the MCA 2005. However, the MCA 2005:

> 56. […] *unsurprisingly does not tell you what kind of decisions you need to make in order to conduct proceedings, and specifically in order to conduct proceedings as a defendant to committal proceedings. Here the experience of the criminal courts as to what sort of decisions a defendant might need to make, and what that means in practical terms, might indeed be valuable as an analogy. In this way the Pritchard criteria, although not directly applicable to contempt proceedings, might nevertheless assist in assessing whether a defendant to contempt proceedings lacked capacity within the meaning of the 2005 Act. Thus if one takes the 6 things identified by HHJ Roberts, and endorsed by this Court, in R v M (John), they are as follows:*
>
> > *"(1) understanding the charges; (2) deciding whether to plead guilty or not; (3) exercising his right to challenge jurors; (4) instructing solicitors and counsel; (5) following the course of the proceedings; (6) giving evidence in his own defence."*

[4] The judgment is a complicated one, as it covers many different grounds of appeal and cross-appeal; we focus here on the sections relevant to those concerned with capacity matters.

> *(see paragraph 45 above). With the exception of (3), the others are all just as applicable to a defendant facing committal proceedings for contempt as to a defendant facing criminal charges.*
>
> *57. In summary, the position seems to me to be this. The criminal test of fitness to plead, and the Pritchard criteria, are not directly applicable to contempt proceedings, where the test for capacity to conduct proceedings is that in the 2005 Act. But the Pritchard criteria may nevertheless assist the Court in assessing whether a defendant to contempt proceedings lacks capacity under the 2005 Act as illustrations of the sort of decisions that such a defendant is likely to have to take in order to be able to defend the proceedings.*

On the facts of the case before, the Court of Appeal found that the judge had applied the correct test, and had also been entitled not to adjourn the sanctions stage of contempt proceedings for further medical evidence as to the defendant's capacity to conduct, on the basis that there was no real prospect of being persuaded to accept conclusions in a recently prepared report casting doubt on their capacity. Nugee LJ noted the first instance judge had properly directed himself that, had been satisfied that there was such a prospect:

> *94.* […] *he would have been prepared to find that the finality principle was outweighed or displaced by two factors, namely the real risk of injustice in imposing a sentence of imprisonment in those circumstances, and the fact that in any event the Court could not have proceeded to sanction her until the question whether she was a protected party had been determined and if she had been finally determined to be a protected party that would have cast significant doubt on the [earlier judgment reached that the defendant had committed contempt]*

Comment

We so regularly see conflation of the concepts of mental capacity and concepts applied in the criminal context (see our webinar here, and this article here), that it is refreshing to see such a clear-eyed analysis from the Court of Appeal of the interaction between the two. The gilding on the lily would have been if the Court of Appeal identified the information that the defendant needs to be able to understand, retain, use and weigh to make each of the 5 decisions set out in the judgment of Nugee LJ. That may have to await another day, but at least it will be an exercise starting from a solid base.

DNACPR decision-making in Wales

Despite the fact that, in many ways, Wales is ahead of England in terms of its approach to DNACPR decision-making, a recent report from the Healthcare Inspectorate Wales has flagged that there is still room for improvement. Of particular note for readers of this Report is HIW's findings in relation to those with impaired decision-making capacity:

> *A key issue to have emerged from our review relates to patients having the mental capacity to make and communicate decisions about CPR, and the quality of how these details were recorded on the DNACPR form. Whilst this section of the form was generally well-completed for people who had capacity, this was not always the case for those who may have lacked capacity. We found some forms and clinical records either contradicted each other, were incomplete, or there was no evidence that a mental capacity assessment had been undertaken and without rationale. We are therefore not assured, based on the records we*

> *reviewed, that the DNACPR decision making process is always completed in line with the all-Wales Policy, for patients who were deemed to lack capacity. This issue must be addressed by health boards and trusts.*

It would also be really helpful, we suggest, if Wales at least could implement HIW's recommendations that:

> *Welsh Government should consider the benefits of an all-Wales electronic patient repository for recording DNACPR decisions, for instance within Welsh Clinical Portal, to help achieve prompt and robust communication of these decisions throughout Wales. This would benefit patients and those close to them, communication nationally across different health board teams in secondary care, and community and primary care, and in care homes, and emergency services.*

Given the zeal with which technology is peddled by evangelists, it is depressing how difficult it seems to be to bring about such (apparently) simple things as ensuring joined-up information about DNACPR recommendations, advance decisions to refuse treatment and advance choice documents about preferences in the mental health context.

IRELAND

A Revival of Wardship?

As discussed in previous reports, there has been significant developing jurisprudence in relation to the court's jurisdiction to make detention orders following the commencement of the Assisted Decision-Making (Capacity) Act 2015 ('ADMCA') and the repeal of the Lunacy Regulation (Ireland) Act 1871. The most recent development on the issue is *In the Matter of AJ [2024] IEHC 166*. In this case Mr. Justice Dignam considered whether the High Court had jurisdiction to make detention orders outside of the wardship process and notwithstanding the pre-existence of an order under the Mental Health Act of 2001 ("2001 Act"), pursuant to Section 9 of the Courts (Supplemental Provisions) Act 1961 ("the 1961 Act").

Background

By way of background, AJ is a young man diagnosed with moderate disability, autism spectrum disorder, significant speech and language and communication difficulties and had a history of aggression towards other people and causing damage to his living environment. He lived with his family his entire life until his admission to an approved adult mental health unit pursuant to the 2001 Act. Prior to this, he attended school in a local national school's autism unit until its closure and then had a period of homeschooling until his enrolment in the autism spectrum disorder unit in the local secondary school, which AJ's mother described as being negative and traumatic. After his graduation, he joined a day service, albeit the placement broke down. While attending the day service, a number of untoward incidents had been reported which eventually necessitated his admission to the hospital – the approved centre – under the 2001 Act. While he was initially discharged in August 2022, he was admitted anew to the approved centre in November 2022 upon his mother's application and upon the recommendation of his general practitioner due to his aggressive behaviours. Despite having been released in December 2022, he was readmitted to the approved centre just two weeks after he was last discharged. The admission was renewed on several occasions in light of the finding that AJ was suffering from a mental health disorder. His detention in the approved centre has been continuous since January 2023. The Health Service Executive

were of the view that his continued detention therein was his detriment and therefore the HSE sought to transfer AJ from the approved centre to an alternative residential setting and to detain him therein.

The High Court determined the matter by considering and resolving the following issues:

(a) Whether the court has jurisdiction to make a detention order on the basis of Section 9 of the 1961 Act.

The court considered section 9 of the 1961 Act which vests in the High Court the jurisdiction in lunacy and minor matters previously held by the Lord Chancellor of Ireland, the Lord Chief Justice of Ireland, and, before the operative date, the existing High Court, exercisable by the President of the High Court or an assigned judge and section 19(1) of the Courts of Justice Act 1924 which transferred the jurisdiction in lunacy and minor matters from the Lord Chancellor of Ireland to the Chief Justice. The court noted that in *AC v Cork University Hospital* [2020] 2 IR 38 O'Malley J held that section 9 directly vests jurisdiction in the High Court rather than transferring it, with the President of the High Court exercising powers conferred by s.9(1) 1961 Act. The court noted that the section 9 jurisdiction is a "*broad protective jurisdiction*" and that the Lunacy Regulation (Ireland) Act 1871 regulated but did not define the jurisdiction, which is broader than the Act's provisions, as explained by O'Malley J in *AC* and Geoghegan J *In The Matter of Francis Dolan* [2007] IESC 26, [2008] 1 ILRM 19. In terms of its basis, the court noted that the Supreme Court has held that the jurisdiction in section 9 originates from Article 40.3.2 of the Constitution and reflects the constitutional duty to protect the personal rights of those who lack capacity. The court found that section 9 is the "*direct or immediate source*" of the court's wardship jurisdiction.

In terms of the court's power to make detention orders, the court found that the power to make detention orders under its wardship jurisdiction in section 9 is well-established, as affirmed by MacMenamin J in *HSE v AM* [2019] 2 IR 115 and the more recent cases *HSE v KK* [2023] IEHC 306 and *HSE v MC* [2024] IEHC 47, and is also supported by the ADMCA, particularly Part 10. However, there was a clear difference in the present case as *AJ* is not a ward of court. The references to the power to make detention orders in various cases pertain specifically to individuals who are wards of court or subject to a formal wardship process, as highlighted by O'Malley J in *AC v Cork University Hospital*, Hamilton CJ in *Re a Ward of Court* (No. 2) [1996], MacMenamin J in *HSE v AM*, Hyland J in *HSE v KK*, and Barniville P in *HSE v MC* [2024].

Given *AJ* is not a ward, and there are no wardship proceedings, the question before the court was whether section 9 allows the court to make a detention order for someone not in wardship. The court found that while previous cases suggest that detention orders under section 9 are typically within wardship, there is a basis to conclude that the court has the standalone power under section 9 to make detention orders outside wardship, grounded in the vested jurisdiction from the Lord Chancellor and the constitutional imperative to protect personal rights. The court considered the decisions *In Re Birch* (1892) and *In Re Godfrey* (1892), where Ashbourne LC found that the jurisdiction, part of the royal prerogative, was intended to provide personal care and protection for these individuals, and was not limited by any specific statute. The court therefore concluded that "*the jurisdiction vested in the High Court by section 9, is not limited to formal wardship processes*".

Considering the issue of the repeal of the 1871 Act the court relied on the decision of O'Malley J in *AC v Cork University Hospital* [2020] 2 IR 38

where she sad that the "*1871 Act regulates certain aspects of wardship but does not create the wardship jurisdiction.*" As a result, Mr. Justice Dignam found that *"the Lord Chancellor's jurisdiction that was vested in the High Court by section 9 was not limited to or by the 1871 Act*". The court found that while the ADMCA repeals the 1871 Act it does not repeal section 9 of the 1961 Act, which suggests that the Court's protective jurisdiction under section 9 continues to apply outside the formal wardship process.

Crucially, and of significant interest, is the effect of these findings. The court itself notes that "interpreting section 9 as conferring a jurisdiction to make protective Orders outside of a formal wardship process in order to vindicate constitutional rights may mean that the area in which the Court's inherent jurisdiction may have to invoked or even can be invoked is smaller".

In coming to the conclusion that the court has jurisdiction to make detention orders pursuant to section 9 notwithstanding the repeal of the 1871 Act, the court noted that the parties in this case were *ad idem* in terms of the law, therefore there was no *legitimus contradictor*, and the court noted that the conclusions "*must therefore be seen as being subject to full argument in an appropriate case*".

(b) The impact of The HSE v KK

Ultimately the court distinguished the decision in *KK* (which is under appeal to the Court of Appeal) because *AJ* is not a ward of court. The court noted that the rationale in *KK* that the court did not have jurisdiction under section 9 to make orders in respect of existing wards of court who did not have detention orders in place at the date of commencement of the ADMCA was that those orders would not benefit from a Part 10 review, which would create inequality and unfairness between wards, simply dependant on whether they had detention orders made prior to or subsequent to the commencement of the ADMCA.

(c) The jurisdiction of the High Court to make a detention order under Section 9 of the 1961 Act despite having established the applicable statutory regime, i.e., the 2001 Act.

The issue in the case stemmed from the restriction in the Mental Health Act 2001 that a person be detained in an 'approved centre'. As noted in the background, the approved centre in this case was not a suitable placement for AJ, and the proposed suitable placement was not an 'approved centre'. Thus, while orders were in being under the 2001 Act, the question was whether orders could be made under section 9 to transfer and detain *AJ* in the residential unit, a non-approved centre.

The court again considered the decision in the *HSE v AM*, in which the Supreme Court examined whether the court could exercise its wardship jurisdiction to detain a person who met the criteria for detention under the 2001 Act. The Supreme Court concluded that a person who satisfied the criteria for involuntary admission under the 2001 Act could be lawfully detained through the wardship procedure if it was necessary and appropriate, provided protections were in place to safeguard the person's rights. The Court found that the wardship jurisdiction is broad, covering the protection and management of individuals of unsound mind, and must be interpreted in light of the Constitution and the European Convention on Human Rights. Furthermore, the Mental Health Acts from 1945 to 2001 did not limit the wardship jurisdiction of the High Court and Circuit Court regarding persons of unsound mind. Section 283(1) of the 1945 Act explicitly acknowledged the courts' continuing power to detain such individuals via wardship when necessary and appropriate. Additionally, the Supreme Court held that the two

jurisdictions—the wardship jurisdiction and the Mental Health Act procedures—must operate separately. Interweaving the procedures under the 2001 Act with the wards of court procedure was deemed impermissible.

Mr. Justice Dignam therefore found that the High Court has the jurisdiction to make such detention order despite the respondent being subject to an order under the 2001 Act, provided that the following conditions are satisfied:

1. The respondent lacks capacity; and
2. The making of such an order is appropriate, necessary and accompanied by the appropriate safeguards.

The court was satisfied that AJ lacked capacity and found that in "circumstances where the evidence is that the placement under the 2001 Act is inappropriate and may even be prolonging the respondent's detention then it must follow that the matter is more properly dealt with under the Court's section 9 jurisdiction". The court did not determine in the ex tempore judgment delivered how the Orders under the 2001 Act were to be discharged, but the court noted that it may be that the responsible consultant psychiatrist can discharge the respondent, they could let the most recent renewal order expire, delay the transfer, or use leave provisions with the Court's inherent jurisdiction.

Given the lack of statutory scaffolding from the 1871 Act, the court had to consider the appropriate safeguards afresh, and while not determined in this decision the court noted that consideration must be given to the frequency of court reviews, the required reporting and evidence (whether from the treating psychiatrist alone or also from an independent psychiatrist), the appointment of an independent solicitor versus relying on the Guardian ad Litem, the payment of review costs, and whether there should be liberty to apply.

Conclusion

One would be forgiven for being confused by the status of wardship in Irish law. This is particularly so given the heralding and much drum-beating about the "abolition of wardship" upon the commencement of the ADMCA just over 12 months ago. Even the Supreme Court in a very much *obiter* comment recently stated "*The Oireachtas may abolish an existing jurisdiction, as it did when it enacted the Assisted Decision Making (Capacity) Act 2015, which abolished the wardship jurisdiction of the High Court (and conferred significant new jurisdiction on the Circuit Court)*". Not correct, it seems. As this case found, the wardship jurisdiction very much survived, just not the legislative regulatory framework, due to the repeal of the 1871 Act.

The net result of the findings of the court in this case when coupled with the findings in *KK* is that wards of court cannot have detention orders made under the broad section 9 wardship jurisdiction, unless such orders were in place prior to 26th April 2023, and must alternatively fall back on the inherent jurisdiction of the court. Whereas those who are not wards of court at all can have detention orders made under the section 9 wardship jurisdiction.

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Conferences

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

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

Adrian will be speaking at the following open events:

1. The World Congress on Adult Support and Care in Buenos Aires (August 27-30, 2024, details here)
2. The European Law Institute Annual Conference in Dublin (10 October, details here).

Advertising conferences and training events

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

Our next edition will be out in July. 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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