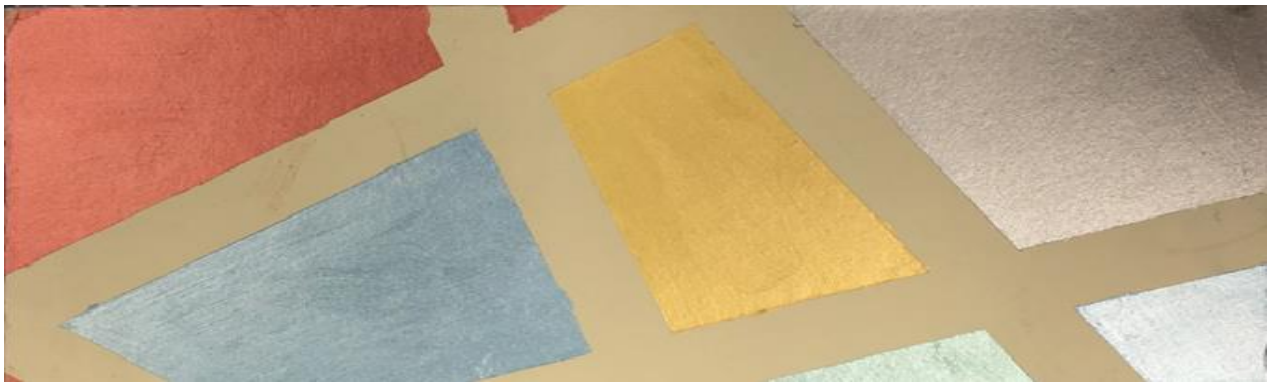

Welcome to the December 2022 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: Collection of sperm where a person is on the edge of brain death; public protection and deprivations of liberty; and many newly-reported 'part 2' judgments tell us what happened next.

(2) In the Property and Affairs Report: Lasting Powers of Attorney bill is published; and deprivations of assets.

(3) In the Practice and Procedure Report: Cross-border placements; and amendments to the Court of Protection Rules.

(4) In the Wider Context Report: 'A gloriously ordinary life'; *Crowter* in the Court of Appeal; consent to adoption and capacity; prolonged disorders of consciousness; and a Strasbourg update.

(5) In the Scotland Report: A new checklist for cross-border placements; a decision to close day centres is reduced; and model laws for advance choices.

You can find our past issues, our case summaries, and more on our dedicated sub-site here, where you can also subscribe to this Report, and where you can also find updated versions of both our capacity and best interests guides.

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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

Collection and storage of sperm from a person on the edge of a brain death diagnosis

Re X (Catastrophic Injury: Collection and Storage of Sperm) [2022] EWCOP 48 (16 November 2022)(Poole J)[1]

Best interests – medical treatment

Summary

This judgment related to a matter heard on an urgent basis on 3 November, with a full judgment reported on 16 November. It related to X, a 22-year-old university student, who had been fit and healthy before tragically suffering a catastrophic stroke of unknown cause on 24 October 2022. He was treated first near his home in South West England, and was then transferred to Kings College Hospital. He underwent surgery to help decompress his brain, but sadly was unresponsive from 27 October 2022 onwards. With the consent of his parents, he removed from life support on 8 November 2022 after doctors concluded that he was brain stem dead.

The application was brought by X's parents on an urgent basis on 3 November. By that time, the medical evidence was that there was *'virtually no prospect he will recover. He may be assessed as being brain stem dead within the next 24 hours.'* [2] X's parents sought an order from the court that *'it would be lawful for a doctor to retrieve X's gametes and lawful for those gametes to be stored both before and after his death on the signing of relevant consents.'* [2] His parents also sought authority to give consent on behalf of X. It was clear from the application that X's parents hoped to be able to use X's sperm at some point in the future so that his biological children could be conceived. The likelihood of the pending brain stem death diagnosis led to the urgency in the case, as there was no application to collect sperm posthumously.

The application was opposed by the Official Solicitor on behalf of X; the treating Trust assisted the court, but took a neutral position on the application. The Human Fertilisation and Embryology Authority did not appear, but made written submissions opposing the application. There was no dispute as to X's lack of capacity in the case.

X's parents argued that he had a clear wish to have his own children; he had spoken about it many times with his family, friends and girlfriend, and had thought about keeping possessions from childhood to pass along to his children. X's parents stated that his girlfriend wished to carry his child. His parents were cognisant of the urgent nature of the application, and sought a stepwise approach in which an order would be made solely for the extraction and storage of sperm, and the court could further consider on a less pressured basis how that might be used in the future.

The court expressed some hesitation at how much could be read into X's expressed wishes and feelings:

> *11. There is no advance decision in this case nor is there any evidence as to X's views and beliefs as they might have been relevant to a decision such as this. It is one thing to have a consistent and heartfelt desire to be a living, caring father. It is quite another thing to wish to have one's sperm collected and stored when unconscious and dying, with a view to the possibility of the sperm being used for conception after one's death, and without having expressed any view when living about how the sperm should be used…*
>
> *25… The application before me is brought by X's parents not his life partner. X has a girlfriend, but I have no evidence of any discussions he has had with her or others about whether he would want his sperm to be collected and stored in the event of his*

[1] Stephanie having been involved in this case, she has not contributed to the report.

> *becoming unconscious with a very limited life expectancy. There is no evidence that X and his girlfriend were in the process of trying to conceive nor that they have tried in the past. There is no evidence of the nature of their relationship. X may have wanted one day to have children, but that is not the same as wishing for his sperm to be collected and stored when unconscious and dying. I cannot know what his wishes and feelings about that decision would be…*

The court considered Schedule 3 of the Human Fertilisation and Embryology Act 1990, which *'deals with consent to the use or storage of gametes.'* [14] The court noted that none of the conditions of the consent which are required to the storage of gametes (which require consent to be given in writing by either the person, or a person signing 'at the direction of' a person physically unable to sign, in the presence of the person unable to sign and witness; consents should also be given after a suitable opportunity for counselling and the provision of information to the person giving consent) could be met in this case.

The court was aware that if the application was not granted out of hours, it may be overtaken by events (where it was considered possible that X could pass away at any time). However, the court was cautious that the urgency of the case should not dictate the outcome:

> *28. If I declared in this case that it was lawful to collect and store X's sperm without any evidence that that is what he would have chosen for himself, then it would follow that the same declarations might be made in many other cases where parents or other relatives wanted their loved one's gametes to be collected and stored with a view to decisions about their use being made at a later stage. I have no evidence as to the practice in hospitals in England and Wales in such circumstances but it would be unlawful under the 1990 Act to store collected sperm without the consents referred to earlier in this judgment. Here, the Trust has not agreed to the procedure and is concerned that without X's actual consent it would be acting unlawfully to collect and store his sperm. If the Court of Protection were routinely to authorise the collection and storage of gametes in cases where there is no or little evidence that the incapacitous, dying person would have consented, then it would undermine the regulatory provisions within the 1990 Act which require actual consent.*

It was held that the Court of Protection did have the power to grant the consent for the retrieval and storage of gametes. However, in this case, there was no strong evidence that this is what X would have actually wanted. The process of collecting sperm would have involved the surgical removal of X's testicle, and would have been an extremely invasive procedure. The court concluded:

> *33… There is no evidence before the court to persuade me that X would have wished for his sperm to be collected and stored in his present circumstances. I cannot accept that there should be a default position that sperm should be collected and stored in such circumstances as being generally in a person's best interests. I cannot conclude that making the declarations as sought would be in accordance with X's wishes, values or beliefs. The process of collecting X's sperm is physically invasive and there is no evidence that X would have consented to it or would have agreed to its purpose…*

Comment

The court's decision in this case was careful and well-reasoned, particularly in its nuanced analysis of what should be read into X's stated wishes and feelings. The decision is also interest

in the court's general finding as a matter of principle that a court could give the relevant consents required under Schedule 3, though the consent may only be given where a person has been given information and counselling in relation to the relevant decision. As we identified in relation to *Y v A Healthcare Trust* [2018] EWCOP 18, this does give rise to two difficulties.

The first is that it is difficult to understand from the judgment itself how the court came to the view that the s.16 MCA 2005 order would comply with the terms of paragraph 1(2) of Schedule 3 insofar as that paragraph requires the consent given on behalf of Z to be at his "direction." There is no doubt that the court was of the view that Z himself would have consented to the storage of the sperm had he been able to. Paragraph 1(2) however seems to demand more than simply identifying what the incapacitated person would have chosen to do. It requires the incapacitated person (here, Z) to direct that the third party gives the consent on his behalf. Given the circumstances of Z's loss of capacity (sudden and unpredicted) there would have been no opportunity for such direction.

The second – linked – problem is that s.27(2)(i) MCA 2005 specifically prohibits anyone, including the court, from "giving a consent under the Human Fertilisation and Embryology Act 2008." It may have been that the court considered that it would not be consenting on X's behalf within the terms of the HFEA 1990, but directing (on X's behalf) another person to execute that consent. That undoubtedly represents a purposive (some might say strained) reading of the wording 'consent' in s.27(2)(i) MCA 2005, which on its face and in its context is addressed to the material giving of consent (i.e. the fact of consenting to storage) rather than the technical execution of the written consent document.

George Orwell and best interests – DoLS and public protection under the spotlight

DY v A City Council & An NHS Trust [2022] EWCOP 51 (6 December 2022)(Judd J)

Article 5 ECHR – DOLS Authorisations

Summary

In *DY v A City Council & An NHS Trust* [2022] EWCOP 51, Judd J has tackled head on the perennially difficult question of whether and how DoLS can provide for public protection. The case concerned DY, a young man in his 20s, who had previously been detained under the MHA 1983. In 2017 he had pleaded guilty to two offences of sexual assault of a girl aged under 13, and received a 26 month Youth Rehabilitation Order. He was placed on the sex offender's Register for 5 years with a concurrent Sexual Harm Prevention Order with a residence requirement and curfew. He was prohibited from having contact with children under 16 save as was inadvertent and not reasonably avoidable in the course of daily life. He was referred to MAPPA and has been assessed as a category 1 offender requiring level 2 management. He was still considered a high risk to children and known adults. To his mother he was considered to pose a risk of violence and sexual assault. To children he was considered to pose a risk of sexual assault. DY was diagnosed with Autistic Spectrum Disorder in 2011, and also with Generalised Anxiety Disorder and Paedophilia. He moved to a care home in 2019, assessed as lacking capacity to make decisions about accommodation and care. He was subject to a DoLS authorisation, always accompanied by male staff when he went into the community, was checked four times a night due to his sexualised behaviour and self harm, and was not allowed to enter bedrooms other than his own in his placement.

DY challenged the DoLS authorisation both on the basis that he did not lack capacity for purposes of Schedule A1, and also that the best interests requirement was not met.

Judd J considered the best interests challenge first, reminding herself that the requirement in paragraph 16 of Schedule A1 is (in our words) "best interests plus" – i.e. that is in the person's best interests, and necessary and proportionate to the risk of harm they would suffer. At paragraph 20, and in response to DY's challenge that the purpose of the DoLS authorisation was public protection, she made clear that:

> *Having heard and read the evidence and submissions on this point, I have come to the conclusion that the primary purpose of the care plan is to avoid harm to DY. There is no doubt that he poses a risk to the public, but it is also clear that it would be very harmful to DY himself were he to commit further offences. DY is a young person who is vulnerable and has engaged in self harming behaviour (albeit not recently). The social worker stated in her evidence that when DY becomes stressed and anxious that this leads to him ruminating and in turn puts him at risk of self harm. If he were to reoffend he would be very distressed, and engage in self loathing. There would also be the risk of retribution from the public. I agree with Lieven J in Birmingham City Council v SR; Lancashire County Council v JTA [2019] EWCOP 28 that it is a false dichotomy to conclude that the protection of P cannot also include protecting him from harming members of the public. As in that case, it is strongly in DY's best interests not to commit further offences, or place himself at risk of further criminal sanctions. In my judgment this falls squarely within the meaning of the qualifying requirement in paragraph 16 schedule A1, 'to prevent harm to the relevant person'. That this harm would come about by his harming others does not detract from this.*

However, she found that the capacity challenge succeeded, basing herself on the "clear, cogent and firm" evidence of the expert, Dr Ince:

> *34: When interviewed by Dr. Ince DY was honest about the risks he posed, and was able to express his fear of what would happen to him if he committed another offence. I agree with his conclusions that DY was not merely repeating what he had been told or saying what the interviewer wished to hear. I do not accept the respondents' submissions that Dr. Ince asked himself the wrong questions or relied too heavily on DY being able to describe the risk factors rather than being able to show what benefit his care and support offers him. It is very difficult for DY to demonstrate the benefit to him in circumstances where he has not experienced being without it (a situation he himself recognises). I reject the submission that Dr. Ince did not appear to consider the impact of the interplay between DY's paedophilic or paraphilic disorder, his anxiety and his autism, for he discussed and explained this at length in his evidence. DY has an impairment/disturbance of the mind or brain by reason of his ASD and accompanying anxiety, but Dr Ince does not accept the additional diagnosis of paraphilia is relevant in this context or that the fact that DY can make impulsive decisions regarding further offending is due to lack of capacity.*

Judd J made clear that she could:

> *35.* […] *entirely appreciate why the respondents in this case are so concerned, because there is a high risk that DY will reoffend if he is given the opportunity to do so. If he is allowed to*

> *make decisions for himself he could go out alone, and in doing so he could put others and himself at risk by acting impulsively and committing a sexual assault. Those responsible for his care are undoubtedly very worried about the effect upon him (and of course others too) were he to do this. Anyone responsible would be concerned about this, as I am myself. But Dr. Ince is right that any further offending is a matter for the Criminal Justice System. The current SHPO is an example of such risk management. The truth is that most sexual offenders and risky adults have capacity, and, like DY are not to be managed by a Deprivation of Liberty within the provisions of the Mental Capacity Act 2005.*

Comment

Putting aside the capacity challenge in this case, which was fact-specific (but illustrates the power of a good expert report), this case might be thought to illustrate the sometimes Orwellian mental gymnastics that are now required to hold two competing thoughts about best interests in one head. In the majority of cases, following *Aintree v James*, we are told to seek to put ourselves in the shoes of P, and to seek to place a very considerable weight upon their wishes and feelings. In cases such as the present, however, we are told to adopt a very different construction to enable public protection to be levered into the constraints of Schedule A1 (or the lesser implicit constraints upon the Court of Protection, which is only statutorily required to consider the standard best interests test, rather than "best interests plus," and could compatibly with Article 5 ECHR find that deprivation of liberty was necessary and proportionate to the risk of harm to others).

Some may think, as did the Law Commission did in its Mental Capacity and Deprivation of Liberty project, that requiring consideration of best interests means that assessors have to reach the "*somewhat artificial*[…]" conclusion that "*the person's own interests include not harming someone else and thereby, for instance, themselves becoming subject to some form of 'harm,' such as civil or criminal proceedings*" (Final Report, para 9.29). Responding to this, the Law Commission's draft Bill included an approach based upon the likelihood of either harm to the person or to others.

The Bill introduced to Parliament adopted the Law Commission's approach in that it did not include an express best interests element; it did not expressly refer to the potential for deprivation of liberty to the authorised on the basis of risk of harm to others. However its provisions were drafted broadly enough to enable this to take place, as paragraph 16 of Sch.AA1 simply provided that arrangements had to be necessary and proportionate. This paragraph was the subject of considerable debate and criticism during the passage of the Bill and at Report Stage in the House of Lords, Baroness Barker tabled an amendment specifically tying necessity to prevent harm to the person, so as "*to make it clear that it is harm to the person, and that the proportionality relates to the potential harm to that person if they are not deprived of their liberty*" *Hansard* (House of Lords), 21 November 2018, Vol.794 (Col.284). The Government resisted the amendment but was defeated in a vote (202-188). It did not seek to reverse this position subsequently.

In light of the fact that the position was expressly debated in Parliament, it is therefore even clearer than was the case under DoLS that LPS cannot be used in the situation where the primary purpose is to protect others from the risk of harm caused by the person. This means that the mental gymnastics – or Orwellian – approach identified in *DY* will be even more necessary: as

per the draft Code of Practice published for consultation in March 2022:

> *16.72 If the person presents a risk of harm to others, it may still be possible to determine that the arrangements are necessary and proportionate to authorise the arrangements to prevent harm to the cared-for person. Such a determination would only ever be appropriate if, as a result of being a risk to others, the person is also themselves at risk of harm. For example, if a person in a care home is likely to harm another resident, who then may retaliate and harm the person, it may be necessary and proportionate to deprive the person of their liberty. However, the greater the risk to another person – as opposed to the person themselves – the greater the need to consider other alternative legal frameworks such as the MHA.*

More broadly, and in line with the decision of the Supreme Court in *JB*, this decision reinforces the point that the MCA is undoubtedly not a straightforwardly empowering piece of legislation. Rather it is, or should be, seen as the framework for the proper determination of capacity and best interests in circumstances where there is legitimate reason to require such an exercise to be carried out.

And 'fusion' enthusiasts[2] might want to reflect on whether the interpretation of 'blowback' harm in this line of caselaw does not lead to a position where, in fact, DoLS (and in future) the LPS provides the groundwork for fused mental health and capacity legislation. In other words, if the MHA was simply repealed, would not the MCA in fact provide a complete capacity-based framework for detention and treatment, taking into account both risk of harm to self, and risk of harm to others?

Care orders and deprivations of liberty

Re E (A Child) [2022] EWHC 2650 (Fam) (19 October 2022)(Richard Todd KC sitting as a DHCJ)

Article 5 ECHR - "Deprivation of liberty"

Article 5 ECHR – Children and young persons

E was an autistic 17-year-old with additional diagnoses of ADHD and learning difficulties. He had previously been accommodated by the local authority with the consent of his parents, due to his challenging behaviour, and was later made the subject of a care order on the basis that, in the words of the Children Act 1989, he was '*beyond the parents' control*'. He was placed in a residential placement. Unfortunately, there were disagreements between the professionals and the parents about E's needs and the causes of his behaviour. The parents were concerned about E's treatment at the placement including alleged harm caused to him by restraint. The court had been authorising E's deprivation of liberty at the placement, and during proceedings E had moved to a new placement. E was reported to have said he wanted to go home and live with his parents.

As the case was being dealt with as a family law case, there was a parenting assessment, which concluded that it was too soon for E to return to his parents. The assessor noted that neither parent believed that E needed 2:1 supervision, and that the working relationship with the local authority was poor. There were other disputes about E's care – his parents did not think that it was ethical to increase E's medication as a means to control him, and did not think he should have his mobile phone withheld from him. The court found that E's parents had undermined his

[2] Thinking here, in particular, of the work of Professor George Szmukler.

placements, and that no placement would be good enough for them, because of the fundamental disagreement about E's needs and how best to meet them.

The court rejected the parents' application to discharge the care order, and continued the deprivation of liberty authorisation until E's 18th birthday. The court held that the civil standard of proof applied, such that the local authority had to prove on the balance of probabilities that the orders they sought should be made.

In the course of the judgment, the court expressed its concern that E's parents had been deemed ineligible for legal aid, saying

> *51. Once care proceedings are issued, a respondent with parental responsibility (which would include these parents) are automatically entitled to non-means assessed legal aid. They receive this regardless of their income. In such a serious matter as the taking of someone's children and the child's corresponding loss of a parent, this is plainly right. It is wholly inexplicable why this is not applied to DOLs proceedings.*
> *52. Moreover, the denial of legal aid is a false economy. The evidence in this case proceeded over 4 days. This was primarily due to the parents' labouring over difficult legal constructs and asking very wordy questions. Had they been represented, then I have no doubt this case would have concluded within 2 days. That would have been a huge saving to the public purse; 2 days' paid time saved of the High Court, senior counsel, solicitor, all the officials from the Local Authority and the Guardian – every single one of whom was paid from the public purse.*
> *53. […] Legal aid was originally one of the pillars of the welfare state. But for these people that prop is removed. The net result is that in DOLs proceedings they are at a real disadvantage against an organ of the State (the Local Authority) who are publicly funded. There is no logical reason for them (and the Guardian) to be treated differently from respondents in care proceedings. Instead, there is a compelling case for them to be treated the same – on grounds of fairness, equality of arms and the simple economic consideration that overall, it should prove cheaper for them to be represented than not.*

Comment

This case is another very sad account of a breakdown in relationship between the family of a young person with additional needs and the statutory authorities involved in providing care and support. A cognitive assessment, functional analysis and PBS plan were due from the Maudsley Hospital, together with a medication review – one wonders whether any of the parents' concerns or views about how best to support E might turn out to be validated as part of that process? The contrast with proceedings in the Court of Protection is interesting – the independent expert assessment in the CoP would be of E and his needs, not of his parents.

Very restrictive medical treatment and finely-balanced decisions

Newcastle Upon Tyne NHS Foundation Trust v MB [2022] EWCOP 43 (30 September 2022)(Morgan J)

Best interests – medical treatment

Summary

This case concerns the medical treatment of MB, a 30-year-old man suffering from neuropsychiatric symptoms. In May 2022 he was given a working diagnosis, following a brain biopsy, of T-cell cancer of the skin, brain and bone marrow. The disease was thought to be affecting his central nervous system, and to be the likely cause of his psychiatric symptoms.

By the time of the application to court, MB was in hospital, deprived of his liberty pursuant to a Standard Authorisation. He was assessed as lacking capacity to consent to the treatment that had been identified as suitable to treat T-cell cancer.

The Trust sought orders for authority to provide a high dose of methotrexate (MTX) under general anaesthetic over several days for up to two cycles, and for deprivation of MB's liberty arising from the use of the chemical restraint and sedation. The need for the anaesthetic and so deprivation of liberty arose from the fact that MB was not compliant with his care and treatment and so all agreed that it was not safe to provide the MTX unless MB was sedated intubated and ventilated.

The particular difficulties in this case were (i) that while there was a working diagnosis of T-cell cancer, there was no '*certain diagnosis*', and so as the Judge pointed out '*it may be that MB is suffering from something else and the diagnosis - and therefore, importantly, that to which the proposed treatment is directed - is not correct*' [21]; and (ii) the mode of delivery of the treatment was novel and the intensivist instructed by the Official Solicitor told the Court that he would not be prepared to undertake the procedure in his ICU.

The focus of the oral evidence was not the issue of capacity, since the parties (and ultimately the court) agreed that MB lacked the capacity to make the relevant decision. Rather it was focused on the question of best interests. By the time of the oral hearing, MB's family were broadly in favour of the treatment being provided. MB on the other hand, who spoke to the Judge, did not accept that he had cancer, and so needed the treatment.

In addition, the views of the clinicians (both treating and experts) were not aligned. The treating clinicians were of the view that the treatment was in MB's best interests, as did Dr Martinez-Calle the consultant haematologist instructed by the Official Solicitor. On the other hand, Dr Chris Danbury, the intensivist instructed by the Official Solicitor considered that the admission to ICU in order to deliver the treatment would do more harm than good.

This was on any view, an extremely finely balanced case.

Viewing the evidence in its totality, the Court concluded that the treatment was in MB's best interests and authorised the plan, concluding:

> *88. I accept that having the treatment may if successful prolong his life and that the starting presumption is protection of his life; that the right to life carries with it strong weight and that even and although the estimate of success is put at 20 % within the context of Article 2 EHCR that is not negligible. Even the most pessimistic of the evidence before me does not suggest the treatment is futile.*

Out of the Past: Backlog special

Several cases which have previously been reported on in this report have had follow-up judgments published; for reasons we are not clear on, these have now appeared on Bailii nearly a year or more after judgments were given.

London Borough OF X v MR & Ors [2022] EWCOP 29 (13 January 2022)(DJ Eldergill)

Judge Eldergill has reported a brief follow-up to *X v MR, PD and AB* [2022] EWCOP 1. Summarised here, the case related to a residence best interests decision in respect of X, who was 86 years old and had advanced dementia. X was reported to be settled and content at the care home where he resided. The question before the court was whether X should move to a care home specifically for Jewish people, which would likely be able to better meet his religious and cultural needs (though there was evidence that his current care home had made attempts

to do so as well). The court ordered that X should move. In the brief follow-up in [2022] EWCOP 22, Judge Eldergill reported that he had received an update on X's progress after his move, and had been told that X's move went smoothly, he was doing 'really well', was getting better care, regularly enjoyed attending synagogue, and overall appeared to have an improved presentation.

AA, Re (Capacity: Social Media and Internet Use) [2021] EWCOP 70 (09 December 2021)(Keehan J)[3]

Capacity – Internet and social media

Keehan J reported a further judgment in the matter of *AA (Court of Protection: Capacity To Consent To Sexual Practices*) [2020] EWCOP 66, which dealt with AA's capacity regarding a number of issues, where AA had a strong interest in autoerotic asphyxiation.

This case concerned a 20-year-old autistic man with an attachment disorder and 'borderline cognitive deficits'. The issue for the court was whether he had capacity in relation to his use of the internet and social media. If he lacked capacity, it was proposed that there would be daily checks of his electronic devices. An independent expert opinion had been sought from a consultant psychiatrist, Dr Ince, who took the view that AA lacked capacity on this issue. AA had previously made very risky decisions, including engaging in autoerotic asphyxiation, and having an online relationship with someone who asked him to send sexually explicit material, although AA had then decided to end that relationship and block the person from contacting him. Dr Ince considered that AA could not 'transpose an acknowledgment of risk in one situation to a different situation' [8] and could not appreciate that doing the same thing again would lead to the same outcome. But the evidence on the ground was that AA had stopped behaving in such risky ways, having received support, and had developed other offline interests which meant that he was using the internet less.

The court declined to accept Dr Ince's opinion and held that AA had capacity to make his own decisions about use of social media and the internet, saying '*Whilst I entirely respect and understand the opinion of Dr Ince, on the basis of the evidence, I reach a different conclusion from him. In the absence of any evidence, for many months now, of AA putting himself at risk of harm in his use of the internet and social media, I am satisfied that there is insufficient evidence for me to conclude that he lacks capacity to make decisions in respect of his use of the internet and of social media.'* [16] Even if AA did lack capacity the court was not persuaded that daily checks of his electronic devices would be in his best interests, as they did not protect him and were contrary to his wishes.

Comment

This judgment is another example of the court, not professionals, being the decision-maker on the question of capacity. The lack of evidence of risky behaviour in the recent past was critical to the court's decision, which underlines the need to look at what people do as well as what they say, when assessing capacity.

The Local Authority v A & Ors [2019] EWCOP 68 (18 June 2019)(HHJ Moir)

Following on from our November newsletter, readers may recall that we covered Poole J's decision in *Re A (Covert Medication: Closed Proceedings)* [2022] EWCOP 44. The case concerned the personal welfare of A, a woman of 23 with a diagnoses of mild learning disability

[3] Neil and Arianna having been involved in this case, they have not contributed to the writing of this note.

and Asperger's syndrome who was found to lack capacity to conduct this litigation or to make decisions about her residence, care, contact with others, and her medical treatment for epilepsy, primary ovarian failure, and vitamin D deficiency.

Prior to Tier 3 Judge, Mr Justice Poole, considering the case, it had been dealt with by Her Honour Judge Moir.

In this judgment, HHJ Moir considered [11]:

1. the validity of a Lasting Power of Attorney for health and welfare held by her mother, B;
2. whether a handwritten document dated 6 March 2019 was an advance decision to refuse treatment ("ADRT");
3. whether it was in A's best interests to receive hormone medication, which would essentially allow A to undergo puberty (which had not been possible previously because of her ovarian failure);
4. whether it was in A's best interests to receive treatment for her epilepsy and vitamin D deficiency;
5. where it was in her best interests to reside, in particular whether she should continue to live in residential care;
6. whether it was in her best interests to receive care in accordance with her care plan; and,
7. what contact it was in her best interests to have with her family.

Judge Moir did not address the issue of covert administration of the hormone medication in this judgment. The focus of this note is therefore the original decision that receiving that treatment was in A's best interests.

The first issue for HHJ Moir was A's capacity to make the relevant decisions. She heard extensive evidence from expert, Dr Ince, and from B (A's mother) and her maternal grandmother. She also undertook a detailed analysis of the written evidence. B's view was that A has a mild form of dyslexia and did not accept that she lacked capacity in any regard but she accepted that she did not understand the endocrinology issue because she had not helped A to understand it [52].

The court accepted the evidence of Dr Ince, which it considered was sufficient to rebut the presumption of capacity in respect (i) conducting the proceedings; (ii) making decisions about her residence and care; (iii) making decisions about her medical treatment; and (iv) making decisions about contact with others. She also concluded that A lacked capacity to execute the lasting power of attorney in favour of her mother at the relevant time.

HHJ Moir considered that the handwritten document, dated 6 March 2018, usefully set out A's wishes and feelings at the relevant time. It stated t that she wanted to live at home with her mother; she did not want social services involved in her life or a social worker; and she did not want to go to appointments. The Judge concluded that the document was not a valid ADRT because A did not have capacity at the time she completed the document and therefore the requirement in s 24 MCA was not met.

In respect of management of her primary ovarian failure, the evidence was that there was no range of medical opinion because the treatment was *"invariably sex hormone replacement therapy"* [73]. Dr X, the consultant endocrinologist, explained, as summarised by HHJ Moir, that [79]:

> *He told me that the likely success of the treatment was 100 percent. There is no failure rate. He told me it transforms a child into a woman. He said it is the basic human right of every girl to blossom into a woman and he found it inconceivable that it should be blocked. He said failure to treat it was unthinkable and it should have been done five years ago.*

The consensus opinion of the professionals

before HHJ Moir had been, at [10], that '*A was at serious risk of health complications, including increased seizures, osteoporosis, fracture risk, and cardiovascular disease*' without the appropriate medication.

B continued to press for an independent assessment of the endocrinological issues and possible treatment, which HHJ Moir considered was *'a perverse position given all the detail provided by Dr X and the level of his expertise.'* [81] She also noted that B's reason for wanting an expert was that *'they have been told different things and have been lied to.* [81]

The Judge concluded that, whilst B said that she accepted the treatment that should be undertaken, she had no confidence that she would encourage A to take the medication or attend hospital appointments. Thus, if A remained in B's care, the administering of the medication would not be supported or occur.

HHJ Moir took into account the Article 8 rights of A, and her right to personal development and autonomy, as well as Article 6(2) of the United Nations Convention on the Rights of Persons with Disabilities states that all appropriate measures should be taken to '*…ensure the full development, advancement and empowerment of women, for the purpose of guaranteeing them to exercise and enjoyment of the human rights and fundamental freedoms set out in the present Convention.'* She determined that the advantages of taking the treatment were *'significant and fundamental'*; balanced against that, it was against A's wishes. [87] In that regard, the court was not satisfied that A had been able to form an independent and informed opinion.

In respect of B, she determined that [88]:

> *Sadly, I find that B has been so obsessed with her own wishes, views, and fears that she is being blinded to the obvious and risk-free advantages to her daughter of encouraging her to undergo the treatment and has, instead, failed to encourage her daughter to engage with the treatment or has actively dissuaded her daughter from doing so. Thus, the prospect that B will in the future support her daughter and positively encourage her to engage with the treatment must be extremely limited. Sadly, it is difficult to reach any conclusion other than B would prefer A not to "grow up" for want of a better description, that she would prefer A to remain the same, dependent upon her mother, and isolated within her mother's sphere without any outside influence or interference.*

The court therefore concluded that it was in A's best interests to undergo the treatment recommendation in respect of her primary ovarian failure.

The court determined that residence in a care home was restrictive, but ultimately in A's best interests. She had already moved into placement A, and the evidence was that she was coping remarkably well in the new living situation. The court considered that B did not understand A's needs; and that B was a continuing negative influence on A. She determined that A's relationship with her mother was *"enmeshed"* and that it would take a long time to alter and diminish B's influence, so that that A can have the *'the opportunity to experience life as an independent adult with proper support.'* [112]

When the care home is the least restrictive option

Reading Borough Council v P & Ors [2022] EWCOP 27 (19 May 2022)(HHJ Owens)

Best interests – residence

P was an 86-year-old and had moved to the UK from Iran in 2002. She suffered from dementia, and in consequence of this had lost the ability to communicate in English (having grown up speaking Farsi). Until 2020, she lived with her daughter KS. In June 2020, she was admitted to hospital for a number of operations to her hip and developed an infection. There was a dispute

over her discharge destination but she was discharged to a care home in February 2021. Proceedings were issued in the Court of Protection, and upon all parties coming to agree it was in P's best interests to remain in the care home, an order was made by consent in May 2021.

Unfortunately, on 1 July 2021, the home served notice, alleging difficulties in their working relationship with KS. P moved to an alternative care home in September 2021 and the matter came back before the court. KS wished for her mother to return to live with her on a trial basis. P's two sons both considered that she should continue to live at the care home, but one of them (SS) considered that if P were to move to live with family on a trial basis it would be better for this to be with him than with KS.

The court noted the history of difficulties between KS and professionals, although noting it was neither necessary nor possible within the confines of the hearing to make any findings of fact. KS was extremely protective of P and probably genuinely believed she was trying to get the best for P, but there was a high risk of difficulties arising with any care agency providing care in KS's flat. Any move would be very disruptive for P given her frailty, and this also told against any trial of living with KS.

The judge also noted the evidence of a deep and permanent rift between P's children, and that P needed to be protected from the consequences of that acrimony. One of the key issues of P living with either KS or SS would be the risk that this prevented her from having as much contact with her family as possible. Ultimately, the risks of fewer family visits for P meant that unusually the least restrictive option in this case was for P to continue living in the care home, which was 'neutral ground' and would enable her to have frequent contact with all her family.

Changes of care plan without court approval

Gloucestershire City Council v AB, SB & NHS Gloucestershire Integrated Care Board [2022] EWCOP 42 (03 October 2022)(Senior Judge Hilder)

The Court has taken the unusual step of publishing the order made in a case, in startling circumstances where a care plan permitting P to self-harm had been introduced without the court – or indeed the parties – being informed despite ongoing proceedings.

AB's case had come before the court in June 2021 under the streamlined procedure. In light of her age (being then 17) it had been removed from the streamlined procedure, and, when she turned 18 and a standard authorisation issued, reconstituted as a challenge pursuant to s. 21A MCA 2005.

The case had been listed for final hearing at the end of September 2022, with questions to be determined regarding AB's capacity to use social media and her best interests in relation to her care and support arrangements. On 21 September 2022, AB's solicitors reviewed the most recent tranche of disclosure they had received and noted that from May 2022 AB had been permitted by her placement to self-harm significantly and retain sharp items, and had been subject to restraint when her self-harm concerned the nursing staff. Both of these were significant changes to her care arrangements and neither had been notified to the parties or the court.

On investigation it transpired that the changes had been implemented by a registered mental health nurse at the placement on the basis that the previous plan (to prevent AB self-harming) was unworkable. During cross-examination, the RMN accepted that this change required to be considered by an MDT including a psychiatrist and/or psychologist. The Trust and ICB agreed that a risk assessment and immediate review were required.

The Official Solicitor submitted that Article 2 of the European Convention on Human Rights gave rise to an operational duty on the public bodies to take reasonable steps to protect AB from a real and immediate risk to her life, and that the current arrangements in respect of self-harm were so risky they should cease. In the exceptional circumstances of the case, the care and support arrangements should be authorised by the court and not under Schedule A1 MCA 2005.

The court invited the parties and provider to consider a hybrid approach to AB's self-harm, in which steps would be taken to prevent implements for self-harm coming into her possession in the first place and support/supervision if AB did come into possession of such an implement or start to self-harm, and this was agreed.

Comment

The fact that changes of this sort were made to the care plan without the approval of the court being sought – or even the parties being informed – is startling. The concession that this should have required MDT involvement was plainly correct, and it is unsurprising that the Official Solicitor contended that the position that the placement could implement their own care plans was clinically, ethically and legally unsustainable. The case is a stark reminder that significant changes to care plans should be notified to supervisory bodies and if necessary court approval sought.

The case is also of interest for the identification that the care and support arrangements fell outside the parameters of Schedule A1. That is clearly right because they went well beyond arrangements to confine the person so as to enable them to receive care and treatment; rather, they constituted (high risk) arrangements seeking to steer a careful line between AB's Article 2 and Article 8 rights.

PROPERTY AND AFFAIRS

Lasting Powers of Attorney Bill receives a second reading

The Powers of Attorney Bill has been published and, on 9 December 2022, received its second reading in the House of Commons. Although technically a private members bill, the Bill has government support and it is very likely that it will become law more or less in its current form.

Though entitled Powers of Attorney Bill and having one (of its three) sections concerning Powers of Attorney generally (amending section 3 of the Powers of Attorney Act 1971 to add an additional authorised person as a certifier of powers of attorney), the main purpose of the Bill is to amend the Mental Capacity Act insofar as it relates to Lasting Powers of Attorney. This it does by the Schedule to the Bill which, broadly speaking, contains provisions amending Schedule 1 of the Mental Capacity Act 2005 concerning registration, notification provisions, identification requirements and objections to and evidence of registration.

The Bill proposes amendments which were the subject of consultation and the explanatory notes to the Bill explain that the main aim of the Bill is to modernise the process of making and registering Lasting Powers of Attorney. The notes say that the effect of the Bill will be that donors will find it easier to create their LPA whilst also being better protected from abuse. Another important aim is stated to be better protection from fraud.

One of the principal changes will be the introduction of a digital channel for making and registering an LPA. Thus, the Bill provides for regulations to provide for different ways to make an LPA, whether digitally, on paper or a mix of the two.

The Bill further provides that only a donor can apply to register an LPA. As a further check on abuse and fraud, the Bill provides for regulations to set out identity verification requirements that must be met for an application to register an LPA to be accepted.

The Bill will require the Office of the Public Guardian to notify the parties when an application to register an LPA is complete and the registration process is starting. The Office of the Public Guardian will also operate a triage system for certain types of objection.

The Bill will allow third parties not named in the LPA to make objection to the registration of an LPA and objections will be made to the Public Guardian, giving the Public Guardian power to register the LPA if satisfied that there is no evidence which reasonably supports the concern.

If, upon receiving an objection, the Public Guardian is satisfied that evidence reasonably supports the objection, then it is up to the donor or the attorney to apply to the Court of Protection for a direction to the Public Guardian to register the LPA.

Plainly, there is much to be awaited in respect of the major changes concerning the way in which applications are made. That will depend on the regulations made under the new provisions. Certainly, however, those changes are in keeping with the modern approach to matters such as this, namely that they are dealt with principally digitally. The other changes are less drastic and are aimed, mainly, to tighten up on one or two avenues by which fraudulent LPAs can be registered. They do nothing, of course, to allay concerns about how genuine LPAs can be abused in practice.

When will the Court of Protection authorise the settlement of P's capital in a disabled person's trust?

F v R [2022] EWCOP 49 (17 November 2022)(Senior Judge Hilder)

By this application, the Court of Protection (Senior Judge Hilder) was asked to grant authority for the settlement of an inheritance P had been left in a will of a relative absolutely on terms that instead of being held by P absolutely, it should be held by trustees on a Disabled Person's Trust.

The value of the inheritance was between £400,000 and £600,000. P's income derived mostly from state benefits totalling £60,293.48 per year, of which £52,381.60 was means tested. P was represented in the proceedings by the Official Solicitor.

The Applicant argued that although there were known benefits to funds being held by deputies rather than behind a trust, those benefits were outweighed by the effect of an absolute gift as opposed to the effect of funds being in a trust, namely that the former is taken into account in the assessment of means tested benefits, whereas the latter is not.

Unfortunately, that benefit was, so the court held at paragraphs 46 to 49, very likely to be nullified by the Local Authority and the DWP taking the view that the intention behind the settlement was simply, as the court found, to deprive P of capital that would otherwise be taken into account in a means tested benefit application.

The court also referred to the *Secretary of State for Justice v A Local Authority & Ors* [2021] EWCA Civ 1527, where both King LJ and Baker LJ, at paragraphs 70, 73 and 74 respectively, emphasised that the Court of Protection is part of a wider system of the administration of justice and the court could not endorse a proposal whose purpose was to preserve an eligibility for benefits which Parliament had decided does not exist. The court went on to hold at [51]:

> *At this point, it is the court's purpose that matters, and the only purpose of the application is to preserve R's means tested benefits, whether that is directly or indirectly by giving effect to the supposed intention of T.*

This was, of course, an individual best interests decision, but it shows quite clearly that the Court of Protection is not likely to sanction any schemes of this sort where it is suggested that any of P's assets should be transferred to a trust in effect in order to preserve benefits.

Upfront notification process for property and affairs deputyship applications in the Court of Protection

HMCTS has recent released a statement on changes to applications for Property and Affairs deputyship orders:

> *From January 2023, the new upfront notification process will become the standard process for all Property and Affairs deputyship applications, following a successful pilot. A new Practice Direction and new Court of Protection forms will be available on GOV.UK.*
> *Benefits of the new process include:*
> - *less paperwork to complete and faster processing times*
> - *increased initial engagement reducing delays caused by objections*
> - *forms CoP20a and COP20b no longer need to be completed*
> - *a new easy to use online service that supports better accuracy of applications*
>
> *Changes from January 2023*
> *New Property and Affairs Deputyship applications received by the court after 1 January 2023 must follow the new notification process using the new forms.*

We are phasing the release of the online service to ensure a smooth transition for our users.
This means:

- *the online service will be available for solicitors/professional users to use from 2 January 2023.*
- *personal applicants will be able to pay and apply online from February 2023*

From 1 February 2023, Property and Affairs Deputyship applications that do not follow the new upfront notification process will be returned to the applicant.

An introduction to the new process
Applicants should notify 3 people who know the person affected by the application, for example, relatives, a social worker or doctor. Applicants should gather the responses before submitting their application. Applicants should send responses and all recordings of notifications to the court with their application.

There are new forms to use for upfront notifications, the COP14PADep and COP15PADep. These forms are both notification and acknowledgement forms combined.
The forms should be returned to the applicant or agent within 14 days of notification where possible. The applicant should then send/upload all acknowledgement forms whilst making the application to the court. After 14 days from notification, the court will assume agreement to the order being made if no acknowledgement form is returned to the applicant and no COP5 is filed by those notified.
If you would like further information, please contact the Civil & Family Business Support team (Civil_and_FamilyBusinessSupport@justice.gov.uk).

PRACTICE AND PROCEDURE

Cross-border placements

In the matter of SV; Health Service Executive of Ireland v Florence Nightingale Hospitals Limited [2022] EWCOP 52 (8 December 2022)(Mostyn J)[4]

International jurisdiction of the Court of Protection – Recognition and enforcement

For comment on this case from a Scottish perspective and further comments which might be of interest to readers in England & Wales, see the Scotland section of this Report.

This application concerned SV, who was 20 years old and an Irish citizen. At [47], the judgment states that *'[s]he has been diagnosed with anorexia nervosa and symptoms of bulimia nervosa, and as a result of these conditions, has been admitted to hospital in Ireland multiple times over the last 18 months. Her most recent admission was to Our Lady of Lourdes Hospital in Drogheda on 15 September 2022 where she remains as stipulated by orders of the Irish High Court which has adjudged her to lack mental capacity to consent to medical treatment.'* The court set out how this matter had come to be before the Court of Protection:

> *48. The view of the healthcare professionals treating SV is that the seriousness of her condition means that she requires placement at a specialist eating disorder unit, which is not available in Ireland. Accordingly, the HSE has found SV a suitable placement in England, at Nightingale Hospital in Lisson Grove, Marylebone, and this new placement was authorised by the Irish High Court on 16 November 2022.*
>
> *49. This application before me is to facilitate SV's transfer to Nightingale Hospital. Specifically, the HSE seeks the urgent implementation of the protective measures contained in the order of the Irish High Court dated 16 November 2022.*
>
> *50. The application is urgent because SV is extremely unwell and in a placement which is unsuitable for her extensive and complex needs. As such, it is plainly imperative that SV is moved to a suitable placement as a matter of urgency. That urgency is recognised by the Irish High Court.*

The substance of the judgment focused on the appropriate procedures for *'recognising and declaring enforceable protective measures made in respect of a protected person'* [1] by courts outside of England and Wales. The court carefully considered the impact of the Hague Convention of 13 January 2000 on the International Protection of Adults; [5] this was

[4] Alex having advised in this matter, he has not contributed to this note.

[5] Article 22 of the Convention *'requires a protective measure in respect of a protected adult ("P") issued in a contracting state ("State A") to be recognised by operation of law in another contracting state ("State B"). An application may be made by "any interested person" under Article 23 for recognition by State B of a protective measure issued by State A.'* [3] *'[T]he merits of the measure made by State A cannot be reviewed by State B (Article 26), and findings of fact by State A establishing its jurisdiction are binding on State B (Article 24).' [4] 'It is important to recognise that the role of the receiving court of State B is subsidiary and ancillary to the primary role of the issuing court of State A. So, to be clear, in common with the 1996 Hague Convention on Parental Responsibility and Measures for the Protection of Children, recognition by State B of a measure made by State A is intended to be almost automatic unless one of the very limited grounds for non-recognition can be shown. Those limited*

signed by the United Kingdom in 2003, but has only been ratified in respect of Scotland. However, the court concluded that the 2000 Convention had been implemented in Section 63 and Schedule 3 to the Mental Capacity Act 2005:

> *14. Section 63 provides:*
>
> > *"International protection of adults*
> >
> > *Schedule 3:*
> >
> > *(a) gives effect in England and Wales to the Convention on the International Protection of Adults signed at the Hague on 13th January 2000 (Cm. 5881) (in so far as this Act does not otherwise do so), and*
> >
> > *(b) makes related provision as to the private international law of England and Wales."*
>
> *Schedule 3 reproduces, almost verbatim, the terms of the 2000 Convention, and came into force on 1 October 2007.*
>
> *15. In doing it this way Parliament bypassed the procedures for ratification at the Hague. Importantly, giving effect to the Convention in this way meant that it would apply in England and Wales as a receiving country in respect of qualifying incoming protective measures wherever made. Therefore it does not matter whether State A is, or is not, a contracting state under the 2000 Convention. The disadvantage is that implementing the 2000 Convention by this route did not, of course, give rise to reciprocity. It did not have the effect that protective measures made here would be automatically recognised and enforced overseas, even in those countries operating the Convention.*
>
> *16. An order reciprocating a protective measure made by a foreign court may be sought under Schedule 3 from the Court of Protection by one or more of the following processes:*
>
> > *i) An application for a declaration under para 20(1) that the measure is recognised in England and Wales;*
> >
> > *ii) An application for a declaration under para 22(1) that the measure is enforceable in England and Wales;*
> >
> > *iii) An application for a declaration under para 22(1) that the measure is to be registered in England and Wales in accordance with Court of Protection Rules.*
>
> *17. The Court of Protection Rules 2017 do not provide for registration of foreign protective measures, so the third option is inapplicable in this jurisdiction. In theory there are circumstances where all that is needed is a declaration of recognition. But where the measure in question is a foreign protective measure relating to welfare rather than property, recognition alone will never suffice as the terms of the measure will invariably require positive action to be taken, and this in turn requires "enforcement".*

The court noted that while the Convention required states to adopt a 'simple' procedure for recognising protective measure, the process of doing so was in fact quite complex. The court observed that *'[t]he principal reason why these cases are so demanding of public and judicial*

grounds categorically do not include State B disagreeing with the measure on its merits. However, once a measure has been recognised by State B then the conditions of its implementation are governed by the law of State B (Article 14).' [5]

resources, is that, notwithstanding the superficial simplicity of the scheme, the Court of Protection has to be satisfied of numerous conditions before the declarations can be made. I have worked out that the Court has to ask in the right order, and receive the correct answers to, 22 separate questions.' [21] As an annex to the judgment, the court prepared *'a checklist or questionnaire detailing the 22 questions, the answers to which must be given correctly and in the right order. The objective of the checklist is not only to ensure the avoidance of any technical pitfalls by me, but also to serve as a judgment writing tool.'* [23]

The court concluded that in proceedings of this nature, the Court of Protection must apply domestic law to five specific issues:

1. The joinder of P:

> *28. Whether P should be joined to the Schedule 3 application has to be considered with care, applying our domestic law. However, where (as here) the application is proceeding without opposition it will be a very rare case where the joinder of P to the proceedings will be considered to be necessary: see Health Service Executive of Ireland v CNWL [2015] EWCOP 48 at [35]. In my opinion, necessity is only likely to be shown where P is not only actively contesting the application but where there are other valid reasons to review the process of the foreign court. This is because mere active opposition to the application is likely to amount to a prohibited attack on the merits of the primary decision of the foreign court. A plausible argument therefore needs to be advanced by or on behalf of P in support of her/his application for party status that there has been some fatal procedural defect in the foreign proceedings and/or that there are good reasons justifying non-recognition within the terms of Schedule 3.*
>
> *29. The party status of P before the foreign court, which is of course the primary court, and P's position in those proceedings, will naturally be relevant to the joinder decision.*

2. Whether P was heard in the foreign proceedings:

> *32. If the foreign proceedings were not being held on an urgent basis and if P was denied the opportunity of being heard in them, then para 19(3)(c)) allows recognition to be withheld on the ground of natural justice. I suspect that this will very rarely, if ever, arise but if it did the assessment of the standards of natural justice will be made in accordance with our domestic law.*

3. Whether P has capacity:

> *34. In Health Service Executive of Ireland v PA & Ors [2015] EWCOP 38 at [98] a scenario*

was posited whereby a protective measure is made in the foreign court in respect of a person who satisfies the test in para 4(2)(a) (in that she is a person who as a result of an impairment or insufficiency of her personal faculties cannot protect her interests) but nonetheless that person has the capacity under ss. 2 and 3 of the Mental Capacity Act 2005 to make the relevant decisions about her care and treatment. In such a case very careful consideration will need to be given to whether recognition of the foreign measure would be manifestly contrary to public policy under para 19(4)(a).

35. *Again, I suspect that this will very rarely, if ever, arise. I struggle to conceive of a case where a capacitous, but nonetheless vulnerable, adult is sought to be sent here from Ireland for invasive treatment which constitutes a deprivation of liberty. The Irish Court would surely know that in such circumstances it would be probable that a refusal of recognition on the ground of public policy would be the outcome*[2].

36. *In determining whether for this, or any other reason, recognition of the foreign measure is manifestly contrary to public policy, this Court applies its own domestic law.*

4. Whether the measure is inconsistent with a mandatory provision of the law of England and Wales

    38. *Again I suspect that this will very rarely, if ever, arise. However, I agree with Mr Setright KC that where the applicant alone is represented, the Court will need to be satisfied that sufficient material has been placed before it to support the averment that there is no inconsistency. The issue is formally determined by applying domestic law.*

5. Whether the measure entails a deprivation of liberty for the purposes of Article 5 ECHR:

    40. *It is well-established that the Court of Protection must adhere to and apply the principles and safeguards developed in our domestic law deriving from Article 5 to a Schedule 3 application which if granted would result in a deprivation of liberty for the purposes of Article 5 of the ECHR.*

    41. *To that end, this Court must be satisfied that:*

    i) Objective medical expertise has established that P's medical disorder is of a type and degree that warrants P's compulsory confinement. See Winterwerp v Netherlands (1979) 2 EHRR 387 at [39], Health Service Executive of Ireland v PA & Ors at [89] and [96], Health

Service Executive of Ireland v CNWL at [17], and Health Service Executive of Ireland v Moorgate [2020] EWCOP 12 at [35];

ii) P has the right in the foreign country to challenge the detention: see Health Service Executive of Ireland v PA & Ors at [97];

iii) The detention is regularly reviewed by the foreign court (ibid).

42. *In reaching its decision the Court of Protection is entitled to conduct a limited review, and to apply a light touch: Health Service Executive of Ireland v PA & Ors at [96].*

43. *It is very important that the Court of Protection, applying our own law, is satisfied of these matters. If there is even one negative answer then the declaration of recognition and enforcement cannot be made until the problem is resolved.*

In SV's case, the court was satisfied that the order of the Irish High Court should be recognised and declared enforceable. The judgment includes Annexes showing how the checklist of 22 questions had been answered, and the order the court had made. The court ended the judgment with obiter dicta on a number of procedural points at paragraph 53:

i) If the foreign court has given a fully reasoned judgment explaining the nature of the measure it has issued, and has summarised the evidence relied on in reaching its decision, then normally it will be unnecessary to place any other written evidentiary material before the Court of Protection when seeking recognition and enforcement. To present this Court with all the evidence which was before the foreign court, as has happened here, is a perilous practice as it implies that this Court should conduct its own review of the merits of the measure. As I have explained above, such a review is impermissible.

ii) If the foreign court can be persuaded to address all the matters in the checklist in its primary judgment then that is likely to make the task of this Court appreciably easier. For example, in this case, Question 5 would have been more unambiguously answerable by me had Hyland J dealt with SV's incapacity using additionally the language of Article 1(1) of the 2000 Convention and para 4(2)(a) of Schedule 3 and had held explicitly that SV cannot protect her interests as a result of an impairment or insufficiency of her personal faculties.

iii) Similarly, Questions 8, 9 and 10, dealing with SV's habitual residence, would have been more easily answered by me if the judgment had explicitly dealt with this factor. A pedant might object that the declaration in the Irish order recording that SV is "domiciled and habitually and ordinarily resident in this State" does not reflect a finding made in the judgment to that effect. My response to such pedantry would be that it reflects an implied finding. For the future I would suggest that the better course is to try to persuade the foreign court when giving the primary judgment to cover all of the matters in the checklist.

iv) The reciprocal order sought will almost invariably authorise the deprivation of P's liberty. In view of the seriousness of such a decision, as well as the international aspects, I agree with Mr Setright KC that such orders should be only be made by a Court of Protection Tier-3 judge (i.e. a

permanent or deputy High Court judge), following an attended hearing in court. If the application is definitely proceeding by consent I would have thought that a listing of one hour would be appropriate. But if the application is not proceeding by consent, or there is doubt as to whether it is or is not contentious, then in my opinion the application should be listed for a day with an interim hearing of one hour being urgently fixed to consider making an interim order permitting the implementation of the foreign measure pro tem.

v) It would be perilous, in my opinion, for applications under Schedule 3, to be routinely directed to be heard in open court but subject to a "transparency" order made under COP PD 4C para 2.1 containing reporting restrictions. That would be an example of us applying our own insular domestic standards to this stand-alone piece of legislation which incorporates an International Convention. In this case, it would be singularly inappropriate to do so in circumstances where the primary proceedings, the result of which has been afforded near automatic recognition here, were heard in camera in Dublin. Further, I personally am very reluctant to make routine orders of this nature in circumstances where I have serious doubts as to whether the present arrangements are "correct": see my decision in Re M [2022] EWCOP 31 at [40] – [45]. In my opinion that issue needs to be resolved urgently either by the Rule Committee or by legislation.

vi) Consistently with my opinion in [44] of that decision, I suggest that the hearings of future Schedule 3 applications should be listed to be heard in private in accordance with COPR r. 4.1(1) but that a direction is issued on the filing of such an application permitting journalists and legal bloggers (but not the general public) to attend the hearing. That direction should be copied to Mr Farmer of the Press Association by the applicant. At the hearing the Court should, subject to submissions made by the press or any party, relax the prohibition in s. 12(1) of the Administration of Justice Act 1960 (and curtail the freedom in s.12(2) to publish fully the terms of the final order), to permit anonymous publication of the proceedings, the judgment and the order. In my opinion it is strongly in the public interest that decisions on applications under Schedule 3 are not rendered secretly. I consider that my suggestion fairly reflects (i) the in camera nature of the primary proceedings in Ireland; (ii) the need for at least some open justice in the despatch of the consequential Schedule 3 application in England; (iii) the decision of the House of Lords in Re S (a child) [2004] UKHL 47, [2005] 1 AC 593; and (iv) the terms of s. 12(2) of the Human Rights Act 1998 and the right of the press to be heard where orders are made that engage Article 10 of the ECHR (see In re the Will of HRH Prince Philip, Duke of Edinburgh (decd) [2022] EWCA Civ 1081 at [17]).

vii) For the reasons given in Re M at [34] – [39], at the hearing I declined to endorse the draft order which had been supplied to me which throughout referred to P acronymically as SV. Of course, this judgment anonymises P. There is no reason why the world should know her identity. Of course, the judgment of Hyland J annexed to this judgment has been anonymised by me for the same reason. Of course, her identity will be redacted from the copy of the order annexed to this judgment, again for the same reason. But the actual sealed order which gives effect to my decision, and which regulates matters between SV, the HSE and the Irish court should unquestionably bear her name. The order made by Hyland J bore SV's name and it would be bizarre, to put it mildly, if we decided to anonymise our

reciprocating order when the primary court did not do so in the principal order.

Court of Protection Rules amended

The Court of Protection Rules have been amended by SI 2022/1192, available here; the changes will come into force on 1 January 2023. The notable changes are that:

- For the purposes of Part 6 (Service of Documents), *'Documents may be served by document exchange or electronic communication in accordance with the relevant practice direction'*, replacing a previous provision that *'A practice direction may set out how documents are to be served by document exchange, electronic communication or other means.'*
- Specific provision is made for commencing Property and Affairs Deputyship applications under Practice Direction 9H;
- Part 21 (Contempt of Court) is wholly replaced by a new provision. The Explanatory Note sets out that this is *'for the purpose of making provision for a consistent approach in relation to contempt proceedings having regard to the relevant provisions of the Civil Procedure Rules 1998 (S.I. 1998/3132 – see Part 81 as substituted by S.I. 2020/747) and the Family Procedure Rules 2010 (S.I. 2010/2955 – see Part 37 as substituted by S.I. 2020/758).'*

THE WIDER CONTEXT

When can a court dispense with the consent of a parent or guardian to a child being placed for adoption on the basis of lack of capacity?

A & C v B & A District Council [2022] EWHC 2962 (Fam) (23 November 2022)(Judd J)

Other proceedings – Family (public law)

Summary

This matter related to a 1993 Hague Adoption Convention order in respect of B, who was 17 years old. She was born in what is described as 'an Asian country' and came to live with her maternal aunt and uncle in England in late 2020. The judgment records B's history:

> *2. B was looked after by both her parents after she was born, but this did not last long. Her mother developed a severe mental illness which meant that she was no longer able to care for B (although she did and does have contact). B's father left the family home shortly after she was born, and has not seen her since. Social workers in country A reported him to be threatening and under the influence of alcohol when they visited him for the purposes of preparing their adoption report. B was brought up by her maternal grandparents for many years…*
>
> *40. …the mother has been diagnosed with Bipolar Disorder with psychotic features, with erratic, shifting moods. She suffers from depression and oversleeping, and also from manic episodes which include aggression and destructive behaviours. She is not compliant with medication…*

B's maternal grandparents also developed health problems and were unable to care for her, so she came to live with her maternal aunt and uncle, who had made an application to adopt her. B's family supported this plan.

B's mother was considered to lack capacity both to conduct proceedings and to make decisions regarding B's adoption:

> *41….even with prompts and a simple explanation, she was unable to understand sufficient information to be able to participate in the proceedings. She could not understand the facts of adoption and/or what happens in court. She was focussed on repetitive thoughts and was not able to repeat any facts relating to the adoption or indeed to repeat a simple sentence or phrase. Her thinking was disorganised and paranoid. She would find travelling overly challenging and stressful. In particular the doctor noted that 'she cannot understand that the adoption process has not yet been finalised even after careful explanation'; she thought the adoption had taken place years ago.*

Under Article 4 of the 1993 Hague Adoption Convention, an adoption within the scope of the Convention may only take place if certain conditions are met, including that the child's country of origin has ensured that:

> *(1) The persons, institutions or authorities whose consent is necessary for adoption, have been counselled as may be necessary and duly informed of the effects of their consent in particular, whether the adoption will result in the termination of the legal relationship between the child and his or her family of origin;*
>
> *(2) Such persons, institutions and authorities have given their consent freely, in the correct legal form, and expressed or evidenced in writing;*
>
> *(3) The consent of the mother, where required, has been given only after the birth of the child;…*

Further, under s.47 Adoption and Children Act 2002:

> *12. …an adoption order may not be made if a child has a parent or guardian unless one of three conditions are met. The first condition, pursuant to s47(2) is that the court is satisfied that either the parent or guardian consents to the making of the adoption order. The second is that the parent or guardian has consented under section 20 and does not oppose the making of an order. The third is that the parent or guardian's consent should be dispensed with. These provisions all apply in a Convention adoption, just as in a domestic one (Regulation 52 Adoption with a Foreign Element Regulations 2005).*

B's father and maternal grandmother had both given written consent to B's adoption; all relevant reports supported B's adoption by her aunt and uncle. B travelled to the United Kingdom in 2020 to live with her aunt and uncle, and by 2022 all reports continued to support her continuing to reside with them.

B's visa was soon to expire, and her aunt and uncle applied to adopt her. However, following the application, it was noted that B's mother had not given her consent to her adoption, and it was unclear as to whether her parental responsibility had ever been terminated. The court recorded at paragraph 21 that '*[t]he authorities in country A have stated that her parental responsibility was terminated by virtue of a provision within their family law as a result of incapacity. As a result her consent to the adoption was not sought or provided by that Central Authority.*' However, B was now settled in the England, which does not have an analogous provision. The court considered that the question of who had parental responsibility needed to be determined by reference to English law rather than the law of country A.

B's mother was automatically joined as a party to proceedings. The court considered whether B's mother should be represented by the Official Solicitor, and ultimately determined she should not due to the delay this would occasion in what had become relatively urgent adoption proceedings due to the pending expiration of B's visa. In these circumstances, the court went on to discharge B's mother as a party, having regard to *Re P (Discharge of a Party)* [2021] EWCA Civ 512. The court concluded that:

> *48. There is thus no foreseeable prospect of the mother being in a position either to care for B or to have capacity to exercise her parental responsibility to agree to any other arrangement, including adoption. I cannot envisage any points that she would either be able to or wish to make to this court about the proposed order (which she believes has already been made) save that I am sure she would want to continue to have contact with B, something which B is able and willing to do.*
>
> *49. In all the circumstances, therefore I cannot see any advantage to anyone (including B's mother) in prolonging these proceedings, and very considerable disadvantages, including long term harm that B may suffer, in doing so. I am prepared, having listened to the submissions of all the parties before me, to make the order removing the mother as a party on the basis that is in necessary and in the interests of justice. To do otherwise would risk causing serious emotional harm to B.*

The court further concluded that the consent of B's mother could be dispensed with. It noted that:

> *63. Section 52 of the ACA provides as follows:-*
>
> > *(1) The court cannot dispense with the consent of any parent or guardian of the child to the child being placed for adoption or to the making of an adoption order in respect of the child unless the court is satisfied that –*

(a) The parent or guardian cannot be found or lacks capacity within the meaning of the Mental Capacity Act 2005) to give consent, or

(b) The welfare of the child requires the consent to be dispensed with.

64. *Here there is clear evidence that the mother is suffering from an impairment of the functioning of the mind within the meaning of section 2(1) of the Mental Capacity Act. Having read the report of Dr. ST it is clear that the mother is unable to make a decision to refuse or consent to adoption because she cannot understand the information even when explained to her simply. She is unable to retain what is said to her, or use the information as part of the process of making a decision. Nor did she seem able to communicate in any coherent form. During the assessment she was unable to follow what she was being told, and indeed to comprehend that B had not already been adopted. Her condition is very long standing, and I can see no likelihood in the future of her regaining sufficient capacity, even with assistance, to make such a decision.*

65. *Counsel's researches have not found any authority where the consent of a parent has been dispensed with on the ground of a lack of capacity to give consent. The use of the word 'or' at the end of paragraph 1(a) suggests that in such a case, once the court is satisfied that it is in the child's best interests to be adopted it does not have to be satisfied of the imperative contained in the wording of s52(1)(b) in quite the same way as is necessary when a parent withholds their consent and does have capacity. Nonetheless, it is important to record that I do consider that the imperative is satisfied, and that B's welfare does require her to be adopted. The alternatives are (as I have recited above in the welfare section) to make a Special Guardianship order, a residence order, or no order at all. Neither and SGO or a residence order would last beyond B's 18th birthday, and none of these alternatives would provide her with the lifelong security of being able in law to have the applicants as her parents and their children as her siblings, which is so important for her future development. Further, the making of an adoption order will secure her immigration status in this country which is also extremely important given the lack of secure family support in her country of origin. I recognise that an adoption order is a grave interference with the rights of the mother to respect for her private and family life pursuant to Article 8 European Convention on Human Rights, for it severs the legal ties with her daughter. Even though the mother has not cared for her for many years, this is still a serious infringement of the mother-daughter relationship. I am satisfied, however, that this interference is necessary and proportionate in order to safeguard B's future welfare. I note the mother believed the adoption order to have been made a long time ago and so, inasmuch as she is able to understand the situation, this is something she has accepted.*

'A gloriously ordinary life': The Adult Social Care Lords Select Committee calls for urgent reforms

Following evidence from many witnesses, *'disabled adults and older people, carers, service providers, local authorities, and academics,'* the Lords Select Committee on Adult Social Care has published its report, *A "gloriously ordinary life": Spotlight on adult social care*. The report includes a number of recommendations on improving adult social care:

Make adult social care a national imperative by:

- *delivering realistic, predictable and long-term funding;*
- *delivering a properly resourced plan for supporting a highly valued workforce, building skills and remedying low pay;*
- *establishing a powerful Commissioner for Care and Support to strengthen the voice and identity of the sector;*
- *finally and fully implementing the principles of the Care Act 2014, rooted in wellbeing, choice, and control;*
- *ensuring that the voice of social care is loud and clear within Integrated Care Systems.*

Prepare for the future by:

- *recognising that more people will be ageing without children*
- *investing in better knowledge and data to inform better policy.*

Ensure people who draw on social care have the same choice and control over their lives as everybody else by:

- *enabling disabled people and older adults a genuine choice as to who supports them, simplifying the recruitment of personal assistants, and making access to direct payments easier;*
- *providing accessible housing and assistive technology to achieve independent living;*
- *working with social care staff to promote the skills to co-produce care;*
- *enabling people to determine who supports them, and what relationship they want with their family and friends.*

Caring for unpaid carers by providing:

- *easier access to, and an increase in Carer's Allowance;*
- *more flexible support for carers who work, including the implementation of Carer's Leave;*
- *more support from health and social care professionals to identify them, signpost support, and ensure that they get it.*

Crowter in the Court of Appeal

R(Crowter & Wilson) v The Secretary of State for Health And Social Care [2022] EWCA Civ 1559 (25 November 2022)(Underhill LJ, Thirwall LJ, Peter Jackson LJ)

The Court of Appeal has upheld the decision of the Divisional Court in the case *Crowter and Wilson v the Secretary of State for Health and Social Care*. The matter related related to Section 1(1) Abortion Act 1967, which generally bans abortions after the 24th week of pregnancy, save for in cases where there are certain defined risks to the mother or her existing children, or where (per Section 1(1)(d) Abortion Act 1967) *'there is substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.'*

The appellants, Heidi Crowter (now Mrs Heidi Carter) and Aidan Lea-Wilson both had Down's Syndrome and argued *'that legislation which permits the abortion, without any restriction, of a foetus which is liable to be born seriously handicapped "perpetuates and reinforces" negative cultural stereotypes about people with handicaps by sending a message that their lives are less valuable; that it thereby breaches their rights under articles 8 and 14 of the European Convention on Human Rights ("the Convention"); and that the Court should accordingly make a declaration of incompatibility under section 4 of the Human Rights Act 1998.'* [3] The case was heard at the first instance in the Divisional Court by Singh LJ and Lieven J in 2021, and permission to appeal was granted solely in respect of grounds relating to Article 8 and 14 ECHR (though was refused on grounds relating to Article 2 and 3 ECHR):

26. *In their grounds of appeal the Appellants sought to challenge the decision of the Divisional Court as regards each of the four articles of the Convention on which they relied. As already noted, this Court refused permission to appeal as regards the case based on articles 2 and 3, which concern, respectively, the right to life and the right not to be subjected to torture or degrading treatment or punishment. The difference between that case and the case based on articles 8 and 14 is that the former is concerned with infringement of what were said to be the rights of the foetus itself, whereas the latter is concerned with the rights of persons born with a severe handicap – referred to in the course of argument as "the living disabled" – whose rights are said to be affected by the negative stereotype disseminated by section 1 (1) (d). The Divisional Court held that the current jurisprudence of the European Court of Human Rights ("the ECtHR") does not accord Convention rights to the unborn, and Peter Jackson and Nicola Davies LJJ held that there was no chance of a successful appeal from that conclusion. We are not, therefore, in this appeal concerned with a challenge to section 1 (1) (d) based on the rights of the foetus but with a challenge based on its impact on the living disabled. That is a distinction of fundamental importance which it is important to bear in mind throughout this judgment.*

The Court of Appeal noted some of the factual background to the case, and specifically some of the statistics relating to those who chose to terminate a pregnancy after a pre-natal diagnosis of Down's Syndrome:

20. *Down's syndrome occurs in approximately 0.16% of pregnancies in the UK. Screening for the risk of Down's (as for many other kinds of foetal abnormality) is routinely offered to mothers at an early stage of pregnancy: if it is diagnosed they will be offered advice about a termination of their pregnancy. In 2018 44% of women who were offered screening opted out of it and/or of being given a diagnosis of Down's. Of the 1,570 diagnoses of Down's in 2018, there were 722 live births and 799 terminations (being about a quarter of all abortions performed under section 1 (1) (d)).*

21. *Because of the availability of early screening it is rare for abortions for Down's syndrome to be carried out after 24 weeks' gestation ("late abortions"). However, the evidence was that there are circumstances – for example where the mother is unaware that she is pregnant – in which early screening does not occur, or for some other reason a decision to terminate is not made within the first 24 weeks, and where there is a late abortion. In 2019 there were 275 late abortions; in thirteen of these Down's was the only reason given, and in a further six it was mentioned in conjunction with other conditions.*

22. *The evidence contains no figures for late abortions for other conditions, but there are some conditions which cannot typically be diagnosed early in pregnancy and where late abortions are performed under section 1 (1) (d): hydrocephalus is one* example.

The claimants aruged that the law added to *'the perpetuation and reinforcement of [negative' stereotypes'* and in doing so, interfered with their Article 8 rights:

> *31…first, because of "the inherent insult to identity and human dignity" which they express and, second, because they promote discriminatory attitudes in society which in turn manifest themselves in discriminatory behaviours by third*

> *parties. I will refer to these as "direct impact" and "societal impact". Mr Coppel accepted before us that it was sufficient for the Appellants to show direct impact, but he contended that the evidence supported a case of societal impact as well.*

The Court of Appeal accepted the evidence of the Appellants that they find it *'offensive and hurtful that the law permits the unrestricted abortion of foetuses who are at risk of being born with serious disabilities, and that they see it as conveying a message that the lives of disabled people are of lesser value',* [56] and that a similar impact *'is likely to be felt by other people with Down's or other serious disabilities.'* [57] However, the court did not accept academic evidence submitted that the legislation in question *'plays any significant role in causing discriminatory attitudes against disabled people generally, or those with Down's in particular…No doubt it might be said that section 1 (1) (d) reflects long-established prejudices, but that is a very different matter from it causing or substantially contributing to them.'* [58] The court also accepted that others would see the message differently to the appellants, as they may *'draw a clear line at the moment of birth and deny that permitting the abortion of a foetus with a serious disability implies anything about the value of the lives of the living disabled.'* [72] The Court of Appeal found that that statute's terms *'cannot be equated with explicit or unequivocal statements of the character of "gypsies are criminals" or "concentration camp survivors behaved like bandits" such as were before the ECtHR in Aksu and Lewit.'* [72]

The court found that Article 8 was not engaged (though Peter Jackson LJ set out slightly different reasoning for reaching the same conclusion at [129-130]):

> *73. I do not believe that in those circumstances the enactment of section 1 (1) (d) can be said to constitute an interference by the state with the private lives of the Appellants. Their perception, however genuine, that the present state of the law devalues them cannot itself constitute or evidence such an interference: the interference must derive from something in its terms or its effect which, applying an objective standard, unequivocally conveys that message. The existence of a legal right cannot depend solely on the subjective perception of the putative victim.*

Given this finding, it was unnecessary for the Court of Appeal to reach the question of whether any interference under Article 8 was in accordance with the law and whether any interference was justified, but it continued to consider these issues given the importance of case, upholding the findings of the Divisional Court on both issues.

NICE Guidance on the Legal Right to advocacy

NICE has produced Advocacy services for adults with health and social care needs (NICE guideline NG227), a very useful guideline which helps advocates, commissioners and health and social care practitioners by setting out the key aspects of service quality. It will also be helpful to those who use advocacy, their families and carers. It covers advocacy delivered by a trained person (rather than familial advocacy) whose sole engagement is to support the person and help ensure that their voice, needs and preferences are heard.

The guideline sets out the legal entitlements to advocacy under the Care Act 2014, MCA 2005, and MHA 1983, along with many recommendations which, when exercising their judgement, professionals and practitioners are expected to take fully into account. Local commissioners and providers of healthcare also have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it.

Education and Training Standards for AMHPs and AMCPs

Social Work England have provided the response to their two 12-week public consultations on the new AMHP/AMCP standards (Consultation response on education and training approval standards for approved mental health professionals (AMHPs) and approved mental capacity professionals (AMCPs)). They received 47 and 31 responses respectively. Amongst other matters, AMHPs sought greater recognition in the standards of the different professional backgrounds of the AMHP role. Whilst for AMCPs, the term "practice observation opportunity" (rather than "placement") was seen as an appropriate term for the requirement that trainee AMCPs should be able to engage.

The next stage is to prepare supporting guidance for how course providers can demonstrate that they meet the standards. SWE will then move towards announcing an implementation date for the new AMHP standards which will then apply to all new approvals or re-approvals of AMHP courses regulated in England. Given the known unknowns with LPS implementation dates, SWE will make a decision on a suitable date in consultation with course providers and other key stakeholders to ensure that there is sufficient time to prepare before the AMCP standards begin.

End-of-life care for patients with prolonged disorders of consciousness following withdrawal of life-sustaining treatment: Experience and lessons from an 8-year cohort

Professor Turner-Stokes et al have published[6] their retrospective analysis of implementing the Royal College of Physicians guidelines 'Prolonged disorders of consciousness: National Clinical Guidelines',[7] in an eight year cohort of 80 patients with prolonged disorders of consciousness (PDOC) who died - End-of-life care for patients with prolonged disorders of consciousness following withdrawal of life-sustaining treatment: Experience and lessons from an 8-year cohort: The guidelines were authored in 2013, but following the Supreme Court decision in *An NHS Trust v Y UKSC*, 2018[8] were updated in 2020, which held that if the provisions of the MCA 2005 are followed and the relevant guidance observed, and if there is agreement upon what is in the best interests of the patient, the patient may be treated (and in particular CANH withdrawn) in accordance with that agreement without application to the court. For our commentary on that case - in which no less than 7 members of chambers were involved – see here.

This study examines the experience and lessons learned from implementing the guidelines in the 80 PDOC patients who have died in one tertiary centre since 2014.The findings of note are as follows:

- CANH was withdrawn in 39 out of the 80 patients (49%), over half of whom were already imminently dying.
- Even in a centre where patients are referred for this purpose, elective CANH withdrawal is comparatively rare (just 14 patients since 2018). All of these had complete documentation using the recommended proforma, and met the standards set out in the national guidelines for documented best interests decision-making and appropriate independent external scrutiny.
- Overall, there was little difference between the groups in whom CANH was, and was not, withdrawn other than that

[6] In Clinical Medicine 2022, Vol 22, No 6, 559 - 565
[7] RCP, 2020. www.rcplondon.ac.uk/guidelinespolicy/prolonged-disorders-consciousness-national-clinical-guidelines
[88] www.bailii.org/uk/cases/UKSC/2018/46.html

the former required higher doses of analgesia/sedation.
- The recommended End of Life protocol provided good symptom control for the majority of patients to support a peaceful and dignified death.
- About a quarter of patients had symptoms that were difficult to control, requiring higher doses of medication, but there was no evidence that this hastened death.

Strasbourg Update

G.M. and Others v The Republic of Moldova 44394/15 (Judgment : Preliminary objection joined to merits and dismissed : Second Section) [2022] ECHR 1010 (22 November 2022)

Arnar Helgi Larusson v Iceland 23077/19 (Judgment : No Article 14+8 - Prohibition of discrimination : Third Section) [2022] ECHR 402 (31 May 2022)

Mortier v Belgium (Application No 78017/17, decision of 4 October 2022, available only in French)

The European Court of Human Rights has decided a number of cases of relevance recently for those concerned with mental capacity.

In *Mortier v Belgium* (Application No 78017/17, decision of 4 October 2022, available only in French), the court considered the compatibility of the Belgian euthanasia regime with the ECHR. The court found that, whilst it was not possible to infer from Article 2 ECHR a right to die, the right to life enshrined in Article 2 could not be interpreted as prohibiting conditional decriminalisation of euthanasia, accompanied by adequate and sufficient safeguards to prevent abuse and thus ensure respect for the right to life. The court was clear that the legislative framework governing pre-euthanasia procedures had to ensure that the patient's decision to request such an end to life was taken freely and with full knowledge. The court found that the provisions of the relevant legislation constituted a framework capable of ensuring the protection of the right to life. However, on the facts of the case (concerning a request for euthanasia on the basis on the mental, rather than physical suffering), the court found the application of that framework had given rise to a procedural breach of Article 2 because of failures as regards the operation of the mandatory post-euthanasia review board, and the length of the criminal investigation launched following the applicant's complaint. The court, however, found that that the applicant's right to respect for his private life under Article 8 had not been breached by his exclusion from his mother's euthanasia process, in circumstances where his relationship with his mother had broken down.

In *GM v the Republic of Moldova* [2022] ECHR 1010, three women with learning disabilities (but who had not been legally 'incapacitated)' were detained in an institution. They were raped by the head doctor there and were forced to undergo abortions and then have contraception implanted against their will. The court noted that, whilst cases concerning medical treatment will normally fall to be considered under Article 8 ECHR, medical interventions against a person's will can be regarded through the prism of Article 3 if they ill-treatment attaining a sufficient degree of severity. This was such a case, given the "invasive medical interventions to which they were allegedly subjected, if established, combined with the applicants' vulnerability - resulting from such elements as their gender, disability and institutionalisation" (paragraph 89) The court also observed that the allegations of non-consensual contraception "could not be seen separately from the allegations of non-consensual abortions, as they could raise issues about a systemic denial of agency to institutionalised women with intellectual disabilities concerning their reproductive rights" (paragraph 90). The court identified that "the Government failed to demonstrate the existence of any legal provisions, safeguards and

mechanisms meant to support persons like the applicants, who were intellectually disabled but had not been deprived of their legal capacity, to express a valid and fully informed consent for medical interventions, especially in respect of abortions and contraception. Even the 2020 updated national standards seem to transfer the decision to the legal representative and do not envisage situations such as that of the applicants […]). In this connection, it has not been shown by the Government that there existed any practice to provide persons with intellectual disabilities with information in a manner accessible to them" (paragraph 124). The court found that the framework in Moldova lacked "the safeguard of obtaining a valid, free and prior consent for medical interventions from intellectually disabled persons, adequate criminal legislation to dissuade the practice of non-consensual medical interventions carried out on intellectually disabled persons in general and women in particular, and other mechanisms to prevent such abuse of intellectually disabled persons in general and of women in particular [and] falls short of the requirement inherent in the State's positive obligation to establish and apply effectively a system providing protection to women living in psychiatric institutions against serious breaches of their integrity, contrary to Article 3 of the Convention" (paragraph 128). Given that the court referred to the CRPD, it is perhaps striking that the court seemed willing to countenance that the situation would have been different if the women had been legally incapacitated (which the CRPD Committee would not accept is legitimate).

In *Arnar Helgi Larusson v Iceland* [2022] ECHR 402, the court considered that, whilst the claim fell within the ambit of Article 8 ECHR, there had been no discrimination for purposes of Article 14 read together with Article 8 against a wheelchair user unable to access two local public buildings. The court noted that Article 14 ECHR had to be read in light of the requirements of Article 2 CRPD regarding "reasonable accommodation" - understood as 'necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case'" - which people with disabilities are entitled to expect in order to ensure 'the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms.' […] Such reasonable accommodation helps to correct factual inequalities which are unjustified and which therefore amount to discrimination" (paragraph 59). (see *Çam*, § 65, and *Toplak and Mrak*, § 114, both cited above). The Court finds that these considerations apply equally to the participation of people with disabilities in social and cultural life. It notes, in this regard, that Article 30 of the CRPD explicitly requires the States Parties to guarantee to people with disabilities the opportunity to take part on an equal basis with others in cultural life (see paragraph 25 above). On the facts of the case, the court found that the authorities had taken "considerable measures to assess and address accessibility needs in public buildings, within the confines of the available budget and having regard to the cultural heritage protection of the buildings in question," and that the State had not failed to comply with its "positive obligations by taking sufficient measures to correct factual inequalities impacting the applicant's equal enjoyment of his right to private life."

Consent to stopping medication: a view from Singapore

Chia Soo Kiang (personal representative of the estate of Tan Yaw Lan, deceased) v Tan Tock Seng Hospital Pte Ltd and others [2022] SGHC 259 (13 September 2022)

In a posthumous personal injury claim, the Singaporean High Court considered whether consent was required for clinicians to cease offering medication.

Tan Yaw Lan was 74 years of age, and had a number of chronic health conditions. She had been admitted hospital due to a heart attack in January 2018, and was treated as an outpatient

later in the year. In April, she was taken to the Emergency Department due to suffering from sepsis (which was complicated by her underlying health conditions), for which she was admitted and treated. However, during her admission, she suffered a further heart attack and passed away three weeks later.

A claim was brought in negligence on the basis both in relation to alleged failures in Mrs Lan's care. A *'second cause of action is founded on a failure to obtain consent from Mdm Tan when the doctors stopped her medication of aspirin, losartan and Lasix'* [11] during the course of her treatment in hospital. The claimants also argued that the change in medication had been negligent, which was rejected on the basis of the expert evidence. The court robustly rejected the contention that doctors required the consent of the patient to withdraw medication:

> *29 …It is indubitably accepted that a doctor cannot commence treatment without his patient's consent, but it has never been contemplated until now that a doctor cannot stop treatment without the patient's consent. This is not because better minds had not thought of it previously, but because the cessation of medication is a strictly clinical decision; and one that exposes the doctor to negligence if he were indeed negligent in doing so — not for failing to get the patient's permission to do so. There are exceptions, as Dr Yeo testified, but they involve major treatments such as those for cancer.*
>
> *30 A wrongful cessation of medication is a matter of negligence simpliciter. Or, if a doctor stops or threatens to stop medication in order to obtain payment, then it is an ethical problem for an ethics committee to investigate. It is inconceivable to expect a doctor, for example, to ask a patient if he would like a Panadol. He may have to check if the patient has any relevant allergies, but does not have a duty to ask if the patient consents to a pain-killer, an anti-inflammatory, an anti-histamine, or such other drugs, though he might tell the patient to stop taking the medication once he feels better. Conversely, if he finds that a given medication is not working for the patient, he will stop it. Saying that he will advise the patient that he should stop using it is a polite way of telling the patient that he should stop it. If the patient refuses, the doctor is entitled to say that he will not prescribe it. He cannot be expected to prescribe a drug that he had just advised should not be used. The patient is not the clinician, but a clinician cannot be expected, as Dr Kang says, to provide a "running commentary". The idea of liability for not seeking a patient's consent to stop medication or treatment under the guise of informed consent is a solution without a problem. On the contrary, it will be the seed of big problems.*

National Mental Capacity Forum

On 7 December, the National Mental Capacity Forum held a webinar, *"Families and the MCA"*. Slides from the webinar, and a recording of the webinar itself are now available here. The slide deck includes a number of live embedded links for accessing further materials.

Short note: when consent is insufficient

In *London Fire Commissioner v Bupa Care Homes (ANS) Ltd* [2022] EWCA Crim 1508, a care home provider unsuccessfully sought to appeal against the sentence imposed for breach of fire regulations following the death of a resident in one of its care homes. The resident, a smoker, was profoundly impaired physically; whilst he had a degree of cognitive impairment, he was described as being able to make many of his own decisions within the home's caring environment. He died after catching fire whilst smoking a cigarette. He Whilst BUPA had

pleaded guilty, it sought to appeal on the basis that the judge should not have found that its breaches of the regulations led to the resident's death. For present purposes, of most relevance is BUPA's attempt to challenge the judge's conclusion that measures requested of smoker residents to reduce fire risk did not amount to aspects of their care and treatment for the purpose of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, such that the residents' consent was not required. The Court of Appeal gave short shrift to this ground of appeal:

> *84. As it did to the Judge, it seems to us entirely counter-intuitive to countenance a requirement for consent in the context of necessary safety precautions. Supervision of resident smokers was a matter pertaining to the manner in which care homes are run in order to keep residents safe. It was not about the provision of care or treatment requiring consent. Put another way, BUPA could not allow its residents to smoke unsafely. If residents could only smoke safely with supervision, then proper supervision had to be put in place. As Ms Naqshbandi put it, lack of consent cannot trump safety.*
>
> *85. The expert evidence was consistent with this approach. Mrs Jejna's evidence was that she had never come across a situation where a resident had refused supervision of smoking. But if it was unsafe for a resident to smoke unsupervised, and supervision was refused, it would be for the care home management team to take further steps to deal with the situation. It might be that the person could be asked to move to another care home. It was not a situation where the resident's wishes came before safety.*
>
> […]
>
> *87. Finally, there is the added complication on the facts that Mr Skyers was in any event never asked to give his consent to supervision for safety reasons, let alone did he refuse to give it. The Judge made no (and was not asked to make any) findings in this regard. But if BUPA was obliged under the* [relevant fire regulations] *to supervise Mr Skyers whilst outside smoking, and there was an obligation to gain his consent for such supervision, then there was another failure on the part of BUPA in failing to seek it or, taking it into the realm of the general, rather than the person-specific, a failure to put in place arrangements for the obtaining of consent from residents.*

The conclusion on this ground of appeal is perhaps unsurprising, but it is a helpful reminder that it is always important before stampeding off to consider questions of capacity to consent that thought is given as to whether the action in question is actually one for which consent is required.

New Zealand decision-making capacity review

The Law Commission of New Zealand has published a Preliminary Issues Paper (PIP) in its review of adult decision-making capacity. The PIP is available on its project website along with summaries of the PIP (including in te reo Māori and accessible formats), and a range of ways to submit. The website also includes a short video about this review, and information about two upcoming webinars. The Law Commission is now calling for submissions, due by 5pm 3 March 2023. Submissions we receive will help inform a second Issues Paper in 2023, where the Law Commission will look at the law in greater detail and likely propose some options for reform. In 2024 the Law Commission will present our final recommendations to the government. Of particular interest to those readers in the United Kingdom is likely to be Chapter 5, showing the Law Commission's initial steps towards trying to think about capacity issues in the Māori context – which may, in turn,

prompt thoughts about how to approach capacity in a multicultural context.

'The Impact of Care Act Easements under the Coronavirus Act 2020 on older carers supporting family members living with dementia at home'

This month saw the publication of the research that Neil has been doing with colleagues at the University of Manchester which has revealed widespread statutory breaches of the Care Act because local authorities did not trigger easements during the pandemic rationing of social care. The full report is available here and below we reproduce the summary briefing:

Context and Project Aims:
The Coronavirus Act 2020 gave emergency and enabling powers across legal domains, including "easement" powers for local authorities in England temporarily to water down the majority of their adult social care duties under the Care Act 2014. Triggering stages 3 and/or 4 easements protected local authorities from legal action for failure to comply with statutory duties if they were unable to do so because of crisis circumstances. Eight out of 151 local authorities triggered stage 3 or stage 4 easements between April and June 2020.

With a focus on older carers of family members living at home with dementia, the project aimed to:

(i) document the impacts of Care Act easements and reinstatement of statutory duties;
(ii) compare these with experiences in local authorities where easements were not formally triggered but services were cut;
(iii) understand how policymakers with safeguarding responsibilities approached the issues;
(iv) understand and document current urgent needs.

Methods:

The project undertook 48 in-depth interviews with people over 70 who had been supporting their spouse or partner living with dementia to live at home in England; in-depth interviews with 27 professionals in social work leadership roles at 20 Local Authorities; a survey of 604 caregivers who were supporting a family member living with dementia at home from across the UK; and legal analysis of the operation of the Care Act easements.

Summary of key findings:

- Easements were differentially implemented based on conflicting advice and understanding. Easements were soon revoked, and not in force for any local authority beyond July 2020.
- Carers in easement and non-easement areas experienced similar and ongoing changes from their usual care and support, unrelated to the easement periods or whether their local authority had invoked easements. Long beyond the easement period, carers struggled without access to many pre-existing support routes while those they cared for were rapidly deteriorating mentally, physically and socially. The research reveals a population in acute distress and suffering from very poor mental health.
- Given the extent of unmet need among carers in this study, on the face of it there appears to have been a high risk of instances where statutory duties under the Care Act owed to carers were not met, without litigation, regulatory intervention or other consequence. There is a danger that this precedent means that Care Act statutory duties may have been permanently undermined, in the context of local authority resources for social care increasingly reported as at a critical point.

Implications:

- The easements legislation did not prevent substantial reductions in support to carers. Legal, practical, and resourcing responses provided insufficient support for older carers in need.

- Care pathways after a dementia diagnosis are problematic with little integration between medical pathways and holistic care and support for carers. Mechanisms need to be developed to identify carers and the people they care for as at risk of needing intervention and support in crisis circumstances. Better practical, logistical and mental health support for carers seems urgently needed.
- Local authorities need resourcing for real alternatives to services closed in the pandemic, and strategies for ensuring safe home and respite care during a pandemic that (a) does not present unacceptable risks and (b) maintains sufficient quality of provision.
- Strategies need to address how to protect and preserve the social care workforce in a crisis.

Monitoring the Mental Health Act

Two recent reports from the CQC make (predictably) depressing reading. The first, Who I am Matters – A report into the experiences of being in hospital for people with a learning disability and autistic people, is a report based upon 8 visits to hospitals in February and March 2022, and found that, although there were pockets of good practice, people with a learning disability and autistic people are still not being given the quality of care and treatment they have a right to expect when they go to hospital. The second, its annual Monitoring the Mental Health Act report, shows that matters are going backwards as regards the delivery of mental healthcare, at precisely the point that the draft Mental Health Bill is being scrutinised by Parliament. With specific reference to DoLS, the report notes that:

> *Lack of training for staff in mental health hospitals is an ongoing area of concern. Without appropriate training, staff struggle to understand people's legal rights under the MHA, MCA and DoLS. In some cases, this means that a DoLS application has not always been considered when at times it should have been. We have also found that there is a misconception that if people were happy to be on a ward, then they could be classed as informal patients, without considering whether they had capacity to consent. As a result, we are concerned that people could be confined in hospital without the appropriate legal framework to protect them or their human rights.*
>
> *In some cases, we have found confusion among nursing staff over the legal status of patients who may be subject to DoLS on the basis of an application that is awaiting action from the local authority. We have also seen examples where the capacity and consent of patients is unclear.*
>
> *We are aware that on some older people's wards, patients are admitted under section 2 of the MHA and when this expires, a DoLS authorisation is applied for to enable a continued stay on the ward if further hospital care is required. In very many cases, this is now effectively arranging for unauthorised detention to start immediately or, at best, in the 14 days after a renewed urgent DoLS authorisation expires and a longer-term authorisation has not yet been granted.*

2000 Hague Convention on the International Protection of Adults update

We covered the Special Commission on the Practical Operation of the 2000 Hague Convention on the International Protection of Adults in the Scotland section of our November report. The Conclusions and Recommendations of the Special Commission have now been published; we await the publication of the Practical Handbook (for true enthusiasts, the draft version can be found here).

SCOTLAND

Decision to close day service reduced

On 20th September 2022 Lady Carmichael, sitting in the Outer House of the Court of Session, reduced a decision of 4th June 2019 by Scottish Borders Council so far as relating to a service called Teviot Day Service, which had previously been attended three times per week by an adult with Alzheimer's Disease identified as CD. The Council's decision purported to close that service.

A petition for judicial review of the decision had been brought by CD's son and guardian, identified as AB. The decision is reported as *B v Scottish Borders Council* [2022] CSOH 68, also at 2022 SLT 1311. AB sought declarator that the Council had failed to perform its public sector equality duty under s149 of the Equality Act 2020, and that the purported decision was unlawful, in respect that it frustrated AB's legitimate expectation that there would be consultation. Readers who detect that they have heard a somewhat similar story before will be recollecting *McHattie v South Ayrshire Council* [2020] CSOH 4; 2020 SLT 399, which we described in the Scotland section of the February 2020 Report. The *McHattie* decision was referred to, and passages from it were quoted with approval, by Lady Carmichael in *B v Scottish Borders Council*.

AB had received various communications referring to "the re-imagining of day services in the Scottish Borders", or similar generalised descriptions, which did not identify any proposal to close the centre attended by his mother. Only on 3rd June 2019 did AB learn from a news release of the terms of a recommendation to be put before the Council's Executive Committee, including closure of the centre attended by his mother. He immediately emailed a number of councillors expressing his concerns, which included that there was no suitable alternative for his mother in Hawick. As to an Equalities Impact Assessment ("EIA"), it would appear that the only information put before the Executive Committee for the meeting of 4th June 2019 was a statement that *'an [EIA] has been carried out on this proposal and it is anticipated that there are no adverse equality implications.'* As to the EIA itself, it would appear that this was contained in a "rolling document", the only record of which was a narrative of various matters over a lengthy period, with no dates attached such as would focus what was available before the decision of 4th June 2019. Counsel for the Council did not submit that the document was completed before 4th June 2019 and conceded that it might have been as late as August 2019.

On 6th June, two days after the decision, AB received a letter from his MP enclosing an email from the Leader of the Council, which included the assertion: "*No day centre will be closed until every client is happy with the package that is in place for them. That commitment is absolute and is confirmed in the paper for the Executive. If day centres were the best option and gave the best outcomes, then we would be continuing with day centres …*". CD was in fact one of two service users for whom the Council was unable to agree alternative packages of care before the centre in fact closed.

Those advising local authorities will no doubt wish to take particular note of Lady Carmichael's criticism of the concept of a "rolling document" (my terminology) without a clear record of what it contained at any particular date and – crucially – what was the state of the claimed EIA put before, or at least reported to, the Executive Committee when it made its crucial decision. Following both *McHattie* and this case, such advisers will no doubt wish to ensure that in future there is a clearly dated record of intimation to those with a legitimate interest of a process that could result in closure of a facility, that they were afforded a realistic opportunity to provide evidence as to the impact of closure, and that their views, including as to the impact of closure, were recorded and taken into account.

Lady Carmichael discussed what is necessary to fulfil the duty imposed by s149 of the 2020 Act upon a public authority to have due regard to the need to eliminate discrimination that is prohibited by or under the 2010 Act, to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not, and to foster good relations between persons who share a relevant protected characteristic and persons who do not. On this she quoted aspects of the decision by Lord Boyd of Duncansby in *McHattie*. Decision-makers must be aware of the duty to have due regard to such matters. It must be fulfilled before and at the time when a particular policy is being considered. It must be "exercised in substance, with rigour, and with an open mind". It is not a question of "ticking boxes". The duty is non-delegable, and is a continuing one. It is good practice for a decision-maker to keep records demonstrating consideration of the duty (paragraph [24] of the decision in *McHattie*). In the following two paragraphs Lord Boyd drew attention to three important aspects of that summary. The duty has to be fulfilled before a policy that might affect a particular class of protected persons is adopted. It must be exercised in substance, with rigour and an open mind. The duty is of a continuing nature, meaning that as policy evolves due regard has to be had to the s149 duty.

Key points noted by Lady Carmichael in her judgment were that the EIA, such as it was, did not relate specifically to the service with which the petition was concerned, but rather to a proposal that "some existing day centre provision" be de-commissioned. There was no assessment before 4th June 2019 of the impact of bringing to an end the service provided at the Teviot Day Centre. It contained "very brief summaries" of the bases on which there might be negative impacts on persons sharing the relevant characteristics. It records "an aspirational assertion" about the development of alternatives, but did not "contain any detail as to the needs of individuals using the service, or any evidence-based assessment that there would be suitable alternatives for the individuals in question". It contained no evidence from users of the service. There was no evidence about the needs of potential future service users who shared the protected characteristics. There was no indication that the Council considered with rigour the possibility that the service might remain open, or that doing so might be necessary to meet the needs of persons with disabilities similar to those of CD. Lady Carmichael concluded that the Council did not fulfil its duty to consult with the users of the service.

This Report picks out selectively some aspects of Lady Carmichael's judgment. It should be read in full by anyone engaged in such processes. While one would hope that the decisions in this case, and before it in *McHattie*, will prevent repetitions of the circumstances addressed in those cases, advisers to clients seeking to challenge such decisions after they have been made should also refer in full to Lady Carmichael's decision.

Adrian D Ward

New checklist for measures to be used cross-border

The decision dated 8th December 2022 in the Court of Protection by Mr Justice Mostyn in the matter of *SV between the Health Service Executive of Ireland (Applicant) and Florence Nightingale Hospitals Limited (Respondent)*, [2022] EWCOP 52, is essential reading for any Scottish practitioners before applying here for a measure of protection (as referred to in Hague Convention 35 on the International Protection of Adults) which may subsequently require an order for recognition and enforcement elsewhere. "Elsewhere" certainly includes the other 13 countries in respect of which Hague 35 has been ratified, together with any such as England & Wales which has effectively incorporated the

regime of Hague 35[9]. It also forms a useful starting-point where any other state is likely to be involved, as experience indicates that the effective requirements in other states – though they may be expressed differently – tend broadly to a align with those of Hague 35, though it is of course necessary to check the private international law rules and any relevant other domestic rules of such anticipated "receiving state".

The principal coverage of the *SV* case is by Arianna in the Practice and Procedure section of this Report, which should be read in conjunction with the coverage here, which focuses solely upon the viewpoint from Scotland. Given the amount of "cross-border traffic" in such matters between Scotland and England & Wales, addressing the decision from the viewpoints of both of those jurisdictions is appropriate. Moreover, doing so at this present time is particularly appropriate, as latest information available to me is that ratification of Hague 35 in respect of England & Wales is still "in the pipeline" of intentions (as confirmed by Minister Tom Pursglove in the context of the World Congress on Adult Capacity in Edinburgh in June 2022), with indications that it might be achieved during 2023. At present, in both geographical and legal respects, ratification of Hague 35 is narrowly limited to European states in the "civil law family". The substantial superstructure of English law and other common law jurisdictions which has been laid on top of our civil law foundations makes us particularly aware of the differences. If England & Wales should indeed be the first common law state to ratify, that might create a useful trigger for further ratifications spread more widely across the legal and geographical landscape. Moreover, the current work of the Hague Conference in relation to Hague 35[10] may also stimulate further ratifications.

The key facts are that *SV* is a 20 year-old female Irish citizen, diagnosed with anorexia nervosa and symptoms of bulimia nervosa, has been admitted to hospital in Ireland multiple times, and in the view of the healthcare professionals treating her, her condition had reached a seriousness where as a matter of urgency she required placement in a specialist eating disorder unit, not available in Ireland, but the applicant had found a suitable placement in England, in a hospital run by the respondent.

The most significant part of the judgment of Mr Justice Mostyn is the "blank checklist" prepared by him and appearing as Annex A to his judgment. That checklist should be followed here in Scotland in relation to any application for a potentially relevant measure here in Scotland. Annex A is to be commended for discreetly improving the occasionally wayward drafting of Hague 35. For example, items (a) and (c) of question 7 reflect the meaning, but not the drafting, of Article 3 of Hague 35. Item (a) reflects verbatim the corresponding item in Hague 35: "the determination of incapacity and the institution of a protective regime". However, it alters item (c): "guardianship, curatorship and analogous institutions" to "guardianship, curatorship or any corresponding system". A basic principle of good draftsmanship requires, as far as possible, language which is clear and unambiguous. The use of "institutions" in (c) does not meet those criteria, and the scope for confusion is increased by the quite different, and appropriate, use of "institution" in (a). On that use of "institutions", see the last paragraph of this item.

Annex A should be read in conjunction with other particularly helpful parts of the judgment, including the identification of five aspects in relation to which the domestic law of the receiving state should be checked, stated in

[9] See Schedule 3 of the Mental Capacity Act 2005, easily remembered as it serves broadly the same function as Schedule 3 of the Adults with Incapacity (Scotland) Act 2000.

[10] See the item "Special Commission meeting of Hague 35" commencing on page 3 of the Scotland section of the November Report.

paragraphs 27, 31, 33, 37 and 39 of the judgment, and explained in the paragraphs following each of those. From a Scottish perspective, it is also helpful that Mr Justice Mostyn has taken particular account of the law of Scotland, inviting reciprocation of that courtesy by Scottish practitioners envisaging that a measure sought here might require to be "exported" to England & Wales. Thus in paragraph 35, explaining the third of those five aspects, he refers to the position as being different in Scotland because of explicit provision in Schedule 3 of the 2000 Act (paragraph 7(1), employing the definition of "adult with incapacity" to be taken from section 1(6)). Also, he gently points out that the Court of Protection serves only England & Wales, where the "imported" Irish judgment refers to the United Kingdom.

However, any practitioners from England & Wales who also read this section, and persist to the end of this item, should note that where in footnote 1 to paragraph 17 of his judgment Mr Justice Mostyn states with reference to rules for registration in Scotland of foreign judgments: "I do not know if any such rules have been passed", the answer is to be found in Part X of the standard English textbook "Court of Protection Practice", re-published in full every year, in the case of the 2022 volume beginning at paragraph 10.144, where reproduced in full is Part XXIV "International Protection of Adults" of the Act of Sederunt (Summary Applications, Statutory Applications and Appeals Etc.) Rules 1999.

On the use of "institutions" in 3(c) of Hague 35, note that in the Oxford Companion to Law (OUP, 1980), Professor David M Walker commences his description of "legal institutions" as: "A term of rather uncertain connotation". That is enough to flag up a potential for ambiguity. He continues: "It sometimes means established and significant elements in a system of law, e.g. marriage, property, inheritance, and courts, as distinct from individual specimens of each, to each of which attach a large number of specific principles and rules attach, defining how and when an individual instance comes into being or terminates, its characteristics, functions, and attributes, and the legal consequences in various circumstances of its existence". That use of "institutions" might have influenced the drafting of Article 3(c), but even then one might question whether guardianship and curatorship, hardly fixed concepts in the many varied uses of the terms or over time, qualify as "legal institutions" or rather as components of the larger subject of mental capacity/adult incapacity (in the rather outdated wording of Hague 35, protection of adults).

Adrian D Ward

Model laws for advance choices

Readers in Scotland might be particularly interested to note that the part that related to advance choices of the work of a cross-committee working group of the Law Society of Scotland, described at page 6 of the Scotland section of the May 2022 Report, is to be carried forward following the adoption by the Council of European Law Institute ("ELI") on 1st December 2022 of a project to draft model laws for advance choices, to be offered for use throughout Europe, with appropriate supporting materials designed to encourage and enable states to legislate, and thereafter to assist each state in education of public and professionals, and encouraging uptake. The announcement of the project appears on the ELI website here.

This is not a private international law project. It does seek to offer optimum provision for advance choices across Europe, with as much consistency as reasonably achievable, which is likely to assist recognition (in the non-technical sense of the term) and operability across Europe. Leading experts from 14 representative jurisdictions across Europe from Portugal in the south west to Finland in the north east, and including both Scotland and England & Wales, have agreed to provide input from the viewpoints of their own jurisdictions, including as to how a regime for advance choices might best fit the overall structure and requirements (including

those of any applicable civil code) of their own jurisdiction. The current coverage, however, does leave some significant "blank spaces" across Europe, with the possible addition of some further jurisdictions.

Appointed to the Advisory Committee for the project have been appointees drawn from both the previous Scottish project and – rather more coincidentally – two who were members of the organising committee for the 2022 World Congress on Adult Capacity held in Edinburgh in June, though they have been appointed more for their analogous knowledge and experience of a range of official functions in relation to powers of attorney, and promotion of uptake of powers of attorney, in particular by the "mypowerofattorney" campaign.

As well as not being a private international law project, the project proposes not to stray into issues of law reform beyond effectively "filling the gap" to enable people to –

- give instructions
- record preferences
- express wishes

with certainty as to how to create advance choices, by documents or other means, and as to the effects of advance choices when they become operable. It is envisaged that the competence and legality of provisions contained in advance choices will be governed by the law of the place of operation at the time when they become operable. Thus, the general principle will be that people will not be able to do or decide anything by advance choice which they could not – if capable – do or decide at time when the advance choice becomes operable. The time-lag, in many cases of uncertain and unpredictable duration, between creation and operability will be the main feature distinguishing advance choices from acts and decisions having immediate effect. Making appropriate provision in law for that, linked to the requirements and safeguards for creation, will be among the challenges to be addressed by the project.

Adrian D Ward

Final report on WCAC 2022

The final evaluation report in respect of the World Congress on Adult Capacity 2022, held in Edinburgh on 7 - 9 June 2022, is now available by a prominent link on the first page of the Congress website, at: www.wcac2022.org. Production of the evaluation report was made possible by the generous support of the Faculty of Advocates.

Adrian D Ward

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Conferences and Seminars

Forthcoming Training Courses

Neil Allen will be running the following series of training courses:

13 January 2023	Court of Protection training
26 January 2023	MCA/MHA Interface for AMHPs
1 February 2023	DoLS Authoriser Training (9:00-13:00)
2 February 2023	Necessity and Proportionality Training (morning and afternoon sessions)
16 February 2023	BIA/DoLS update training (9:30-16:30)
16 March 2023	AMHP Legal Update (9:30-16:30)
23 March 2023	Court of Protection training (9:30-16:30)
30 March 2023	BIA/DoLS update training (9:30-16:30)

To book for an organisation or individual, further details are available here or you can email Neil.

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 February. 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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