Essex CHAMBERS

MENTAL CAPACITY REPORT: COMPENDIUM

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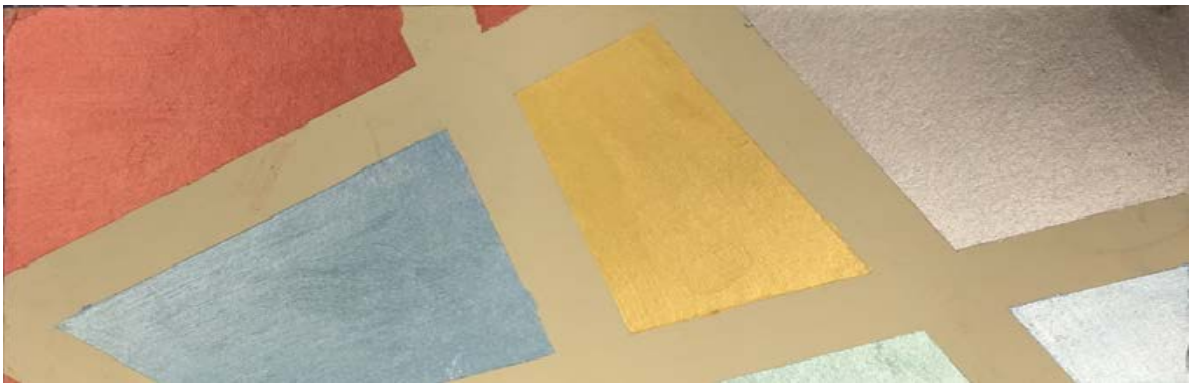

Welcome to the July 2024 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: sexual capacity complexities, wishes and feelings in the balance, and finding the P in a PDOC case;

(2) In the Property and Affairs Report: deputy bond provider problems and a job opportunity in the Official Solicitor's office;

(3) In the Practice and Procedure Report: how far can the Court of Protection go to ensure its orders are complied with, and risk taking, best interests and health and welfare deputies;

(4) In the Mental Health Matters Report: Tier 4 beds (again) and the Mental Health Tribunal and the Parole Board;

(5) In the Wider Context Report: local authority consent to confinement, the Irish courts continue to grapple with the consequences of the framework, and Strasbourg pronounces on assisted dying;

(6) In the Scotland Report: exasperation at the pace of the Scottish Government's Mental Health and Capacity Reform Programme.

There is one plug this month, 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.

Alex trusts that readers will not mind a slight blowing of the trumpet at his having been awarded Outstanding Legal Achievement at the 2024 Modern Law Private Client Awards for his work sharing knowledge about the Mental Capacity Act 2005 (and hence, in significant part, thanks to his fellow editors on this Report), and being appointed Professor of Practice at King's College London from August 2024 (a position which reflects the opportunities given by Chambers to him to moonlight so often away from the day job – for which he is very grateful!).

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, sexual relations, silos and public protection – an impossible tangle for the Court of Protection?

A Local Authority v ZX [2024] EWCOP 30 (HHJ Simon Burrows)

Mental capacity – assessing capacity – sexual relations – contact

Summary

In this case, HHJ Burrows was confronted, to his considerable (and understandable) disquiet, with the need to determine whether an 18 year old man had capacity to make decisions about engaging in sexual relations with others. His discomfort arose from the fact that the local authority was having to have recourse to the Court of Protection to respond to a situation where the man in question was posing a (largely self-reported, but on the face of it non-trivial) sexual threat to others, but whether neither mental health services nor the criminal justice system could respond.

The facts of the case make disturbing reading, and we do not set them out here. A particular

concern of HHJ Burrows was that much of the evidence about the risk posed to others by ZX arose from self-reporting to therapists and social workers.

> *27. The Court has not been asked by either party to carry out a fact-finding exercise. Indeed, it is almost impossible to see how such an exercise would have been even remotely practicable. However, this does mean that this Court, as well as the LA, has to base its decision on a factual matrix that could potentially be largely illusory. The Court, however, has no option but to do so.*

The evidence from the clinical psychologist who had known ZX for some three years summed up the position starkly, identifying:

> *A scenario of future harmful sexual behaviour by ZX where he is alone with a potential victim. The victim is likely to be of a similar age to him, no more than 3 years difference, but vulnerable individuals would be at greater risk regardless of age. The nature of such harmful sexual behaviour is likely to be due to a need to increase his self-worth, to remove negative mood states or sexual satisfaction. In regard to severity of harm, the psychological harm and physical harm to the victim would be expected to be high. The imminence of his risk is likely when ZX is experiencing heightened low self-worth, alongside experiencing a negative mood state or is seeking sexual release. This imminence is likely to escalate if he is struggling to manage his negative mood state. The frequency of his harmful sexual behaviour is likely to be on at least several occasions if the context presents and is expected to be chronic. The likelihood is expected to be common, and based on his history, and without intervention, it is likely to re-occur.*

ZX had been subject to a set of intense restrictions upon him to respond to this threat, initially authorised by the High Court exercising its inherent jurisdiction over minors, and then by the Court of Protection on an interim basis. In order to decide whether they could continue to be justified, HHJ Burrows had to determine whether ZX had capacity to decide to engage in sexual relations and contact; the present judgment focused on the question of sexual capacity.

HHJ Burrows undertook a review of the case-law, including the emphasis placed by the *Supreme Court in A Local Authority v JB* [2021] UKSC 35 on the need for the person deciding to engage in sexual relations to understand, retain, use and weigh the fact that) the fact that the other person must have the capacity to consent to the sexual activity and must in fact consent before and throughout the sexual activity. Having done so, he observed that:

> *75. It seems to me the state of the law is clear. When making assessments of a person's mental capacity concerning decisions across a range of domains, the Court (and any assessor, for that matter) must strike a balance between treating each domain as a distinct area of assessment without taking into account other domains (the "silo" error) on the one hand, but on the other, approaching the assessment in such a general manner, taking into account too many diffuse issues, leading the assessor to lose sight of what is being assessed. Being stuck in a silo represents overly strict rigidity. The opposite however leads to flexibility that verges on arbitrariness. The former leads to extremely difficult management issues for P's carers and care planners. The latter leads to a large number of people with difficulties in decision making in one area being found to lack capacity in others when they may not*

> *need to. The burden is on the assessor to strike a properly reasoned balance.*
>
> *76. I would take this argument further when dealing with capacity to engage in sexual relations. By placing capacity to engage in sexual activity away from most other decision making domains by removing the possibility of a decision being made on behalf of P, Parliament has created its own statutory silo. By placing the threshold so low, as the caselaw does, the assessor is directed to ensure factors that would be relevant to one decision making area (such as contact, for instance) may not be relevant to sexual relations.*

A problem for HHJ Burrows in applying the law to the facts of the case was that the expert had changed his mind, following the decision of Theis J in *A Local Authority v ZZ* [2024] EWCOP 21, in which the Vice-President of the Court of Protection had concluded that HHJ Burrows had fallen into a silo in his analysis of the individual's capacity to make decisions about engaging in sexual relations and contact. At paragraph 110, HHJ Burrows, reflecting on the appellate judgment, identified that the question he had to ask himself was about ZX whether:

> *If ZX is engaged in sexual activity or is in a situation where sexual activity is anticipated/expected by him with a person and consent from the other party is either not forthcoming or is withdrawn will ZX be able to make a capacitous decision about whether to stop that sexual activity accordingly?*

As HHJ Burrows continued:

> *112. The answer to that question must be based on the evidence I have read and heard. It seems quite likely that ZX may find himself alone with a vulnerable would-be sexual partner, quite likely by design.*
>
> *113. Once in that position, the question is not whether he would respect the refusal of the other party to consent to sexual activity, or the withdrawal of consent once sexual activity had begun. The question is whether he would be able to respect that refusal, or whether, because of his mental disorder as described by Dr Ince he would not be able to use and weigh (or process) his understanding of their right to refuse being respected. That would be what Dr Ince refers to as "in the moment".*

At paragraph 114, HHJ Burrows then set out his route to the conclusion that ZX lacked the material decision-making capacity:

> *The evidence I have seen and read, leads me to conclude:*
>
> *(1) ZX has developed a longstanding appetite for sexual experience in which the coercive nature of the experience is part of the appeal, the thrill. Indeed, due to his trauma it may have become a necessary part of the experience in order for him to feel fulfilled.*
>
> *(2) Although Dr. Ince identifies impulsivity, or at least he infers the existence of impulsivity, I am not satisfied that impulsivity is what I see. I see in ZX a young man who is cunning and opportunistic but is also capable of planning sexual contact with other people within the context of such liaisons being forbidden. Hence the reference made about his waiting until adults are out of the way before initiating sexual contacts.*
>
> *(3) ZX was able to satisfy the JB test in his assessments with Dr Ince.*
>
> *(4) However, and on reflection in the light of Theis, J's judgment in ZZ, he concludes that "there is sufficient evidence within the chronology and*

[ZX]'s recent acts to demonstrate that firstly what he says within an assessment setting cannot be relied upon, and also that he continues to display a range of behaviours that disregard the norms and education provided to him". (see the exchange with the Judge).

(5) It is not clear to me whether Dr Ince only refers to "in the moment" here. In his first report (from 11.5.20) onwards, he refers to a ZX's "range of deficits within his executive functioning- and causally- would rely upon the presence of a neurodevelopmental disorder as an explanation for his observed difficulties", and then identifies the areas in which this affects. These are:

- *Impaired working memory (impacting upon his ability to retain and use information)*
- *Poor impulse control (as evidenced in the chronology and risk assessments)*
- *In attention (and the impact upon learning and decision-making)*
- *Difficulties with planning, organisation and consequential decision-making*
- *Cognitive flexibility (and the ability to transition between tasks and transfer learning from one situation to another)*
- *Emotional regulations (and the ability to transition between tasks and transfer learning from one situation to another)*

(6) It seems to me these features would apply to any situation in which ZX had the urge to engage in sexual activity with another person. It may lead to him planning to enable him to be alone with that person. It would certainly apply where he was involved in sexual activity and there was an absence or withdrawal of consent by the other party.

(7) Dr Ince is a jointly instructed expert, and his expert evidence is not countered by another expert. Although it is for me as the Judge to reach a conclusion of his own, and not blithely to follow what the expert says, I need to give a good reason if I come to a different conclusion.

(8) In order for me to reach the conclusion that ZX lacks capacity to consent to sexual activity I need to be satisfied on the basis of all the evidence I have read and heard that ZX is not be able to satisfy the JB test and particularly "in the moment" in the real world, rather than in a mental capacity assessment with Dr Ince.

(9) I am concerned this may involve speculation on my part as to what ZX may do if those circumstances arose. As Ms Gardner put it both in her questioning of Dr Ince, but also in her closing submissions, there is no evidence base for this. In other words, the Court has no evidence of what ZX does or would do when confronted with the absence or withdrawal of consent during sexual activity.

(10) The response to that is twofold. First, there is a good deal of evidence from ZX himself and his brother that he has engaged in non-consensual sexual activity with other people over the years. Secondly, Ms France-Hayhurst would invite the Court not to allow ZX to engage in activity that provides an evidence base, at the expense of ZX's liberty and the devastating experiences of his victims.

(11) In response to the first of these, my answer is that the evidence considered within Dr Ince's conceptual framework (post ZZ, in any event) does allow me to conclude that ZX does not "pass" the test in JB at limb (2). I am extremely concerned about doing so. It seems to

> *me this is an hormonal 18 year old man with a considerable sexual appetite. If I conclude he lacks the capacity to engage in sexual activity, he will be subjected to an extremely restrictive regime where his only sexual "outlet" will be masturbation whilst watching selected on-line pornography; censored, I would imagine, to avoid images of violent rape, children and animals.*
>
> *(12) On the other hand, I have to avoid what has been called the protection imperative. I must not tailor my formulation of the capacity assessment to ensure a particular outcome. Normally, that means trying to protect a vulnerable person who would otherwise be exploited or harmed unless protective measures can be put in place. Here, the same applies except it is ZX's potential as a perpetrator in a serious sexual offence, and the consequences that flow for him, rather than his potential victim is what he is being protected against.*

HHJ Burrows made clear at paragraph 114(14) that:

> *At first glance, this is a somewhat perverse use of the MCA. However, it is explicitly sanctioned by the Supreme Court in JB. Naturally, I must follow that judgment.*

He therefore found that:

> *115.* […] *At the moment this judgment is written, I am satisfied that his behaviour in connection with sexual activity in combination with his mental disorder [identified earlier in the judgment as conduct disorder, ADHD and attachment difficulties] means that he is unable to use and weigh relevant information concerning his would be or actual sexual partner's refusal to, or withdrawal of, consent in in real time.*

He then continued:

> *116. I would add that I am intensely uncomfortable about the need for the LA to have to resort to the Court of Protection in a case of this sort. In the absence of the ongoing and active involvement of mental health services, and the absence of anything it seems the criminal justice system is able to do, they are required to use this Court.*
>
> *117. However, what now follows is the LA will have to comply with their positive obligation to ensure that ZX gains capacity (if he can) in this domain: see, for instance, CH v A Metropolitan Council [2017] EWCOP 12(Hedley, J.).*
>
> *118. At the same time, they will have to implement a care plan that is restrictive enough to remove ZX's opportunity for sex, with other people at least, whilst, at the same time ensuring he is able to engage in the normal activities of an 18 year old person. The Court will scrutinise both during the process.*

HHJ Burrows concluded by observing that the parties would need time to consider his judgment and, potentially, to consider an application to appeal. At the time of writing, it does not appear that such an application has been made.

Comment

HHJ Burrows' observations about the need for balance between salami slicing into silos and an over-broad approach to capacity at paragraph 75 are crisply put, and we would suggest of wider application.

When it comes to the question that was central to the case, however, it might be thought that the decision makes good the thesis of a chapter Alex has co-written in an edited volume due out shortly, namely that it is difficult to escape the

impression that we have started to ask questions in the context of capacity and sexual relations that the law perhaps should not have asked. That is not to say that the issues posed are not serious and important. They engage extremely complex questions, amongst others how the State is expected to balance its positive obligations to secure individuals against non-consensual sexual activity, and its obligations not to intervene unnecessarily between consenting sexual partners. They also raise very difficult issues of the interaction between the concept of capacity underpinning the MCA 2005 and the different concepts underpinning criminal responsibility (as to which, see here).

However, it might be thought that this decision reinforces the point that looking at matters through the prism of capacity to decide to engage in sexual relations causes both practical and legal complexities of the highest order. An oddity of JB's case, and one upon which it might have been thought that the Supreme Court would have alighted, was that there was agreement between the local authority and the Official Solicitor on JB's behalf, that he lacked capacity to make decisions about contact, and that it was in his best interests for a care plan to be enforced which "*include*[d] *restrictions on his access to the local community, on his contact with third parties and on his access to social media and the internet. Under his care plan, he ha*[d] *1:1 supervision when out in the community and, in particular, when in the presence of women*" (paragraph 11). On the face of it, and for so long as the care plan continued to be in force, JB would never have had the opportunity to engage in sexual relations, so the question of whether he had capacity to make decisions about it might have been thought to be academic.

Similarly, in the instant case, it might be thought that the mission-critical point to determine was ZX's capacity to make decisions as to contact with others, where one of the purposes of that contact was to have sexual relations with them. Although the judgment does not say so expressly, the expert is recorded as saying that ZX lacked capacity to make decisions about contact, and the plan contemplated could only have been based upon a conclusion that he lacked that capacity.

However, if ZX lacked capacity to make decisions about contact, and if plans were being put in place to regulate that contact, then on one view the question of whether he had capacity (in isolation) to make decisions about engaging in sexual relations would not be of the first importance. After all, what would be the difference between a situation where ZX had capacity to make decisions about engaging in sexual relations and was choosing to impose himself on others irrespective of their consent, and the situation where he lacked that capacity and was seeking to do the same? From the perspective of the State's obligation to secure against the risk that ZX might pose to others, arguably none. From the perspective of the criminal law seeking to resolve the question of whether criminal acts had been committed, there might be a difference, but the criminal law and the MCA are asking different questions, and the entire point of the framework being sought by the local authority was to stop such acts taking place in the first place.

For Alex, reading the judgment whilst in Belfast talking for the Royal College of Psychiatrists in Northern Ireland about capacity complexities, it was also striking to see how the regime in England & Wales is (or could be) moving by way of judicial interpretation towards a capacity-based public protection regime. Public protection is an express aspect of the MCA (NI) 2016, embedded in the DoLS provisions there (the main substantive part currently in force). But the Northern Irish legislation was intended to

replace standalone mental health legislation, and the public protection aspect was always clearly understood to be necessary in consequence.

Conversely, there was never any stated Parliamentary intention in England & Wales that the MCA 2005 was to replace or in some way encompass the terrain of the MHA 1983 (hence the notorious interface between the two set out in Schedule 1A to the MCA 2005). Decisions such as this (and indeed *JB*) make clear that we may well be well on the way to creating a fused regime by the back door, where restrictions on the basis of public protection can be justified on the basis of a lack of capacity to make decisions about contact, and the argument that it is not in a person's best interests to carry out acts that harm others. And, at the same time, we now regularly see difficult cases, above all those concerning anorexia where the risk is to the person alone and which were once looked at through the prism of the 'appropriate treatment' test in the MHA 1983, put before the Court of Protection to be determined on the basis of capacity and best interests. Both of these may well be necessary and important developments, limiting the scope of the MHA 1983 (in effect) solely to those who are identified as having capacity to take the relevant decisions, but pose a risk to themselves or others on the basis of mental disorder. But it might be thought that this was something Parliament would wish to consider.

In any event, we are certainly a long way from the talk of empowerment that accompanied the launch of the MCA 2005 (even if Lucy Series has done, and continues to do, vital work in teasing out whether that language was ever justified).

Wishes and feelings in the balance

MA v Gateshead Council & Ors [2024] EWCOP 34 (DJ Simpson)

Best interests – residence

Summary

This s.21A MCA application related to a contested hearing of whether it was in the best interests of MA, a 90-year-old woman with a diagnosis of dementia residing in a care home, to have a trial return to her home with a package of care. MA was widowed and had five children, three of whom held both her health and welfare and property and affairs LPAs. The three attorneys took the view that it was in MA's best interests to reside in a care home, while her two non-attorney family members took the view that it was in her best interests to return home with a care package of four care calls a day. The Official Solicitor, acting on behalf of MA, supported the position that she should have a trial return home.

MA had been placed in a care home following a hospital admission in the summer of 2023 after she had a fall. She had previously lived in her own home with a package of three care calls a day. MA was objecting to residing in the care home and wished to return to her own home.

Capacity was not in issue, and the proceedings related solely to best interests. The Official Solicitor argued that MA's wishes and feelings should be of "magnetic importance" (paragraph 32). The local authority argued that MA would be at risk at home, but also that the quality of her life would deteriorate if she were to do so.

The evidence of the social worker was that MA's needs were primarily around continence (for which she was declining to use continence pads) and prompting for activities of daily living. The social worker was concerned that MA would not be able to use a 'lifeline' pendant if she had a fall at home, or would not remember how to do so. The social worker also had concerns that as MA's family were not close by, she may become lonely or have low mood if her only human

interactions were with carers. MA had been resistant to care calls, and wanted no more than one carer attendance daily; she referred to four daily visits as a 'deal-breaker.' She also did not want carers to undertake care tasks. Carers would also not have the flexibility to return to MA if she did not wish to get out of bed or undertake care tasks at the times they were present. The local authority felt that "*how MA will present after two weeks at home following an extended period of 24/7 care is not representative of how she will present in the longer term. They also believe an assessment of compliance with care at home requires a longer review, but that is not possible whilst keeping MA's bed at placement 1 available*" (paragraph 52). The local authority also felt her falls risk was increasing with time. The local authority also submitted that MA did have a good quality of life at the placement, and the court noted that this was "*not fully disputed*" (paragraph 56)/

MA's family members who supported her having a trial period at home stated that they would continue to visit her, and could act as emergency contacts for her; the nearest such relative lived 40 minutes away by car. They felt that MA had strong and clearly expressed wishes not to be in a care home, both historically and now. They felt that with more regular domiciliary care calls than she had had previously (leading to regular eating) she would fare better than she had prior to her admission to hospital. They accepted that MA overestimated her abilities to look after herself, and that if she did not accept a home care package, she would need to return to the care home. It was also accepted that a fall at home could be catastrophic, but they emphasised that this had not happened at home and did not feel the falls risks were reduced in the care home. They felt that a two-week trial would be a good indication of whether a safe return home was possible. The Official Solicitor also submitted that a trial at home should be attempted before it was ruled out as an option.

The family members who opposed the placement agreed that MA did not want to be in a care home, but felt that she was less vocal on this point than she had previously been. They felt that the 'home option' had been tried before she was admitted to the care home, and had not worked. The did not feel that she was safe, and did not think it was in her best interests to attempt a trial they felt would not work.

District Judge Simpson noted that a future question might arise of releasing MA's place in the care home if the trial was successful, as it was not clear that it would be maintained for more than two weeks; however, that issue did not yet arise. District Judge Simpson accepted that MA had chosen to live at home when she had capacity, and that she "*has been vocal and resistant at times to care at home and does not wish to reside at placement 1 despite her accepting the care she receives is good. I accept this would likely influence her decision if she had capacity, I also accept she has been resistant to care in her home in the past which resulted in her admission to hospital and then placement 1*" (paragraph 65). A balance sheet exercise was carried out, producing the answer that the matter was "finely balanced," although the conclusion of District Judge Simpson was that:

> *[a] trial placement at home would be the least restriction option, be in accordance with MA's wishes and feelings and can be undertaken for a short two week period whilst her room at placement 1 remains open to her in the event of a breakdown. On that basis I authorise the trial placement at home.*

Comment

As ever, it is very good to have judgments from District Judges, given that they hear the vast majority of cases before the Court of Protection.

In this regard, we note that it is a shame that the very detailed guidance just published relating to publications of judgments in family proceedings (including expectations as to the numbers) was not accompanied by guidance relating to judgments in the Court of Protection, leaving us reliant on what is now rather dated guidance from Sir James Munby.

One point to note about the balance sheet used by District Judge Simpson is that some of the senior judiciary have been cautious – and in the case of Hayden J and Sir Andrew McFarlane – actively negative about the use of such balance sheets, running the risk of they do as serving as a substitute for analysis, rather than a structure. District Judge Simpson did not fall into this trap here, but for more on why it can be a problematic issue, see here.

Short note – finding the P in a PDOC case

NHS North Central London ICB v PC et al [2024] EWCOP 31 concerned a 31 year old woman, who suffered a cardiorespiratory arrest and collapsed at home. A lack of cardiac output for about 30 minutes led to her brain being deprived of oxygen, which caused a severe hypoxic ischaemic injury. She was left in a Prolonged Disorder of Consciousness ('PDOC'), at the low end of the spectrum of awareness, for four years and was now 35. An application was made by the ICB, who commissioned her inpatient hospital care, that it was not in her best interests to continue clinically assisted nutrition and hydration in circumstances where there was a lack of agreement from some members of her family.

An agreed legal summary was set out at paras 8-30. There was no real hope of recovery. The evidence as to her wishes, feelings, values and beliefs were limited, given the unexpectant event so early on in her life. Cusworth J concluded that PC would be concerned at her family's upset and suffering and would want to avoid that if she could. However:

> *Considering the competing arguments it is impossible to form a conclusive view about PC's likely attitude here - whether she would choose to remain in her current state, and so leave her family, desolate as they are, continuing to visit her perhaps for another decade; or whether to enable an ending now which might prove the start of a healing process, but having first brought to a head their building grief. I must conclude that she could form either view as to the best course for her family, so I am left to look primarily at her personal best interests.*

There was no evidence of PC experiencing any positives, and no evidence of any enjoyment of life. The only evidence was of her exhibiting discomfort and pain. If treatment was withdrawn, "[s]*he will be spared the burden of living a life which does not obviously bring her anything other than pain. Her death will bring great sadness for her family, but it will be sadness not augmented by further years of her suffering before it arrives*." Ultimately the benefits of continuing were clearly outweighed by the significant burdens and she would not wish to continue with life in her current condition. Accordingly, palliative care was decided to be in her best interests.

Comment

This decision demonstrates the complexity of determining whether to withdraw treatment where not much is known as to what P would have wanted. The judgment displays a careful attention being paid to the medical and family evidence, against the backdrop of there being no evidence of enjoyment, only discomfort and pain.

Short note: when trials have been tried

The decision in *NHS South East London ICB v AB, M and London Borough of Southwark* [2024] EWCOP 28 is the sequel to a 2020 case ([2020] EWCOP 47). At that stage, the court refused to recognise a guardianship order made by the New York courts. A subsequent trial period of AB living with her mother for just over 7 months ended in failure because it proved impossible to establish satisfactory working relationships between her mother and paid carers. A further trial of them living together with a support package also failed and her mother decided to end it after her interactions with a support worker. Senior Judge Hilder concluded that no further attempts should be made. If AB was able to express a view, it was likely that she would want "settled security over disappointed hopes". Accordingly, Senior Judge Hilder concluded, it was in AB's best interests to remain in residential care.

PROPERTY AND AFFAIRS

A bond problem

[*This is a guest post by Sheree Green of Greenchurch Legal Services Limited*]

Readers may recall that with no consultation and very little notice back in 2023, the Office of the Public Guardian (OPG) announced new arrangements for the provision of security bonds that underpin Court of Protection deputyship orders.

There would be three separate providers for these bonds going forward; Howden UK Ltd ("Howden"), Marsh Limited and Insync Insurance Solutions Ltd, replacing the single provider, Howden, who had been providing bonds since 2016. Would choice and potential commercial competition bring benefits for P?

The immediate impact of this development was a significant increase in premium, with Howden increasing premiums by 167%. Marsh became the more affordable option and the go-to bond provider when a new order was made, whereas Insync never in fact made security bonds available.

The other impact of the change was delay, as we moved from a regime where the Howden bond was set up seemingly automatically and certainly seamlessly to a system which required an active choice followed by necessary action on the part of the deputy, with an ensuing wait for the sealed orders to then be issued.

Just over a year into the new arrangement and Howden has sent a letter by email to professional deputies on 30th May 2024 advising that, "*unfortunately it is our view that Howden's…commercial position has now become untenable, and it is with regret that we have made the decision to cease the issuance of new Deputy Bonds from 31 May 2024 onwards*". (They will continue to provide and service existing bonds). They say they have given notice to the Ministry of Justice. We don't know their notice requirement, but we assume the contract required rather more than 24 hours given to professional deputies. Interestingly neither the MOJ nor the OPG has made any announcement about this.

And so we are back with a single bond provider, with increased costs compared with the pre April 2023 position. A great deal of effort appears to have produced little by way of benefit for P.

Indeed, a new set of challenges may be on the horizon for deputies using Marsh, with reports of the provider being reluctant on occasion to issue a bond, including where a deputy is not based in the United Kingdom, and insisting that deputies increase their professional indemnity insurance over and above the cumulative cover for all of their security bonds.

Job opportunity in the Official Solicitor's office

The Official Solicitor's office is recruiting for a property and affairs lawyer. The details can be found here, and the deadline for applications is 31 July 2024.

PRACTICE AND PROCEDURE

How far can the Court of Protection go to ensure its orders are complied with?

LB Hackney v A, B and C [2024] EWCOP 33 (John McKendrick KC, sitting as a Deputy High Court Judge and a Tier 3 Judge of the Court of Protection)

CoP jurisdiction and powers – injunctions

Summary

John McKendrick KC has answered a question which, as he noted, had curiously not been answered since the MCA 2005 came into force – namely how far-reaching a set of injunctive measures it can grant to compel compliance with its orders.

The issue before the court was as to the steps that could be taken to compel P's mother to return him to the placement where the court had determined it to be in his best interests to live. An order had been made by a Tier 1 judge requiring P's mother and her partner to return P to the placement; a copy of this order had been given to her, and she had ripped it up. Further orders were made, backed by penal notices, but the local authority could not serve them because they did not know where the mother and partner (and P) were. Matters were then escalated to Tier 3, with the local authority seeking a collection order, and an order against two telephone companies for the disclosure of information to assist in identifying where P's mother was. The urgent application came on on the basis of orders being sought under the MCA 2005; an undertaking was also made that an application would be issued under the inherent jurisdiction.

John McKendrick KC noted the seriousness of proceeding without notice to the mother and partner, but that this was a consequence of them having failed to engage with the proceedings (paragraph 10). He then noted that he had been referred to the pre-MCA 2005 decision of *HM and PM and KH* [2010] EWHC 870 Fam, in which (sitting in the inherent jurisdiction), Munby LJ had examined in characteristic detail the jurisdictional basis of the High Court's powers to grant injunctions under the inherent jurisdiction, and had made a whole raft of orders directed to locate and bring about the safe return of the subject of the proceedings.

Whether the Court of Protection had such wide-ranging powers was, John McKendrick KC, not the subject of a reported judgment. He noted, however, that the Court of Appeal had made clear in *Re G* [2022] EWCA Civ 1312 that the Court of Protection had the power to make injunctions under s.16(5) MCA 2005 where it was just and convenient to enforce a best interests decision. He also referred to the subsequent judgment of Senior Judge Hilder in *HM and PM and KH* [2010] EWHC 870 Fam, which also considered the same issue.

John McKendrick KC noted that "*if there is a statutory scheme, then the court must follow that scheme as Parliament set down and resort to the Inherent Jurisdiction only in those limited circumstances where a true statutory gap and where it is necessary to do so. I paraphrase*" (paragraph 23).

John McKendrick KC found that, in the very concerning circumstances of the case, and the "*very highest level of concern*" (paragraph 24) he had for P, it was "*necessary, proportionate, and overwhelmingly just and convenient*" (paragraph 26) to make a collection order to locate and safeguard him by returning him to his home. He considered that it was necessary to make such an order enforcing the Tipstaff and police to enter into third party properties for those purposes, and that he had the jurisdiction to do so under s.16(5) MCA 2005 (see paragraph 27).

John McKendrick KC noted, however, that there was a potential debate about whether a Tier 1 or Tier 2 judge could have made this order by importing the High Court's inherent jurisdiction via s.47 MCA 2005. And, to put the jurisdictional basis of his order beyond doubt, he also made the same order sitting as a High Court judge exercising the inherent jurisdiction (see paragraph 28).

John McKendrick KC also found that he had the ability to make the orders sought against the telephone companies as *"orders made in connection with the Court of Protection's jurisdiction and the* […] *earlier best interests order in respect of A's residence*" (paragraph 29).

In a postscript, John McKendrick KC recorded that A was returned to the placement some days later, although tantalisingly, he does not say by whom.

Comment

As John McKendrick KC made clear, the judgment was one delivered at speed and ex tempore (i.e. on the spot). It is entirely understandable, therefore, that he deployed the belt and braces approach of both making the orders sought as a Court of Protection judge exercising powers under s.16(5) MCA 2005 (and, following *Re G,* by importing the High Court's powers to make injunctions under s.47) and sitting as a High Court judge exercising his powers under the High Court's inherent jurisdiction.

It is, however, to be mildly regretted that he did not roll up his judicial sleeves and determine whether a Tier 1 or Tier 2 judge themselves could have made the orders. It is undoubtedly the case – 23would suggest – that the Court of Protection cannot simply import the High Court's inherent jurisdiction to make substantive orders about those who do not lack capacity applying the test in the MCA 2005.[1] However, that jurisdiction is distinct to the inherent common law power of the High Court to control its own processes and enforce compliance with its decisions (see e.g. Griffin v Griffin [2000] EWCA Civ 119 at paragraph 21). If the Court of Protection cannot import the High Court's own powers to do "hefty" stuff to enforce its best interests determinations it means that Tier 1 judges (who hear the vast majority of cases) are hamstrung in their ability to enforce their rulings. Every time their orders are frustrated in the way that happened here, they will need to refer the case to a judge with the power to sit as a High Court judge, hearing a (fresh) application issued under the inherent jurisdiction.

For what it is worth, we are of the clear view that Court of Protection judges can use the magic sparkle dust of s.47 MCA 2005 (allied, I would suggest, to s.16(5) to make clear why) to import the extensive suite of powers available to the High Court to ensure that their orders are given effect to. That does not mean that they should have ready recourse to it, nor that there is not good reason to transfer up particularly high octane cases to be heard by Tier 3 judges, but those are both separate matters.

Risk-taking, best interests and health and welfare deputies

AB v CD [2024] EWCOP 32 (HHJ Baddeley)

Deputies – welfare matters

Summary

This case concerneed the best interests of a 27 year old man with a moderate learning disability, and visual and hearing impairments. At heart, it was a dispute between his mother, who had (in her own words) brought him in a "very alternative

[1] As to which see our guidance note.

way", and the local authority responsible for his care and placement in a supported living placement, KL. His mother, who described how she had moved away from South Yorkshire some years previously, having experienced harassment, wished him to move to south west England to live with her; Sheffield City Council resisted this. HHJ Baddeley helpfully summarised his findings thus:

> *i) CD is safe and generally content at EF.*
>
> *ii) KL could do more to promote different activities and CD's psychosocial development.*
>
> *iii) KL have adopted a risk averse approach and have been slow to implement change.*
>
> *iv) CD enjoys spending time with AB. He did not want to leave South West England on his visit early in the year. However, this may have been his reaction to a lovely weekend rather than the result of a considered analysis of the pros and cons of a permanent move to South West England.*
>
> *v) AB has a very different attitude to risk to the professionals. She believes that risks are worth taking so that CD can fly.*
>
> *vi) The conflict between AB and professionals, particularly at KL, has been harmful to CD. AB must take some of the responsibility for that. Sometimes she has communicated in ways that have increased the conflict, which has worked against her son's best interests.*
>
> *vii) AB's plans for CD in South West England are not fully developed. She plans for him to stay with her in her two-bedroom flat initially with support from personal assistants. She was clear that this arrangement was only to be a "stepping stone." There is a lot of uncertainty around the longer-term plans. Whilst enquiries have been made by AB of potential personal assistants, no supported or semi-independent placements have been identified in South West England.*
>
> *viii) Professionals find AB difficult. It is not known whether AB will be able to develop a working relationship with professionals in South West England that would further CD's interests.*

HHJ Baddeley agreed with the independent social worker that it was in CD's best interests to remain at EF for another year, with the issue of his potential relocation to South West England to be considered at his next annual deprivation of liberty review. He also endorsed changes to the contact arrangements. He noted that

> *118.* […] *there now needs to be a comprehensive assessment of whether CD does require 2:1 support or whether 1:1 is sufficient. This is an issue that has been contentious throughout the protracted litigation […] and does need to be resolved now. This is obviously highly relevant to the issue of whether it is in CD's best interests to be able to spend time alone with his mother, which she dearly wants, for understandable reasons.*

As regards the appointment of a deputy, HHJ Baddeley noted that this was unusual, but that:

> *106. I am however satisfied that this is one of those rare cases in which it is in CD's best interests for a deputy to be appointed, for the reasons put forward by Mr Wall. As Miss Gardner put it in her submissions, "Hopefully, a health and*

welfare deputy will draw a line in the sand – because the current arrangements are not working."

107. I am pleased to learn that SCC is willing to fund a Deputy for an initial 12-month period. Maria Christine Hutchinson has agreed to act in this role. I have considered the COP4 form that has been filed. She appears to be well qualified to act in this role, having a knowledge of the care system and how the Act operates. I understand that she has no links with any of the parties and so can bring a fresh pair of eyes to this difficult case.

108. No other potential deputies who are willing to act have been identified.

109. I shall appoint Maria Christine Hutchinson as health and welfare deputy.

110. The powers of the Deputy shall be as follows:

"The court authorises the deputy to make the following decisions on behalf of CD that he is unable to make for himself at the time when the decision needs to be made:

(i) Overseeing and consulting with SCC and NHS South Yorkshire Integrated Care Board about arrangements made by them as the responsible s.117 MHA bodies, for his care and support and by KL as the provider of care, to include liaison/consultations with clinical/medical professionals, representatives of bodies with social care and health care responsibilities, and CD's family about CD's care;

(ii) Making arrangements for contact between CD and his family including communicating the nature of those arrangements to the providers of CD's care and the family;

(iii) Making health and welfare decisions not already decided for CD by the court, in consultation with providers of care services, clinical/medical professionals, representatives of bodies with social care and health care responsibilities, and CD's family;

(iv) Raising any issues of concern or complaints about CD's care or treatment with the appropriate authority/person for investigation as applicable, and deciding which concerns and complaints raised by others are to be taken forward for investigation by the appropriate authority/person.

(v) In liaison with SCC, KL and AB agreeing and keeping under review a communication agreement setting out a mechanism by which communication will take place between the parties.

The deputy has permission to obtain any medical and social care records held by third parties in relation to CD. Any party (save for CD's legal representatives) requesting records relating to CD shall make a request to the deputy, who will decide which documents, if any, should be provided."

Comment

This case provides an example of when (unusually) the Court of Protection considers that it is in the best interests of P to appoint a health and welfare deputy. The judge of the former Vice-President of the Court of Protection, Hayden J, in *Re Lawson, Mottram and Hopton (appointment of personal welfare deputies)* [2019] EWCOP 22 explored in considerable detail why it is unusual to appoint a health and welfare deputy, whereas the appointment of property and affairs deputies is routine. In short, this is because s.5 MCA 2005 provides an informal 'workaround' for the inability of the person to

consent to acts and care treatment; there is (broadly) no such workaround for the inability of a person to make decisions about property and financial affairs. In consequence, formal authority is required for the latter in a way that is not required for the former.

The case also provides a useful outline of the powers that were considered – at this stage – to be necessary for the deputy to exercise in CD's best interests.

Court of Protection statistics January – March 2024

The most recent set of statistics have been published by the Ministry of Justice.

They show that there were 2,022 applications in January to March 2024 relating to deprivation of liberty, the highest number in the current series of data. Of these, 653 were s.21A applications relating to DoLS authorisations, 1,221 *Re X* applications for judicial authorisation of deprivation of liberty, and 158 were 'conventional' applications under s.16 for orders involving deprivation of liberty. process.

The future of contempt

The Law Commission has published its consultation paper on contempt law, including provisional proposals affecting the operation of the contempt rules in the Court of Protection. For details, see here. The closing date for the consultation is 9 November 2024.

The dangers of judicial research

D and A (Fact-finding: Research Literature) [2024] EWCA Civ 663 (Court of Appeal (Baker, Phillips and Elisabeth Laing LJJ)

Other proceeding – family (public law)

Summary

This judgment concerned the use of medical research literature as evidence in care proceedings under the Children Act.

The appeal was brought by the parents of two boys, D, aged 6, and A, 2. D and A had lived in the family home until February 2023. The family had no involvement with social services prior to this time and had not come to the attend of any professional agency.

On 2 February 2023, A's parents took him to hospital "*reporting that, whilst at home, he had fallen on the sofa, hitting his head on the arm rest in which there were wooden slats. He cried, then went floppy and his eyes rolled. He did not lose consciousness but remained drowsy and floppy for about 10 to 15 minutes*" (paragraph 4). A was approximately 7 months old. The parents, maternal grandmother and step-grandfather were all present in the room when this occurred, but all stated that they had not seen A fall. Doctors were not concerned with his presentation and he was discharged home. However, "[o]*n the following day, the mother returned A to the hospital reporting that he had slept poorly and vomited during the night. A CT scan conducted that day revealed intracranial bleeding. Further examinations, including fundoscopy and an MRI of A's head and spine on 5 February 2023, revealed*" (paragraph 6). significant injuries which were relied upon by the local authority in the public law proceedings to demonstrate that the threshold was met. Hospital staff suspected non-accidental injuries and alerted children's services; A and D were accommodated by the local authority under s.20 Children Act from 4 February. A made a complete recovery from his injuries, and after stays with family members, A and D were eventually returned to the care of their parents.

In the interim, care proceedings were commenced in relation to both A and D. A was made subject to an interim care order and D

subject to an interim supervision order in early March 2023. Permission was granted for a range of medical experts to be instructed, with an experts' meeting taking place on 1 August 2023. The fact-finding hearing took place in October 2023, with the local authority seeking finding "*that A's injuries had been inflicted by one of four individuals – the mother, the father, the grandmother or step-grandfather – and, if the injuries had been inflicted by one of those four adults, that the parent, or parents, who had not inflicted the injuries had failed to protect A from harm*" (paragraph 10). After seven days of evidence from ten witnesses (five medical experts, the social worker and four family members), "*the local authority told the judge that it was now taking a "neutral position" on whether findings should be made. After discussion, counsel asked for time to consider the position. Later that day, the local authority informed the court that it was seeking to withdraw the proceedings*" (paragraph 11.) The local authority's application to withdraw was made on the basis that the medical expert opinion was inconsistent, and four of the five experts considered that A's injuries could have been accidental and in keeping with the accounts of the adults. Additionally, the social worker had not had further concerns about the adults during the proceedings. "[T*he local authority submit[ted] that this is a case where they are unable to satisfy the threshold based on the oral evidence*" (paragraph 12). The application to withdraw was supported by all parties including the children's guardian.

The first-instance judge hearing the case gave an ex tempore judgment refusing the application for leave to withdraw, on the basis that it would promote the children's welfare to have a fully reasoned judgment on the application, and to be assisted by a rigorous consideration of the literature in this case, the expert evidence and the family evidence' in submissions from the parties. The parties filed written submissions, with no party inviting the court to make findings, and the local authority setting out lengthy submissions in support of its application to withdraw. Baker LJ summarised the first-instance judgment:

> *16.Judgment was handed down on 15 November 2023. It was lengthy and detailed and was accompanied by three annexes: (A) a summary drafted by the judge of various research papers cited by the experts; (B) a note on the law for fact-finding hearings agreed by counsel, and (C) a plain English summary of the judge's findings. The judge made findings on the basis of which she concluded that the threshold criteria for making orders under s.31 of the Children Act 1989 were satisfied.*

The first instance judgment was very critical of the local authority's submissions on the basis that they did not sufficiently engage with the detailed and complex medical evidence in the case. The court's own analysis was extremely lengthy, and discussed points of both the medical evidence and the research which had been filed. The ultimate conclusion was that A likely did have an incident of falling off the sofa, but the first-instance judge was not satisfied that the sofa incident was the cause of his injuries. She considered a more significant force would have been involved in causing his injuries (discussed in terms of 'acceleration' and 'deceleration'), of which the parents were aware.

An appeal was subsequently brought. During the pendency of the appeal, the children were at first living away from their parents, and eventually spending increasing amounts of unsupervised time with them. The underlying proceedings were eventually brought to an end on 28 March 2024, with the children returning to their parents without a supervision order. Five grounds of appeal were brought, but the primary issues were Grounds 1 and 2:

> *69. (1) The judge acted as her own expert and conducted her own analysis of the medical research material. She was wrong to make findings that were not supported by evidence but were in the main made as a result of her analysis of the medical research literature (grounds 1 and 2).*
>
> *70. It was argued that the judge elevated her own analysis of the literature to a status far above other evidence, and used that as the prism through which she evaluated all the other evidence in the case. The judge tried to find the answer buried within literature and, having found what she thought was the answer, applied it to the case. As a result she failed to analyse or give any proper weight to the totality of the expert evidence.*

The judge dismissed one research paper and finding that little weight could be given to it, when none of the experts took that view, and some experts considered it a significant and relevant paper. The appellants also argued that it was the judge who introduced the theory of an earlier incident which had caused A's injuries.

After reviewing case law on the use of research literature in expert evidence (and noting that research literature only becomes part of the evidence if it is cited by an expert in a report or put to them on cross-examination), and the FPR on expert evidence, Baker LJ summarised the key principles:

> *85.In considering the research literature, however, the judge must exercise caution. First, she should not use analysis of research as a stand-alone method of trying to decide what happened. It can help to confirm the accuracy or reliability of the expert's opinion. It is not a tool for the judge to use herself independently when analysing the evidence. She is not the expert.*
>
> *86.Secondly, in areas of scientific controversy and uncertainty (such as causation of intracranial bleeding in infants), there is a risk that the judge may be drawn into too extensive an analysis which will distract from the central issue in the case. There is a danger that the obligations on the expert in Practice Direction 25B to identify the literature and research material they have relied on in forming their opinion and to summarise the range of opinion on any question to be answered will lead the judge into an unnecessarily detailed analysis of the material.*
>
> *87.Thirdly, there are particular difficulties with the research literature about the causation of intracranial bleeding in infants* [….]
>
> *88.Fourthly, when a large volume of research is cited, there is a danger that it may obscure other important parts of the evidence. As Peter Jackson J observed in Re BR (Proof of Facts) [2015] EWFC 41 at paragraph 8, (cited by the judge at paragraph 169 of her judgment) "the medical evidence is important, and the court must assess it carefully, but it is not the only evidence". In A County Council v K D & L [2005] EWHC 144 (Fam) at paragraph 39, Charles J observed,*
>
> > *"It is important to remember (1) that the roles of the court and the expert are distinct and (2) it is the court that is in the position to weigh up the expert evidence against its findings on the other evidence."*

Baker LJ considered that while the first-instance judge had approached this matter conscientiously, "*she went astray in her treatment*

of the research evidence in a number of respects" (paragraph 89).

> *90. The judge's exhaustive analysis of the medical literature and the expert evidence is testament to the care she devoted to this case. But on any view it was unnecessary and disproportionate. As I have already noted, the diagnosis of inflicted head injury, and in particular the question whether a baby can sustain intracranial bleeding from a low level fall, have been matters of controversy for a number of years. But the current state of medical opinion is clear. As Peter Jackson LJ recently observed in Re R (Children: Findings of Fact) [2024] EWCA Civ 153 at paragraph 15, "the debate about serious head injury from low-level falls is well-trodden territory". The preponderance of expert opinion at the moment, which was reflected in the opinion of the experts in this case, is that low-level falls usually do not cause intracranial and retinal bleeding of the sort suffered by A but may do so on rare occasions. The presence of intraspinal bleeding is thought to be an indication of abusive shaking, but this is a grey area and the causes of such bleeding are not at present well understood. There was nothing in the research literature considered by the judge which materially added to this.*
>
> *91.By itself, the fact that the analysis in Annex A was disproportionately long would not, of course, justify interfering with the judge's findings. I am, however, persuaded by Ms Farrington's submission that the judge elevated her analysis of the research to such an extent that it became the prism through which she assessed the rest of the evidence.*

Baker LJ agreed that the local authority had not provided the rigorous consideration of the literature the judge had sought, but "*it was not the role of counsel to provide an independent assessment of the literature. Literature and research material is only admissible in so far as an expert has referred to it in forming his opinion. Counsel's submissions could only extend to addressing the question whether the literature supported the expert's opinion. In fairness to local authority counsel, it should be pointed out that her submissions did contain a reasonably full summary of the evidence given by the experts including some of their references to research in their reports and in oral evidence*" (paragraph 92).

Baker LJ accepted that it was appropriate to consider the research literature given the experts' discussion of it, but the manner in which it occurred "*elevated the literature to a position of decisive importance which it did not warrant. There is a strong impression that she treated the research literature as the primary source of the opinion evidence and the experts' testimony as ancillary to it*" (paragraph 93). Baker LJ also considered that the judge's summary of one paper "*was irregular and her conclusions about it were wrong*" (paragraph 96). Baker LJ reviewed the paper himself, and considered that the paper "*provides reliable support for the unanimous view of the expert witnesses as to the timing of injuries. The judge's reading of this paper led her to downplay the significance of their evidence as to timing. I recognise, of course, that, in putting forward my interpretation of a paper which was neither considered by nor put to the experts, I could be said to falling into the same error as the judge. The real problem is that the paper was not properly part of the evidence because it was not considered by any of the expert witnesses. This is particularly important because the judge attached significant weight to it when reaching her conclusion that the child had suffered an earlier acceleration/deceleration event at some prior to the sofa incident*" (paragraph 102).

Baker LJ ultimately considered that the judge's conclusions had been "*based on a mixture of her reading of the literature and speculation, not on the evidence*" (paragraph 103). The judge should have allowed all experts to comment on the theory considered by the judge, and not only raise this point briefly with the single expert who disagreed with the other four.

Baker LJ concluded that the fact-finding conclusions could not stand, noting that "*important elements of the judge's ultimate findings were never explored with the parents in evidence nor with counsel in submissions*" (paragraph 110).

The appeal was allowed, and the judge's findings of fact set aside. As the children had already been returned to their families, the Court of Appeal proposed to allow the local authority leave to withdraw the proceedings.

Comment

In a judgment equally applicable in proceedings before the Court of Protection, the Court of Appeal has given a clear and robust summary of existing case law on how research literature should be treated, and what its role should be within proceedings. Such evidence enters through experts to support their opinions, but is not 'stand-alone' evidence for the court, and the court should resist the temptation to act as its own expert. The facts of this case plainly troubled the first-instance judge, where a child had come to major injuries in a manner which appeared to be possible, but quite unlikely. However, as the Court of Appeal noted, the findings made by the first-instance judge were also unlikely, and where this theory was not advanced by the parties, it had not been ventilated in the proceedings and fully considered by the experts. The Court of Appeal's judgment in this matter is a caution for the court to consider its own limitation in looking at research literature, and to ensure that findings of fact are grounded in the evidence specific to the case.

MENTAL HEALTH MATTERS

Tier 4 beds – again

Re MK: Deprivation of Liberty and Tier 4 Beds [2024] EWHC 1553 (Fam) (High Court (Family Division) (Lieven J))

Mental Health Act 1983 – treatment for mental disorder

Summary[2]

This case concerned MK, a seventeen and a half year old girl who was subject to a care order and so was therefore a looked after child. MK was described by Lieven J in the following way:

> *MK has a significant mental health history with difficulty regulating emotions, fluctuating mood, and suicidal ideation. She is currently an in-patient in a paediatric unit children's ward of a general hospital run by the Applicant, which is not intended to be a secure unit.*

The matter came before Lieven J on the application of an acute hospital trust who sought an order allowing it to deprive MK of her liberty on their paediatric ward.

Prior to the index admission, MK had had a series of placements in both in-patient children and adolescent (CAMS) mental health beds (referred to as Tier 4 placements in the context of the commissioning structure), and community placements (some of which had been authorised by the High Court as amounting to a deprivation of her liberty). MK had also had very frequent admissions to the acute hospital.

Since March 2024 MK had begun to take frequent overdoses of paracetamol. In the few weeks before the hearing, there had been a deterioration in MK'ss mental health in that she had become increasingly dysregulated and much more determined to end her life. The matter came before the court after MK, who had been found trying to climb across a motorway bridge having taken an overdose of paracetamol, was taken to the acute hospital, where she was assessed by two doctors approved pursuant to s.12 of the Mental Health Act ('MHA 1983') and an Accredited Mental Health Professional ('AMHP'), as meeting the criteria for detention under s.2 of the MHA. As the Judge noted, in order for a young person to be offered a Tier 4 bed, an application must be made to NHS England (who commission all NHS tier 4 placements). NHS England have developed an access assessment procedure (which in practice is devolved to a number of Provider Collaboratives across the country) to determine whether a placement or bed will be offered at a Tier 4 unit.

The access assessment undertaken in respect of MK did not lead to an offer of a tier 4 bed being made. The reasons for this were set out by one of the CAMHS Consultant Psychiatrists (Dr M) as follows:

> *[MK's] health needs can be understood as emotional crisis in context of several stressors rather than due to severe and enduring mental illness. Moreover, admission to inpatient psychiatric unit may cause side effects including increase in severity of risk behaviours, 'contagion effect' due to unhelpful dynamics with peers and institutionalisation."*

The parties positions before the Court were as follows:

[2] Arianna having been involved in the case, she has not contributed to this note.

- Despite it being agreed by the acute Trust that a placement in a Tier 4 bed would be counter-therapeutic for MK, the acute Trust submitted that there was an "*immediate need …. to prevent MK from significantly harming herself, absconding and committing suicide, or dying through misadventure brought on by dysregulation"* which in the acute Trust's submission was "*more easily achieved in a Tier 4 bed with the potential for locked doors and segregation, than the paediatric ward of a general hospital, or a placement in the community in what can only be described as unsuitable accommodation*"

- The local authority's position was that if MK could not be placed in a Tier s4 bed they would provide a community placement "*in an Airbnb, not designed to be a therapeutic placement, which is a mid-terraced house of normal* construction" with "*a series of carers who would try to keep MK safe to the best of their ability.*"

- It was accepted by NHS England that MK had a mental disorder within the meaning of the MHA 1983 (namely emerging Emotionally Unstable Personality Disorder) and met the criteria for detention under the MHA 1983. However, it submitted that the court could not force a unit to offer a Tier 4 bed to MK in light of the view taken that such an admission would be anti-therapeutic.

Lieven J acknowledged that her powers were very limited – having no power to force NHS England or the Tier 4 assessment unit to admit MK to a Tier 4 bed or to provide her with treatment it believes to be countertherapeutic. However, she went on to set out her conclusions in order "*to try to persuade the Mental Health Trust and NHS England to focus on what in my view is the real issue in the case*." Her conclusions were as follows:

With respect to the local authority's position, Lieven J found that

> *no community placement can provide MK with anything that can be described as suitable care, because it is very unlikely to be able to keep her safe. Great efforts have been made by the LA to find a suitable therapeutic placement, but there simply are no such placements available that are prepared to offer MK a bed.*

With respect to the position put forward by NHS England:

> *It is a common misconception put forward in these cases that when a young person is experiencing emotional distress due, it is said, to "environmental" factors or behavioural issues, that they do not fall within the MHA. That is plainly wrong.*

She went on to state that Emerging Personality Disorder is a mental disorder within the meaning of the MHA: "*The fact that a person has such a disorder does not mean it is beneficial to them to be detained but does mean that the person is detainable because they meet the MHA criteria*."

Lieven J accepted that a placement in a tier 4 bed might be counter-therapeutic "*in terms of psychological therapy and future effective functioning*" but as a result of the article 2 ECHR operational duty on the State (which requires the state to do all that can reasonably be expected to prevent a patient from taking their own life where the state knows that a particular patient presents a real and immediate risk of suicide) she held that:

> *Unless MK is provided with a very high level of supervision and containment,*

> *she will abscond and there is a real and immediate risk that she will buy paracetamol and try to kill herself. The obligation at present is simply to keep her alive and in that context, the fact that her treatment needs may not be well met in a Tier 4 bed simply misses the point. In my judgement, it must be the case that the State is more likely to achieve its obligations under Article 2 by keeping her in a locked unit, than either on a general paediatric ward or in Airbnb with high turnover of staff and not physically designed for containment*

She concluded:

> *I fully appreciate that the Mental Health Trust does not want and should not in an ideal world, be forced to use Tier 4 as a containment facility for a suicidal person. However, unless and until somewhere else is found that can effectively protect MK from a significant risk of killing herself (whether through suicide or misadventure) and meet her therapeutic needs, it is, in my view, in her best interests to be admitted to a Tier 4 bed. Arts 2 and 3 ECHR are engaged and the State, particularly NHS England, is on notice of what was said by the House of Lords in Savage: "article 2 requires them to do all that can reasonably be expected to prevent the patient from committing suicide."*

Comment

Mrs Justice Lieven noted at the outset that "*the decrease in judgments in such cases is a function of the existence of the National DOLS list, there are fewer cases going to full-time High Court Judges, and is not a function of there being fewer cases or fewer troubled children.*" Indeed anyone practicing in this area is all too familiar with the high number of cases that are still coming before the court. These are tragic cases involving acutely distressed children who will in almost every case, have experienced a number of failed placements.

What is interesting about this judgment is that Lieven J chose not to focus on the State's failure (via the local authority) to find MK a suitable therapeutic placement to protect her given the statutory duty on local authorities to provide sufficient places for looked after children in their area (see section 22G of the Children Act 1989). Lieven J noted that that there is a national shortage of such placements (a situation that has existed for many years) but did not suggest that the local authority was on notice that Articles 2 and 3 are engaged so as to require the local authority to do all that could be reasonably expected to prevent MK from taking her own life. Instead, she focused her comments about the State's obligations under Articles 2 and 3 ECHR on those who have refused to offer KM a bed in circumstances where it was accepted that such a placement was likely to cause MK iatrogenic harm. It hardly needs saying that such beds are precious resources, which, on their face, should be reserved for those who will benefit therapeutically from them. The distinct sense of 'pass the parcel' that the judgment engenders is one that is also exercising Alex considerably in his current work at the Law Commission on the Disabled Children's Social Care project.

Short note: the Mental Health Tribunal and restrictions

A very heavily redacted decision of the Mental Health Tribunal has recently appeared on the Mental Health Law Online judgment.[3] It is so heavily redacted that it does not have a name,

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

and the decision has been reduced from 8 pages to barely as many paragraphs. However, it is of considerable interest given how infrequently decisions of the Mental Health Tribunal are published.

The patient argued that she should be discharged from the conditional discharge under s.37 / 41 MHA 1983 to which she was currently subject. Her argument was that she should be discharged on the basis that the "life licence" conditions to be imposed by the Parole Board could replicate the framework of the MHA 1983. The Responsible Authorities resisted this argument on the basis that the MHA 1983 framework was a specialist one, operating with the involvement of clinicians and politicians and with a specialist focus on helping those with mental disorders.

Granting the application, the Mental Health Tribunal determined that the purpose of s.41 MHA 1983 must be determined in the moment – "now" - rather than at some future date on which the patient might be released (see paragraph 27).

The patient/prisoner, it held, would be detained until the Parole Board was considered it was no longer necessary for the protection of the public. In the event this stage were ever reached, and in the event the patient were released, it would be on licence only, meaning she could be recalled to prison without the need for another offence to be recalled; in such circumstances, the Tribunal considered, the ongoing supervisory power of a conditional discharge under s.41 MHA 1983 was unnecessary.

Comment

The logic of this decision is clear, the licence conditions and the conditional discharge essentially fulfilling the same function. They make interesting reading alongside the judgment of the Court of Appeal in the *Calocane* case we reported on in the June 2024 report, where essentially the same point was made from a different perspective. They do, however, raise the question of the respective purposes of the custodial and mental health regimes – a question which may come into sharper relief depending on the attitude the new Government takes towards prison more generally.

THE WIDER CONTEXT

Local authorities, care orders and consent to confinement

Re J: Local Authority consent to Deprivation of Liberty [2024] EWHC 1690 (Fam) (High Court (Family Division) (Lieven J))

Article 5 ECHR – deprivation of liberty – children and young persons

Summary

Lieven J's campaign against the decision of the Supreme Court in *Cheshire West* continues. In *Re J: Local Authority consent to Deprivation of Liberty* [2024] EWHC 1690 (Fam), she has held that a local authority can in the exercise of its 'corporate' parental responsibility, consent to the confinement of a child under 16 subject to a care order, so as to take the child's circumstances out of the scope of Article 5 ECHR. At paragraph 19, she identified that:

> *The rationale for the court considering DoLs applications in circumstances such as this may be, as suggested in Cheshire West and subsequent cases, to ensure that safeguards are in place and there is court oversight of the process. Article 5 requires that any deprivation of liberty must be "in accordance with a procedure prescribed by law". The Supreme Court in Re T (A Child) [2021] UKSC 35 held that the use of the High Court's inherent jurisdiction fell within the "in accordance with law" requirement. However, the need for a legal process if there is a deprivation of liberty cannot itself be relevant to the substantive content of the right. If the LA can provide valid consent in J's case, then there is no requirement for a DoLs order, whatever the possible benefits of "safeguards" of a court process, in this case the High Court DoLs List.*

The local authority argued (albeit somewhat faintly) that it could not give such consent, basing itself on the clear statement to that effect by Keehan J in *Re D (A Child) (Deprivation of Liberty)* [2015] EWHC 3125:

> *29. Where a child is in the care of a local authority and subject to an interim care, or a care, order, may the local authority in the exercise of its statutory parental responsibility (see s.33(3)(a) of the Children Act 1989) consent to what would otherwise amount to a deprivation of liberty? The answer, in my judgment, is an emphatic "no". In taking a child into care and instituting care proceedings, the local authority is acting as an organ of the state. To permit a local authority in such circumstances to consent to the deprivation of liberty of a child would (1) breach Article 5 of the Convention, which provides "no one should be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law", (2) would not afford the "proper safeguards which will secure the legal justifications for the constraints under which they are made out", and (3) would not meet the need for a periodic independent check on whether the arrangements made for them are in their best interests (per Lady Hale in Cheshire West at paragraphs 56 and 57)."*

Lieven J considered that Keehan J's analysis:

> *23.* […] *conflates two separate issues relevant to Article 5. For present purposes I accept that the first and third limbs of Storck are met, because the LA, or in fact its agent the care provider, does not allow him to leave the premises unaccompanied. Therefore the restrictions on J are imposed by the State. However, that does not mean that the LA, acting as the corporate parent under s.33 CA, cannot consent to that deprivation.*

Lieven J considered s.33(b) CA 1989, and the observations of the Court of Appeal in *Re H (Child)* [2020] EWCA Civ 664 (a case about vaccination) that "*some decisions are of such magnitude that it would be wrong for a local authority to use its power under s.33(3)(b) to override the wishes or views of a parent*." She considered that:

> *31. Although that case concerned a very different issue to the present, namely the giving of vaccinations, there is no obvious reason why the core test should not be the same. Namely, is the decision that the LA is being asked to make under s.33(3)(b) CA "of such magnitude" that it cannot be made by the LA, but rather must be made by the Court.*
>
> *32. There is no doubt, as Lady Hale said, and is clear from Guzzardi, that the removal of an individual's liberty is a significant infringement of their human rights and an important decision. However, in this, as in every other aspect of human rights law, context is all and it is necessary to consider the facts of the individual case.*
>
> *33. The approach that the LA can never exercise its powers of parental responsibility under s.33(3)(b) to grant valid consent for a deprivation of liberty rests on the proposition that a deprivation of liberty is necessarily a decision of such magnitude as to require the role of the court. Although logically that conclusion might flow from what Lady Hale said in Cheshire West and Re D, neither of those decisions concerned the scope of parental responsibility in respect of children under the age of 16, let alone the scope of s.33(3)(b) in decisions concerning children of that age and deprivation of liberty.*
>
> *34. Further, if one applies the test to the facts of J's case, it is in my view clear that the decision to deprive him of his liberty is an inevitable one, which no reasonable court or parent would depart from. One way of testing this proposition is to consider what would happen if the LA, or those authorised to look after J i.e. the Children's Home, did not put in place the restrictions sought. They would very obviously be in breach of their duty of care to J, given his known vulnerabilities and the manifest risks to his safety if he was allowed to leave the home unsupervised. In reality it is the obligation of any responsible carer of J to place restrictions upon him in order to keep him safe. Therefore, far from the restrictions amounting to a serious infringement of his rights that no LA could lawfully consent to, they are restrictions essential to ensuring his best interests, and indeed required by the State's positive obligations under Article 2 ECHR to protect his life. In those circumstances in my view they fall within the LA's statutory powers in s.33 CA.*
>
> *35. Therefore the decision to "deprive him of his liberty" is not in my view a decision of such magnitude as to fall outside the LA's powers, but rather an exercise of their statutory duties to him. In my view the LA have the power to consent to the restrictions and therefore to the deprivation of his liberty, and no DoLs order is needed.*

Comment

At the time of writing, it is not known whether there will be an appeal. As with Lieven J's other recent case in this context, it would be very unfortunate if there were not, because it is difficult to square her decision with the approach taken by the appellate courts to deprivation of liberty. It also is at direct odds not just with the decision of Keehan J in *Re D*, but also the decision of Sir James Munby in *Re A-F* [2018]

EWHC 138 (Fam), in which the then-President of the Family Division held:

> *12 (i)* [w]*here a child is subject to a care order (whether interim or final) neither the local authority nor a parent can exercise their parental responsibility in such a way as to provide a valid consent for the purposes of Storck component (b): see In re AB (A Child) (Deprivation of Liberty: Consent) [2015] EWHC 3125 (Fam), [2016] 1 WLR 1160* [i.e. *Re D*]*, paras 26-29, 36, considered in Re D (A Child) [2017] EWCA Civ 1695, paras 48, 109-112.*

That decision, unfortunately, does not appear to have been cited to her by the parties.

Looked at on its own terms, there is, further, a somewhat troubling sense of 'boot-strapping' in the approach taken.

As the decision of the Supreme Court in *Re D* makes clear, the ability of 'true' parents to give consent to the confinement of their child (below the age of 16) arises in consequence of the interaction between Article 5 and Article 8 ECHR in circumstances where "the responsibility of parents to bring up their children as they see fit, within limits, is an essential part of respect for family life in a western democracy" (see *Re D* at paragraph 3).

It is difficult to say that a local authority, as corporate parent – and as an agent of the state – could itself enjoy Article 8 rights, or require respect to be owed to it as regards how it chose to bring up 'its' children. Indeed, it is precisely because the child's 'true' parents are either unable or unwilling to look after their child that the law empowers the state to intervene in the child's life by way of a care order.

It is therefore unsurprising that Lieven J in her judgment does not rely upon Article 8 ECHR as part of her argument.

However, if Article 8 falls away, so does any argument for relaxing the strict requirements of Article 5 ECHR.

On what basis, therefore, can a local authority be said to be acting within its powers to consent to the confinement of a child under 16 so as to take their circumstances out of the scope of Article 5 ECHR? That basis, Lieven J explains, is because it has the statutory power to do so. But, with respect, that argument is circular, because it would mean that the state had at the same time empowered itself to confine a child and to consent on behalf of that child to that confinement so as to take its circumstances outside the scope of Article 5 ECHR. The entire point of Article 5 is that it is supposed to constrain the exercise of state power to prevent it being deployed in an arbitrary fashion even if the person wielding it considers that they are doing so in a beneficent fashion. As the Strasbourg court noted in *HL v United Kingdom*:

> *121.* […] *While the Court does not question the good faith of those professionals or that they acted in what they considered to be the applicant's best interests, the very purpose of procedural safeguards is to protect individuals against any "misjudgments and professional lapses" (Lord Steyn, paragraph 49 above)*

On the logic adopted by Lieven J, further, the Court of Protection could empower a deputy to consent to confinement on behalf of an adult lacking capacity, and, by enabling the deputy to give that consent, remove the person's circumstances from the scope of Article 5 ECHR. That logic has clearly not won favour with the European Court of Human Rights. As Lady Hale noted in *Re D*:

> *42.* […] *But, as also pointed out in Cheshire West, it is striking that the European Court of Human Rights has*

> *consistently held that limb (b)* [i.e. that the confined person is not consenting] *can be satisfied despite the consent of a person with the legal right to make decisions on behalf of the person concerned: see Stanev v Bulgaria 55 EHRR 22, DD v Lithuania [2012] MHLR 209, Kedzior v Poland [2013] MHLR 115, Mihailovs v Latvia, unreported, [2013] ECHR 65, and now Stankov v Bulgaria [2015] 42 ECtHR 276. In Stanev, the court did observe, in passing, that "there are situations where the wishes of a person with impaired mental facilities may be validly replaced by those of another person acting in the context of a protective measure and that it is sometimes difficult to ascertain the true wishes or preferences of the person concerned" (para 130). However, as Keehan J observed in the Court of Protection (para 118) that is very far from adopting a general principle of substituted consent. The consent of a legal guardian may have been sufficient to make the confinement lawful in the domestic law of the country concerned, but that did not prevent its being a deprivation of liberty, or guarantee that it fulfilled the Convention requirement of legality. In the cases where limb (b) has been held to be satisfied, it is because the evidence showed that the person concerned was willing to stay where he or she was and was capable of expressing that view. Parental consent, therefore, cannot substitute for the subjective element in limb (b) of Storck.*

Re D, as Lieven J pointed out, concerned a child over 16. But the logic of the passage immediately above (and the cases from Strasbourg referred to) is not age dependent. Rather, and with respect, it might be thought fatally to undercut the basic premise on which Lieven J's argument in J's case is based.

The logic of Lieven J's decision also leads to a result which might be thought to be odd, even for those who might be attracted to it. Care orders do not stop at age 16 (even if restrictions start to bite about applying for them as the child moves towards 18). Even if Lieven J could distinguish *Re D* as it applied to J when he was under 16, her approach logically suggests that the local authority's consent must be able to continue throughout the life of the care order. When he turns 16, the local authority would then be armed with greater powers to exercise parental responsibility than his true parents would have been, given *Re D* is binding authority for inability of parents to consent to confinement of those over 16. It is worth repeating that this restriction on parents exists even with Article 8 in the parental corner, a right that the local authority cannot itself pray in aid. No explanation for this anomaly is given in the judgment, nor, in truth, is it apparent as to what explanation could be given. In this regard, it is noteworthy that in the course of examining the concept of deprivation of liberty carefully and confirming that a local authority could as corporate parent control the mobile phone use of a 16 year old subject to a care order, it did not appear to have crossed the mind of MacDonald J that the local authority could also consent to the confinement of the child in *Manchester City Council v P (Refusal of Restrictions on Mobile Phone)* [2023] EWHC 133 (Fam).

The logic of the paragraph above further raises the somewhat disturbing prospect of a local authority caring for an older teenager, highly resistant to the restrictions on them, opting them out of the protections of Article 5, on the basis that the local authority considers (with no external scrutiny) that it is acting in the child's interests.

The argument can be tested another way. Article 5 ECHR requires a procedure prescribed by law. It also provides that there is a limited and exhaustive set of circumstances under which

someone can be deprived of their liberty. It might – just – be said that a local authority could consent to the confinement of a child subject to a care order if in so doing it is following a procedure prescribed by law.[4] However, there is no suggestion that the local authority in J's case was in giving consent to confinement in purported exercise of powers under s.33 Children Act 1989 doing so by reference to the criteria under either Article 5(1)(d) (detention for the purpose of the educational supervision of a child) or Article 5(1)(e) (detention on the basis of 'unsound mind'). So it would be difficult to argue – and in fairness, Lieven J does not seek to suggest – that the local authority in exercising its apparent 'consent' power was directing itself in such a way as to comply with Article 5 ECHR. Rather, and to reiterate, Lieven J concluded that it was acting in such a way as to take itself outside the scope of Article 5 altogether. Which many people might find challenging as a conclusion.

Finally, and as *Cheshire West* and *Re D* make clear, the fact that a local authority may be directly or indirectly confining the child in furtherance of positive duties towards the child (for instance to save their life) goes to the question of whether the deprivation of liberty is justified, rather than to whether there is a deprivation of liberty in the first place.

Taken together, therefore, we would suggest that this case needs to be read with a very large health warning – but, again, that the situation of children under 16 needs to be examined urgently by the appellate courts so as to resolve the increasingly complicated position that is unfolding.

[4] Albeit it would be better, perhaps, to describe it as authorising the confinement, rather than consenting to it.

IRELAND

HSE v. P.T. [2024] IEHC 397

This judgment, available here, is a particularly interesting judgment concerning the evolution of safeguards in respect of detention orders under the inherent jurisdiction of the High Court. The matter concerned when the court might accept that the respondent's views are not required to be ascertained. P.T. was admitted to wardship in 2017 and is in his thirties. The court was asked by the HSE to extend existing detention and treatment orders concerning P.T. In determining that application, the court considered the issues of capacity, vindication of the respondent's rights, and whether or not his views should be ascertained. The court described it as "a very unusual scenario". The proposal not to ascertain the respondent's views on the application was supported by his multidisciplinary team ("MDT"). His MDT felt that he would not have the capacity in respect of the relevant information, regardless of how it was communicated to him, and that it would be distressing for him.

The court accepted that it was appropriate in the circumstances to proceed without the participation of the respondent as his challenges prevent him from participating in a meaningful way, and he would only be caused avoidable distress by insistence on participation.

This is really interesting when one compares it with the requirement to not only serve a Relevant Person with a Capacity Application but to explain to them the nature and consequences of the application. This judgment perhaps opens a window of possibility that if there was sufficient evidence in a given case, it may be appropriate not to serve the Relevant Person. However, this

is also contrasted with the adage adopted by the High Court in *KK (No. 2)* "nothing about them without them".

Emma Slattery BL

IN THE MATTER OF M.D., A WARD OF COURT [2024] IEHC 394

This is a very short but striking judgment, which illustrates well a further operational difficulty arising with Part 10 of the ADMCA. M.D. is a young man who resides in a specialist facility in England & Wales, as such care is not currently available in Ireland. He was admitted to wardship in 2017 and his detention in the UK has been periodically reviewed by the wardship court. In accordance with Part 10 of the ADMCA, all wards who are detained at the time of commencement of the ADMCA are required to have their detention reviewed under section 107 or 108 of the Act, and either have that detention continued under that section or be discharged from detention. Evidence from both an Independent Consultant Psychiatrist ("ICP") and Responsible Consultant Psychiatrist ("RCP") is required.

In this case, no ICP report had been made available to the court to allow the court to complete the Part 10 review. Mr. Justice Heslin found that "as a matter of law it is not open to this court to dispense with the requirement for an ICP report". Given that there was no ICP report available to the court, Mr. Justice Heslin found that it was impossible to carry out the Part 10 review and noted that the position in this case was "materially different" to the position in M.C. Consequently, the court found that an application could be made pursuant to the court's inherent jurisdiction.

It is not clear from the judgment what type of Orders are required under the inherent jurisdiction that can't be made under the court's existing wardship jurisdiction, assuming the ward has not yet been discharged from wardship. It is similarly not clear whether wards such as this will ever have the benefit of their statutory entitlement to a Part 10 review if an ICP report cannot be made available to the court.

Emma Slattery BL

Decision Support Service Annual Report

The 2023 Annual Report from the Decision Support Service (DSS) highlights its activities since the commencement of the Assisted Decision-Making (Capacity) Act 2015 on April 26, 2023. During its first operational period, the DSS received various submissions for decision-making support arrangements, including 15 decision-making assistance agreements (of which nine were acknowledged), and 29 applications for co-decision-making agreements, with 10 registered. Additionally, there were 185 court-issued decision-making representation orders, of which 83 were registered, alongside 407 applications for enduring powers of attorney, with 385 registered. By year's end, the DSS portal maintained active applications across several categories: 96 for DMAA, 61 for CDMA, and 1,671 for EPA, collecting total fees of €21,477. Also noted were notifications involving ten registered co-decision-making agreements and one accepted notification of an enduring power of attorney.

The report further reflects on the operations across its divisions, including the establishment of a panel comprising 92 decision-making representatives, 44 general visitors, and 34 special visitors, with 30 nomination requests received from the panel, largely from court orders related to wardship discharges. The DSS handled 25 complaints in 2023, with various outcomes including ongoing investigations, discontinuations, and some resolved amicably. Additionally, no requests were made for visits by special or general visitors in 2023,

demonstrating a year focused on foundational activities and public engagement.

Emma Slattery BL

Research Corner

[A message on behalf of this brilliant [5] project: *Use of the Mental Capacity Act 2005 with people experiencing multiple exclusion homelessness in England*.]

Are you a health, social care or homelessness practitioner in England who works with people experiencing homelessness and disadvantage such as mental illness or substance use? Your views are important, whether you work occasionally, or wholly, with this population, and whether or not you conduct capacity assessments.

This survey will only take 10 mins of your time: https://app.onlinesurveys.jisc.ac.uk/s/kings/mental-capacity-homelessness-national-practitioner-survey-202-1

To receive the research findings and/or enter the £100 voucher draw just add your email at the end.

Thanks for helping improve understanding and support for this population.

The human condition and physician assisted dying – the latest view from the European Court of Human Rights

Karsai v Hungary [2024] ECHR 516 (European Court of Human Rights (First Section)

Other proceedings – civil

In *Karsai v Hungary*, the European Court of Human Rights has made clear that, whatever the current political head of steam behind moves towards legalising assisted dying / assisted suicide, there is only limited judicial appetite to frame it as a matter of rights.

Mr Karsai, a leading human rights lawyer in Hungary, has motor neurone disease (or ALS as it is known elsewhere). He unsuccessfully challenged the ban in Hungary on obtaining what was described in the judgment as some form of physician assisted dying (it is not entirely clear from the judgment whether he wished to receive assistance, but take the final step himself, or to be administered the lethal medication himself. He brought his challenge to Strasbourg, and, unsurprisingly, sought to raise every argument that he could to challenge the Hungarian ban by reference to the ECHR. In a submission which may well be thought to chime with what is often read in the media:

> *96. The applicant pointed out that over twenty years had passed since the judgment in Pretty (cited above). Referring to the judgments in Haas and Mortier(both cited above), the applicant argued that the case-law of the Court had evolved, as had the legislation in many member States, which increasingly recognised the right to make end-of-life decisions. Referring to recent judgments in Italy, Germany, Austria and Canada, and to the legislation in the countries where assisting suicide had been decriminalised through a legislative process, the applicant argued that there was an emerging consensus in the Euro-Atlantic legal space on the disproportionate nature of the absolute ban on all forms of assisted suicide with respect to terminally ill patients who were fully mentally competent but*

[5] Alex is biased; he is involved in it.

> *unable to terminate their life without help. In his submission, the European consensus was reflected also in the attitude and acceptance of PAD by the general population and the medical profession. The applicant referred to the results of several opinion polls on the extent of public acceptance of PAD in Hungary.*

Interestingly (and unusually), the court heard from two experts; a palliative care expert and a bioethics expert, as well as considering submissions from the Italian government, as well as bodies arguing both in favour and against assisted dying. The court also undertook a review of comparative law across the Council of Europe and further afield, including reviewing cases decided domestically in England & Wales, Germany, Italy and Canada.

The Government of Hungary sought to argue that Mr Karsai's case was inadmissible, on the basis that there was no right to self-determined death under the ECHR, and the Article 8 did not apply, as the question of the prosecution of third parties who might wish to assist him did not touch upon his own interests. The Court had little truck with this argument, finding that his:

> *87.* […] *complaint falls to be examined as concerning an aspect of the applicant's right to respect for his private life within the meaning of Article 8. As regards the question whether this Article goes so far as to require the respondent State to allow or provide the applicant a certain form of PAD, this is a matter which can be resolved only through an examination on the merits, with due regard to the conflicting considerations and the State's margin of appreciation.*

When it came to the merits of the case, the ECtHR first asked itself whether the case involved the State's negative and / or positive obligations. Negative obligations are (in essence) rights not to have things done to you by the State (for instance, a right not to be tortured). Positive rights are (in essence) things that you can demand from the State. It noted that anyone who provided Mr Karsai with assistance to die in Hungary, or to a Hungarian national abroad, could be punished under Hungarian criminal law. On the fact of it, therefore, this appeared to be a situation where his right to respect for private life under Article 8 ECHR was being interfered with – i.e. this was a case purely about negative rights. Importantly, however, the court continued:

> *136. This being stated, the Court notes that the applicant himself argued that the State should be under a positive obligation to secure the conditions for the effective exercise of the right to a self-determined and dignified death, and that the decriminalisation of certain forms of assisted suicide would require strict regulation and appropriate safeguards (see paragraph 94 above). In the case of PAD, this would also necessarily involve a positive provision of access to medical intervention, such as access to life-ending drugs (see paragraph 48 above, and also Haas, cited above, § 53). The applicant's complaint therefore goes beyond mere non-interference, engaging negative and positive obligations, which are intertwined. In this respect, the Court would reiterate that the boundaries between the State's positive and negative obligations under Article 8 do not always lend themselves to precise definition. However, the applicable principles are similar. In both contexts regard must be had to the fair balance that has to be struck between the competing interests.*

The court then turned to see whether the ban in Hungary was compatible with Article 8, requiring it to examine:

> *138.* [..] *whether a fair balance has been struck between the applicant's interest in being able to end his life by means of PAD, and the legitimate aims pursued by the legislation in question, regard being had also to the positive obligations entailed by decriminalisation of PAD (see paragraphs 135 and 136 above) and the State's margin of appreciation in this domain.*

The ECtHR:

> *143.* [could] *not but note that a certain trend is currently emerging towards decriminalisation of medically assisted suicide, especially with regard to patients who are suffering from incurable conditions (see paragraph 63 above). Nevertheless, and even if access to PAD has recently been or is being deliberated in the parliaments of certain other member States (see paragraph 60 above), the majority of member States continue to prohibit and prosecute assistance in suicide, including PAD (see paragraph 61 above). Moreover, the Court notes that the relevant international instruments and reports (see paragraphs 35-41 above), including the Council of Europe's Oviedo Convention, provide no basis for concluding that the member States are thereby advised, let alone required, to provide access to PAD (contrast, mutatis mutandis, Fedotova and Others, cited above, §§ 175-77).*
>
> *144. In view of the foregoing and noting that this subject continues to be one that raises extremely sensitive moral and ethical questions, and one on which opinions in democratic countries often profoundly differ (compare A, B and C v. Ireland [GC], no. 25579/05, § 233, ECHR 2010), the States must be granted a considerable margin of appreciation (see Haas, cited above, § 55). From the perspective of Article 8 this margin extends both to their decision to intervene in this area and, once they have intervened, to the detailed rules laid down in order to achieve a balance between the competing interests (see Pejřilová v. the Czech Republic, no. 14889/19, § 43, 8 December 2022, and Evans v. the United Kingdom [GC], no. 6339/05, § 82, ECHR 2007-I). Having said that, the Court would reiterate the long-established principle that even when the margin of appreciation is considerable it is not unlimited and is ultimately subject to the Court's scrutiny (see Handyside v. the United Kingdom, 7 December 1976, § 49, Series A no. 24; A, B and C v. Ireland, cited above, § 238, and Verein Klimaseniorinnen Schweiz and Others v. Switzerland [GC], no. 53600/20, §§ 450 and 541, 9 April 2024).*
>
> *145. Having regard to the arguments raised by the Government and some of the third parties (see paragraphs 99-100, and 114-116 above), the Court finds it appropriate to point out that it has already found that Article 2 does not prevent the national authorities from allowing or providing PAD, subject to the condition that the latter is accompanied by appropriate and sufficient safeguards to prevent abuse and thus secure respect for the right to life (see paragraphs 126 and 127 above). It is in the first place for the national authorities to assess whether PAD could be provided within their jurisdiction in compliance with this requirement.*

The Hungarian government placed considerable reliance on the argument that relatxation of the relevant legislation could "*expose vulnerable people to overt and covert pressure to end their lives, affect their sense of self-worth, undermine trust in the medical profession, and create the effect of a 'slippery slope'*" (paragraph 149). In response, the ECtHR noted that:

> *150.* […] *any system of PAD - even one limited to terminally ill patients with refractory symptoms (see paragraph 94 above) - would require the development of a robust regulatory framework, capable of being effectively and safely applied in practice, and willingness to cooperate on the part of the medical profession. It notes in this connection that the safeguards which are already in place with respect to RWI in Hungary and some other contracting States might admittedly be of some relevance (see paragraphs 21, 77, 79, 94, above; compare also the criteria for compatibility with Article 2 of PAD and withdrawal of life-sustaining interventions, summarised in paragraphs 127 and 130 above). However, it cannot be overlooked that the provision of PAD in respect of patients who are not dependent on life support may give rise to further challenges and a risk of abuse (compare Pretty, cited above, § 74).*
>
> *151. In this connection, the Court notes that both of the experts heard by the Court referred to the challenges in ensuring that a patient's decision to use PAD is genuine, free from any external influence and is not underpinned by concerns which should be effectively addressed by other means (see paragraphs 49 and 54 above). Furthermore, the process of communication with the patient must be capable of accommodating the real possibility that the patient will change his or her view on PAD as the disease progresses. Ensuring the ongoing validity of the request can be particularly difficult in the case of medical conditions, such as ALS, where patients might ultimately lose the ability to communicate (ibid., and paragraph 12 above). In any case, the Court understands from the expert evidence that effective communication with the patient requires special skills, time and significant commitment on the part of medical and other professionals, as does the provision of adequate palliative care, which both experts considered to be a necessary precondition for considering recourse to PAD (see paragraphs 49 and 54 above). The Court notes in this connection that the assessment and allocation of such resources is, in principle, a matter which falls within the margin of appreciation of the domestic authorities.*

An important plank of Mr Karzai's case was that he would be condemned to "*existential suffering*" in the period of time before a combination of the withdrawal of life-sustaining treatment at his request (in the court's jargon, "RWI," for "refusal… or withdrawal of life-sustaining or life-saving interventions). As the court noted, he appeared to "*rely heavily on this alleged lack of any alternative means of addressing his suffering*" (paragraph 154).

The court identified that "*according to the expert evidence heard by the Court, the available options in palliative care, guided by the European Association of Palliative Care's Revised Recommendations, including the use of palliative sedation, are generally able to provide relief to patients in the applicant's situation and allow them to die peacefully*" (paragraph 154).

Mr Karzai did not dispute this, but instead:

> *155.* […] *argued that he would refuse such a course of action, since, by being medically sedated, he would lose what is left of his autonomy (see paragraph 91 above; see also the concerns expressed by the German Federal Administrative Court, paragraph 71 above). The Court notes that this is a legitimate personal choice, and one of an undoubtedly crucial nature (see paragraph 46 above). However, it considers that a personal preference to forego otherwise appropriate and available procedures*

> *cannot in itself require the authorities to provide alternative solutions, let alone to legalise PAD. To hold otherwise would effectively mean that Article 8 could be interpreted as encompassing PAD as a right that is enforceable under the Convention, regardless of the available alternatives.*

The court noted that the existential suffering to which Mr Karzai referred was not uncommon in patients with ALS / MND, but not exclusive to them, and also that "*existential suffering may be refractory to medical treatment* […] *and that the use of sedation to alleviate it might be contested or unwarranted in certain situations.*" It continued:

> *158. The gravity of the applicant's suffering can in no way be underestimated. However, in the Court's opinion, it is part of the human condition that medical science will probably never be fully capable of eliminating all aspects of the suffering of individuals who are terminally ill. Moreover, although it amounts to genuine and severe anguish, existential suffering relates essentially to a personal experience, which may be susceptible to change and does not lend itself to a straightforward objective assessment (see, for instance, paragraph 43 above). It is not for the Court to determine the acceptable level of risk involved in PAD in such circumstances; it is enough to note that the difficulties in objectively appraising refractoriness and other relevant elements of existential suffering may further exacerbate the risks addressed above (see paragraphs 149-151). For this reason, the Court is unable to accept this argument as one which militates for an obligation under Article 8 of the Convention to legalise PAD. However, this heightened state of vulnerability warrants a fundamentally humane approach by the authorities to the management of these situations, an approach which must necessarily include palliative care that is guided by compassion and high medical standards. The applicant did not allege that such care would be unavailable to him (see paragraph 154 above), and the domestic authorities cannot therefore be regarded as falling foul of any positive obligation that might arise from Article 8 of the Convention in this regard.*

The ECtHR dismissed relatively briefly Mr Karzai's claim that the criminal prohibition in the Hungarian law (including the application to assisting him to having recourse to it abroad) was disproportionate, placing particular weight on the considerable margin of appreciation granted to member States of the Council of Europe. It reiterated that "*the applicant's complaint that he was prevented from having recourse to PAD in Hungary because of the criminal-law prohibition on its use cannot be examined separately from the question of the positive provision of PAD, which it has already addressed. That is because, as explained previously* […]*, the introduction of an exception to the impugned prohibition would inevitably require positive measures and regulation of PAD by the State*" (paragraph 159).

In conclusion, on the "pure" Article 8 ECHR claim:

> *166. The Court emphasises that the issue it has been asked to determine in the present case is not whether a different policy - such as one providing for PAD - might have been acceptable, but whether in striking the particular balance that they did between the competing interests, the Hungarian authorities remained within their considerable margin of appreciation (compare, for instance, Hristozov and Others, cited above, § 125). Against the above background, the Court does not find that the Hungarian authorities overstepped that margin. It thus follows*

that there has been no violation of Article 8 of the Convention.

167. That being said, the Court would reiterate that the Convention has to be interpreted and applied in the light of present-day conditions. The need for appropriate legal measures should therefore be kept under review, having regard to the developments in European societies and in the international standards on medical ethics in this sensitive domain (compare S.H. and Others v. Austria, cited above, § 118, and Y v. France, no. 76888/17, § 91, 31 January 2023).

The ECtHR then turned to the question of whether Mr Karzai was discriminated against because Hungarian law did not provide him with an option to hasten his death, although it did provide such an option to terminally ill patients who were dependent on life-sustaining treatment. It dismissed this complaint briskly:

174. The Court takes note of the Government's argument that RWI and PAD are inherently different acts in terms of their causation and intent (see paragraph 172 above), and that the applicant cannot be compared to those persons whose lives depend on life-sustaining treatment (see paragraph 171 above). However, the Court is not required to determine these contested points as, in any event, the alleged difference in treatment has objective and reasonable justification. As a further preliminary point, it should be noted that the applicant also argued that terminal illness as the condition to have recourse to RWI was not defined in law (see paragraph 170 above). The Court notes that the Healthcare Act refers to a serious illness leading to death within a short period of time (see paragraph 21 above). While the Healthcare Act does not specify that period in further detail, the Court does not find this of particular importance, especially since the applicant's main argument is based on the fact that he is expected to need continuous life-sustaining treatment, if at all, only at the very end stage of his disease.

175. The Court notes that the right to refuse or request discontinuation of unwanted medical treatment is inherently connected to the right to free and informed consent to medical intervention, which is widely recognised and endorsed by the medical profession, and is also laid down in the Oviedo Convention (see paragraphs 35, 36, 41 and 56 above; see also Mayboroda v. Ukraine, no. 14709/07, § 52, 13 April 2023, and Reyes Jimenez v. Spain, no. 57020/18, §§ 29 and 30, 8 March 2022). This point has also been consistently reiterated by the Court with regard to situations where the refusal to accept a particular treatment might lead to a fatal outcome (see Pretty, cited above, § 63; V.C. v. Slovakia, no. 18968/07, § 105, ECHR 2011 (extracts); and Jehovah's Witnesses of Moscow v. Russia, no. 302/02, § 135, 10 June 2010). It must be acknowledged that the refusal or withdrawal of treatment in end-of-life situations is the subject of particular consideration or regulation because of the need to safeguard, inter alia, the right to life (see paragraphs 37, 38, 130, and 171 above); however, such refusal or withdrawal is intrinsically linked to the right to free and informed consent, rather than to a right to be assisted in dying.

176. The Court further notes that it has found it justified for Hungary to maintain an absolute ban on assisted suicide, on account, among other aspects, of the risks of abuse involved in the provision of PAD, which may extend beyond those involved in RWI (see paragraph 150 above); the potential broader social

implications of PAD (see paragraph 149 above); the policy choices involved in its provision (see paragraphs 151, 157 and 161 above); and the considerable margin of appreciation afforded to the States in this respect (see paragraph 144 above). Similar cogent reasons exist under Article 14 for justifying the allegedly different treatment of those terminally ill patients who are dependent on life-sustaining treatment and those patients who are not, and who in consequence cannot hasten their death by refusing such treatment. The Court would note in this connection that, in contrast to the situation with regard to PAD, the majority of the member States allow RWI (see paragraph 59 above). Furthermore, as mentioned above, the right to refuse or withdraw consent to interventions in the health field is recognised also in the Oviedo Convention, which, in contrast, does not safeguard any interests with regard to PAD (see paragraphs 35 and 36 above). The Court therefore considers that the alleged difference in treatment of the aforementioned two groups of terminally ill patients is objectively and reasonably justified.

177. It follows that there has been no violation of Article 14 taken in conjunction with Article 8 of the Convention.

The arguments under Articles 3 and 9 ECHR were not considered to raise any separate issues.

Judge Wojtzczek would not have held that the application was admissible. Judge Felici wrote a strong dissent suggesting that the court could have developed its case-law to allow for PAD, even if this needed to include a positive obligation on the state under Article 8 ECHR. Judge Felici also strongly regretted the fact that the case had not been remitted to the Grand Chamber "*which would have allowed a more up-to-date approach to the principles regarding end-of-life care and PAD, which, given the extreme importance of the subject, was certainly the task and responsibility of the Grand Chamber*."

Comment

In line with our normal approach to this issue, we will not comment on the merits of whether what we will call here PAD (after the judgment) should be made legal. It is, however, a decision which makes interesting reading given the prominence of the issue in politics in the United Kingdom (and its surrounding islands) at the moment. It is, indeed, a decision which we suggest makes necessary reading for those wanting to grapple with the underpinning rights issues in a way which goes beyond soundbites (and, for those wanting to go behind headlines, this explainer from Alex may also be useful). The court's decision is, in particular, helpful in making clear how legalising PAD is not simply a matter of the State getting out of the way of willing doctors wishing to prescribe medication to wanting patients. Rather, as the court makes clear, it inevitably involves positive actions on the part of the State, including providing "access to medical intervention, such as access to life-ending drugs." That is, in itself, not an argument for or against legalisation. It is, however, an argument for clarity about what it entails.

SCOTLAND

Law reform and the paralysed Parliament

We reported the publication by Scottish Government of its Initial Delivery Plan for the Mental Health and Capacity Reform Programme in the June 2024 report. The Plan was published as that Report went to press. In it, we provided a link to the Plan. Coverage was limited to a quick reflection of some points picked out from the document upon its initial publication. We indicated that we envisaged further coverage of the Plan, and of ensuing developments, in future Reports.

In this article I describe in more detail the content of the Plan insofar as relevant to adult incapacity law, and the practical implications of the Plan in the context of progress in the development of adult incapacity law in Scotland over the last three decades. The scene is set by the Scotland Act 1998, section 1 of which established the Scottish Parliament, and section 28(1) of which provided that:

> *"Subject to section 29, the Parliament may make laws, to be known as Acts of the Scottish Parliament."*

Section 29 defines the legislative competence of the Parliament. What we now know as adult incapacity law is within the competence of the Parliament. With power comes responsibility. The Parliament has the power to legislate within its areas of competence, and the obligation to ensure that those areas do not fall into significant disrepair. It is a truism that the quality of a society is to be judged by how it treats its most vulnerable members. The performance of a legislature can be judged by how well it makes and maintains provision for our most vulnerable citizens. Specifically in Scotland, the test is the performance by the Scottish Parliament of its obligation to keep adult incapacity law in sufficiently good order to avoid significant harm and disadvantage to those whom our adult incapacity law is primarily addressed, meaning not only those who currently have significant vulnerabilities within the scope of the legislation, but those caring for them, those significantly concerned at an immediate personal level about the adequate safeguarding of their rights, interests and welfare, including those who have taken on professional responsibilities towards them, and everyone seeking to put in place appropriate provision for themselves, against the possibility that they may in future have needs within the scope of adult incapacity law.

These responsibilities are responsibilities of the Parliament, and collectively of every member of the Parliament, whether at any particular time those responsibilities are performed in the context of government, or in the context of holding government to account.

The timetable for this overview of the Parliament's performance begins with the lead-up to its establishment. Scottish Law Commission issued a Discussion Paper in September 1991 which initiated a programme of consultation, and then hard work by the Commission itself, leading to publication in September 1995 of a draft Bill which in its essentials – and much of its detailed provision – became the Adults with Incapacity (Scotland) Act 2000 ("the 2000 Act"). From December 1997, over 70 voluntary, professional and other organisations from across Scotland came together in the "Alliance for the promotion of the Incapable Adults Bill" campaigning initially to achieve legislation by the UK Parliament in 1998/1999. In a clear example of the need for the Scottish Parliament, campaigning, and lobbying at Westminster achieved no response from the UK Parliament. The Scotland Act received Royal Assent on 19th November 1998, whereupon some provisions immediately

commenced in force, and the entire Act entered into force on 1st April 2000. With the commitment of all Scottish parties, the Parliament's discharge of its legislative obligations was achieved with alacrity. The Adults with Incapacity Bill was introduced to the Parliament on 8th October 1999 and the 2000 Act received Royal Assent on 9th May 2000. Parts 1, 2, 3 and 7 entered into force on 2nd April 2001; Part 6 on 1st April 2002; Part 5 on 1st July 2002; and Part 4 on 1st October 2003. The "Improving with Experience" programme led to the improvements enacted as part of the Adult Support and Protection (Scotland) Act 2007. By then the Mental Welfare Commission for Scotland had already picked up on concerns that we would now categorise within the topic of deprivation of liberty, with a consultation in 2004. However the 2000 Act, as updated in 2007, gradually fell into disrepair as both Scottish society and the international human rights scene have developed. What has been the performance of the Scottish Parliament as legislature since 2007 to remedy such disrepair? The answer, to date, is nothing. What is now promised? We shall come to that.

As has been well documented in this Report over several years, the failures to date of the Scottish legislature in general and Scottish Government in particular to meet the basic human rights obligation under Article 5 of the European Convention on Human Rights to put in place procedure to permit deprivations of liberty in terms of Article 5 to be achieved lawfully, in ways compliant with Article 5 as interpreted by the European Court of Human Rights, have remained scandalously unperformed, even though (by way of example) England & Wales has had such provision for over 15 years now. A culture of endemic discrimination against older people, and those with disabilities, has in consequence developed, on the part of government and many of those discharging statutory functions under the umbrella of government. Examples abound, but it is not necessary to look further than the unlawful discharge of hospital patients to care homes, evidenced – for example – by litigation brought by the Equality and Human Rights Commission in which such unlawfulness on a significant scale was conceded prior to the pandemic; massive unlawful dumping of elderly and disabled hospital patients into care homes during the pandemic; and since the pandemic, equally unlawful transfers of patients no longer requiring hospital treatment into other health service accommodation, and in some cases forcible retention there. There have been other manifestations of this culture of unlawfulness and discrimination, for instance the decision *Scottish Borders Council v AB* we covered in our December 2019 report.

This has all occurred despite the publication by Scottish Law Commission of draft legislation in the form of a new Part 5A to the 2000 Act, with accompanying Report, in October 2014 – over a decade ago now, or, put another way, twice as long as the timescale from the Commission's 1995 Report to the 2000 Act receiving Royal Assent, despite the lack of significant progress prior to establishment of the Scottish Parliament.

In parallel with that particular topic has been the question of accumulating needs for straightforward practical updating of the 2000 Act. These were addressed in responses to Scottish Government consultation in 2016, re-stated and updated in response to consultation in 2018. The issues are proving to be a major impediment to the operation of the legislation, and they have continued to accumulate. There is an example in the next item in this Report, followed by another item with an example of failure to remedy another substantial impediment which would not require legislation at all.

One might reasonably have expected both the issue of deprivation of liberty and the need for straightforward improvements to the 2000 Act to have proceeded at no less than the speed with which the Parliament was able to produce the 2000 Act, promptly following upon the 2018 consultation.

Instead, in 2019 Scottish Government established the Scottish Mental Health Law Review ("the Scott Review"). Adult incapacity legislation was included in the remit of the Review, despite the emphasis upon mental health law in both the title and much of the work of the Review. On 19th March 2019, in its announcement of the Review, Scottish Government expressly undertook to continue work on deprivation of liberty, and on essential AWI reform generally, in parallel with the work of the Review. The announcement by the then Minister for Mental Health of the establishment of the Review included the following:

> *"At the same time as the review takes place, we will complete the work we have started on reforms to guardianships, including work on restrictions to a person's liberty, creation of a short term placement and amendments to power of attorney legislation so that these are ready when the review is complete."*

So far as can be ascertained, Scottish Government did not implement that undertaking in parallel with the Scott Review, nor at all during the course of the Review. It appears to have done nothing to carry those matters forward for over five years from 2018, until it commenced work following upon the publication of the Scott Report.

It is against that background that we now have the Delivery Plan that was announced in the Parliament on 3rd June 2024 and published on the 4th. The announcement in the Parliament was as follows:

> *"Fulton MacGregor (Scottish National Party): To ask the Scottish Government whether it will provide an update on its plans to reform legislation on adults with incapacity, as recommended by the Scottish Mental Health Law Review.*
>
> *"Maree Todd: In our response to the Scottish Mental Health Law Review, published in June 2023, we committed to establishing a Mental Health and Capacity Reform Programme. We are due to publish the first Delivery Plan under this Programme shortly. Our main priority for early law reform centres on the updating of the Adults with Incapacity Act. Work has already begun to consider options for addressing long-standing gaps in Adults with Incapacity law, to ensure stronger rights, protections and safeguards."*

As we noted in the June 2024 Report, the urgent need for law reform is summarised in a table headed "Strategic Aim 1: Law Reform". That is a table with target dates, and with 15 specific action-points referring to existing adults with incapacity provision.

All that is said about meeting the urgent need for legislation on deprivation of liberty is in a single sentence: "Ensuring there are safeguards for the adult in the event of a deprivation of their liberty, including a standalone right of appeal". One could have said that immediately following the issue by the European Court of Human Rights, 20 years ago, of its decision in the "Bournewood case". On other areas, we have:

> *"we will consider how to update Part 2 Powers of Attorney Scheme"*
>
> *"improve the accessibility of taking out a Power of Attorney"*
>
> *"consider integration of Part 3 Access to*

Funds and Part 4 Management of Residents' Finances into a new Guardianship Scheme"

"consider how to strengthen Part 5 of the AWI Act and enhance the safeguards for an adult to challenge a decision and introduce stronger safeguards for interventions such as the use of force"

"develop a specific provision to authorise conveying a person to hospital"

"review the provision of section 49 of the AWI Act so that the restriction on treatment is not applied widely"

"ensure there is clarification around the powers of force and detention"

"consider how to update Part 6 intervention orders to promote the rights, will and preferences of adults with incapacity"

"review the application process for interveners and guardians to see where improvements can be made whilst enhancing the safeguards of the adult"

Unsurprisingly, one hears comments that all of this could have could have been scribbled on the backs of a few envelopes in about half an hour some several years ago.

On the crucial issue of timescale, a column headed "Milestones (Oct 23 – Apr 25)" includes the following:

"options for possible legislative change to be considered by summer 2024" (twice)

"consideration as to how we might enhance safeguards and improve accessibility of powers of attorney will be undertaken by summer 2024"

The above are all selected quotations under the heading "Priority 1: Adults with Incapacity Law Reform". Other actions and milestones are listed, apparently with primary reference to mental health law. All are worth reading, and it will not take long to do so. Other topics addressed with similar brevity include those within the Adult Support and Protection (Scotland) Act 2007.

There is neither commitment nor even an indication as to when urgently required legislation will be introduced to the Parliament. Suffice to report that "by summer 2024", said in various tones of sarcasm and exasperation, has already become a standing joke in training sessions and similar since the Plan appeared.

We know that a substantial and able team of Scottish Government officials has been working assiduously on the whole question of law reform within the ambit of the three Acts of 2000, 2003 and 2007. It seems not unreasonable to attribute the lack of commitment or action to members of the responsible legislature themselves, primarily those within Scottish Government, but so far – noting the lack of apparent challenge – all of them. Specifically at government level, we understand that any commitment to legislate will not appear until announcement of the next Annual Programme for Government in the autumn. To retain any credibility in this whole area, that would appear to be Scottish Government's "last chance saloon".

Adrian D Ward

Amendment of powers of attorney: OPG policy change, reform needed

With effect from 30th October 2023 the Public Guardian's previous Power of Attorney Amendment Policy 2012 was replaced with the Power of Attorney Administrative Updates Policy 2023. There have been long-running issues

about the extent to which an existing registered power of attorney can be amended without the expensive and cumbersome need to revoke an existing power of attorney in whole, and replace it with a new one. Under section 6(2)(b) of the Adults with Incapacity (Scotland) Act 2000 the functions of the Public Guardian include maintaining separate registers of "all documents relating to continuing powers of attorney" and "all documents relating to welfare powers of attorney". In the respective registers, the Public Guardian must "enter any matter which [the Public Guardian] is required to enter under [the 2000 Act] and any other matter of which [the Public Guardian] becomes aware relating to the existence or scope of the power, authorisation or order as the case may be".

In the early days after Part 2 of the 2000 Act came into force on 2nd April 2001, the focus unsurprisingly was on registering newly granted powers of attorney, as the transitional provisions of Schedule 4 to the Act kept existing powers of attorney and the appointments under them in force, and recognised that new appointments under an existing power of attorney occurring after the Act came into force should be recognised as continuing attorneys or welfare attorneys, as the case may be, but expressly disapplied the registration provisions of section 6(2)(b), so that any changes that were competent in respect of powers of attorney governed by the transitional provisions could be effected without any requirement for registration. None of this is greatly helpful regarding amendment of registered powers of attorney, and as time has gone by, and more and more time has elapsed since original granting of 2000 Act powers of attorney, issues around amendment have become more prominent. As regards the provisions of Part 2 themselves, the only procedure now available under section 22A, inserted by the Adult Support and Protection (Scotland) Act 2007, is that only an entire power of attorney, or powers conferred under it, can be revoked by notice given to the Public Guardian. The 2012 Policy sought to be more accommodating than that, whereas the 2023 Policy has followed more strictly the terms of the statute – unhelpfully but in my view essentially. This means that anything other than total revocation of the document, or of particular powers, appears to be unprovided for in Part 2. From 30th October 2023 the Public Guardian will continue to accept an "administrative update" to a registered power of attorney which will include "anything which does not change the fundamental substance of the power of attorney deed", for example: a change to the name or address of a granter, attorney, or substitute attorney. It confirms that "if a registered power of attorney needs a significant alteration which either requires a certificate of capacity or the production of a new certificate of registration", then a fresh power of attorney deed should be submitted for registration. The 2023 Policy confirms that "significant alterations would include adding an attorney, substitute attorney or perhaps adding powers".

Very recently, it has been necessary for the Public Guardian to confirm that simply revoking the appointment of a potential substitute attorney, under substitution provisions that have never been triggered (and may never be triggered), all the formality of revocation followed by granting a fresh power of attorney, identical to its predecessor except for removal of the relevant substitution provision, is necessary. With reference to the preceding item in this Report, this is one more item where reform is essential and would be non-controversial, to add to the substantial list already in place at the time of responses to the 2016 consultation, which as indicated in the preceding item has continued to grow. Like so many of the deficiencies affected by the failure of the Parliament to convert aspirational statements of intention into

performing its obligations as legislature, this places significant blocks in the form of delay, trouble and above all expense, in the proper operation of the powers of attorney scheme.

Adrian D Ward

Reports for Part 6 applications

A long-running issue hindering proper operation of the provisions of Part 6 of the 2000 Act, principally in relation to obtaining intervention and guardianship orders, and also in relation to the renewal of guardianship orders, has been difficulty in obtaining the necessary reports. Recently, this has become acute when reports are sought from general practitioner practices. It is unlikely that it would be considered appropriate to place outright obligations in adult incapacity legislation itself, but it is necessary that obligations be clarified in one or more of (a) statute law, (b) terms of NHS appointment, and (c) the professional obligations of doctors to their patients. Only very recently have there been reported to me cases not merely of difficulty, but of outright refusal by GP practices, refusing to see existing patients for the purpose of preparing a report as they will "only see patients for NHS matters and this is not an NHS matter". This suggests an answer under (b) above, but provides none under (c) above. Unfortunately, revisal of the General Medical Services Contract (GMSC) in 2018 failed to provide clarity. Provision of such reports appears not to be included as a "basic duty" under the categories of "essential", "additional", or "enhanced" services. Local agreements with health boards could cover specific responsibilities regarding provision of medical reports, but it appears on available information (for which I am most grateful for the assistance provided in that regard) that no health boards have clarified this, nor (for example) included good practice written examples of a local contract.

Likewise, professional guidelines from professional bodies, principally British Medical Association, and including the General Medical Council, provide guidance on how GPs should handle requests for medical reports but appear not to cover the obligatory duties of GPs as to whether to provide medical reports upon request.

This is a serious impediment to the proper operation of Part 6 of the 2000 Act which could readily be addressed, without need for legislation, but where Scottish Government appears neither to have taken appropriate action itself, nor to have addressed the issue with those who could also have provided clarification.

Adrian D Ward

Mental Welfare Commission for Scotland – Annual Report 2023-24

The Mental Welfare Commission has published its 2023/24 Annual Report. It demonstrates the impressive extent and depth of the work it undertakes in monitoring the implementation of the Adults with Incapacity (Scotland) Act 2000 and Mental Health (Care and Treatment) (Scotland) Act 2003. It is also encouraging to see that it continues to publish 'closure reports' which follow up on whether the Commission's recommendations in some of its earlier reports are actually implemented, its most recent one relating to its 2022 themed visit report *Ending the exclusion: Care, treatment and support for people with mental ill health and problem substance use in Scotland*.

However, the report also highlights a number of areas of concern, notably the increasing gap between supply and demand in Scotland's mental health and learning disability services. The Commission reports that staff shortages are impacting on the quality and availability of hospital and community care, and pressures on

health and social care services are pushing responsibility onto other services which are arguably not as well-equipped to address the issues of the individuals involved.

It notes with concern that compulsory measures under mental health legislation which are designed to address short-term solutions are continuing into the long-term. This is particularly so for some people remaining for extended periods of time in out of NHS area placements a long way from home or on Compulsory Treatment Orders in the community.

Whilst the Commission also mentions good practice where it is found it also notes where there is a lack of understanding of relevant legislation leading to service and care failures, and distress to the individuals concerned and their families.

Importantly, Sandy Riddell, in his Chair's Foreword, states that in bringing about change:

> *'Finances are of course vital. I know the strain on budgets across health and care services and I will always call for budgets to be protected.*
>
> *But along with money, there is the question of what changes can be made to our systems of care and treatment, and how to make them.'*

The Commission also, once again, reiterates its support for the recommendations of the Scottish Mental Health Law Review.

More detail on the information summarised in the Annual Report can be found in individual monitoring, themed and investigation reports on the Commission's website.

Jill Stavert

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Conferences

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

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

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

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 September. 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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