

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

- (1) In the Health, Welfare and Deprivation of Liberty Report: the Court of Appeal grapples again with sexual capacity, and important reminders of best interests as good governance and operating in an imperfect world.
- (2) In the Property and Affairs Report: Simon Edwards retires, and deputyship updates;
- (3) In the Practice and Procedure Report: flight risk, and a coercive control dilemma regarding a lasting power of attorney;
- (4) In the Mental Health Matters Report: a Mental Health Bill update, detainability and the courts, and Right Care, Right Person under scrutiny;
- (5) In the Wider Context Report: Assisted dying / assisted suicide developments, capacity and surrogacy and two important Strasbourg cases;
- (6) In the Scotland Report: Kirsty Mcgrath retires, and a blank space for developments regarding legislative reform in Scotland.

There is one plug this month, for a [free digital trial](#) of the newly relaunched Court of Protection Law Reports (now published by Butterworths). For a walkthrough of one of the reports, see [here](#).

You can find our past issues, our case summaries, and more on our dedicated sub-site [here](#), where you can also sign up to the [Mental Capacity Report](#).

Her fellow editors know that you will join us in congratulating Arianna on her recent appointment as a Recorder: she will sit in Family cases on the North Eastern circuit (alongside sitting as a fee-paid First-Tier Tribunal judge, (Mental Health) and fee-paid Court of Protection judge).

As is now standard, there will be no January report (but Alex will give essential updates on his [website](#)); we hope that at least some of you will get something of a break over the December period.

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

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HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

Capacity, sexual relations and public protection – another go-round before the Court of Appeal

Re ZX (Capacity to Engage in Sexual Relations) [2024] EWCA Civ 1462 Court of Appeal (Sir Andrew McFarlane P, Baker and Andrews LJ)

Mental capacity – sexual relations

Summary¹

This was a leapfrog appeal from a Tier 2 Judge to the Court of Appeal; a relatively recent innovation. It concerns the thorny issue of capacity to engage in sexual relations. At first instance HHJ Burrows had been confronted, to his considerable (and understandable) disquiet, with the need to determine whether an 18 year old man had capacity to make decisions about engaging in sexual relations with others. His discomfort arose from the fact that the local authority was having to have recourse to the Court of Protection to respond to a situation where the man in question was posing a (largely self-reported, but on the face of it non-trivial) sexual threat to others, but where neither mental health services nor the criminal justice system could respond.

The independent psychiatric expert, Dr Ince, changed his mind following the decision of Theis J in A Local Authority v ZZ [2024] EWCOP 21, which Dr Ince considered had changed the law. In particular, Dr Ince took the view that there was sufficient evidence to demonstrate that what ZZ said within an assessment setting could not be relied upon, and that he continued to display a range of behaviours that disregarded the norms and education provided to him. HHJ Burrows considered that:

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

At paragraph 115 HHJ Burrows held that:

At the moment this judgment is written, I am satisfied that his behaviour in connection with sexual activity in combination with his mental disorder [identified earlier in the judgment as conduct

¹ Tor having been involved in the case, she has not contributed to this.

disorder, ADHD and attachment difficulties] means that he is unable to use and weigh relevant information concerning his would be or actual sexual partner's refusal to, or withdrawal of, consent in in real time.

Three grounds of appeal were put forward:

- That HHJ Burrows had applied the wrong legal test to the decision, and in doing so erroneously lowered the standard and quality of evidence that was required to rebut the presumption of capacity enshrined in s.1 MCA.
- That HHJ Burrows was wrong to conclude that ZX lacked capacity to consent to sexual relations by reason of being unable to use or weigh information "in the moment".
- That HHJ Burrows was wrong to consider wider issues relating to the protection of the public and the non-availability of mental health services and/or involvement of the criminal justice system when determining whether ZX had capacity to make the decision; and to accept the evidence of Dr Ince given Dr Ince's reliance on these considerations.

Baker LJ, giving the lead judgment identified as a starting point that:

58. The assessment of capacity to engage in sexual relations presents challenges to psychiatrists and judges alike. The evaluation of whether P is unable to understand, retain, weigh and use the information identified in JB because of an impairment of, or disturbance in, the mind or brain is never straightforward and often difficult.

However, he continued:

In this case, there were specific difficulties which made the assessment undertaken by Dr Ince and the judge even more arduous than usual. I regret to say, however, that the decision that ZX lacks capacity to engage in sexual relations was flawed and will have to be reconsidered.

He made clear that:

59. The approach to be followed when assessing capacity in this area under sections 2 and 3 of the MCA is as prescribed by the Supreme Court in JB. It has not been materially amended by any subsequent decision. The decision in Re PN did not change the law. In some cases, as suggested by Poole J, it may be appropriate to focus on whether P is able to use the relevant information "in the moment", (i.e. when he is initiating, or about to initiate, sexual activity with another person) and, if not, whether that inability is due to an impairment of, or disturbance in, the mind or brain. The second limb of the information specified in JB includes not only "the fact that the other person must be able to consent to the sexual activity" but also that the other person "must in fact consent before and throughout the sexual activity". That is consistent with a focus on whether P is able to use the information "in the moment". It is also entirely consistent with the observation of this Court in Re M, endorsed by the Supreme Court in JB, that "the notional decision-making process attributed to the protected person with regard to consent to sexual relations should not become divorced from the actual decision-making process carried out in that regard on a daily basis by persons of full capacity".

Further:

60. Similarly, the decision in *Re ZZ* did not change the law in this regard. In that case, Theis J allowed an appeal because of a series of errors by the judge at first instance. I am unclear why it was considered necessary or appropriate in the present case to send Dr Ince a 3-page summary of the decision. In their submissions to this Court, Mr O'Brien and Ms France-Hayhurst stress that it was never suggested to Dr Ince that *Re ZZ* had changed the law, the "test" in *JB*, or the "threshold". But it is plain from the transcript of the hearing on 2 May that Dr Ince thought it had. His response to receiving the 3-page note was to study the whole judgment on *BAILII*. He said that "in the light of the *ZZ* judgment I've revised my view around capacity to engage in sexual relations". Later he said that he thought the decision had "changed where the bar is". This misinterpretation undermined the reliability of his conclusions in his addendum report.

In turn:

61. In his judgment, the judge correctly stated that *Re ZZ* had not changed the law but was rather an application of the existing law. But he did not give sufficient consideration to whether Dr Ince's misunderstanding about the judgment undermined the reliability of his revised opinion. I accept Ms Butler-Cole's submission that the erroneous basis on which Dr Ince proceeded significantly raised the bar as to what a person needs to understand in order to have capacity.

62. For those reasons, the whole process of assessing capacity in this case was flawed. The judge should have declined to proceed on the basis of an assessment conducted on an erroneous basis. I also accept Ms Butler-Cole's submission that, given the radical change in Dr Ince's understanding of the basis of assessment between his first and addendum reports, the proper course would have been to direct a further interview and assessment before the court reached a conclusion.

Baker LJ then went to make clear, in any event, why HHJ Burrows' approach was flawed on its own terms:

64. The central planks of Dr Ince's analysis were (1) that ZX's impulsivity was the reason for concluding that, "in the moment" of sexual activity with another person, he was unable to use or weigh the fact that the other person must be able to consent to the sexual activity and must in fact consent and (2) that this impulsivity was due to his diagnoses of ADHD, conduct disorder and attachment difficulties. The judge rejected Dr Ince's view that ZX was acting impulsively, holding instead that he was "cunning", "opportunistic" and "capable of planning sexual contact with other people within the context of such liaisons being forbidden", but nevertheless concluded that he lacked capacity in this area. His conclusion was flawed for two reasons.

65. First, the judge erred in basing his conclusion on the basis of ZX's history of offending. That pattern of conduct is not by itself indicative of an inability to understand, weigh or use information about consent. It is at least as consistent, if not more consistent, with having the ability to understand and use the information but choosing not to do so. Whilst not endorsing the terms in which the judge described ZX's conduct, Ms Butler-Cole acknowledged that there were "multiple examples of ZX expressing his intention to offend". The judge concluded at paragraph 114(10) and (11) that "there is a good deal of evidence from ZX himself and his brother that he has engaged in non-consensual sexual activity with other people over the years" which "considered within Dr Ince's conceptual framework (post *ZZ*, in any event) does allow me to conclude that ZX does not "pass" the test in *JB* at limb (2)". But a key element in Dr Ince's "conceptual framework" was ZX's

impulsivity. If that is removed, the only evidence is the history of non-consensual sexual activity. There is no explanation in the judgment of why the judge concluded that this history established that a young man who was “cunning”, “opportunistic” and “capable of planning sexual contact with other people within the context of such liaisons being forbidden” was unable to understand, use or weigh information about consent.

66. *Secondly, even if the judge was entitled to find on the basis of the history of non-consensual sexual activity that ZX was unable to use or weigh information about consent, he failed to establish a clear causative nexus between that inability and his mental disorders as required by s.2(1) of the MCA as explained in JB. At paragraph 114(5) of the judgment, he listed a number of deficits in ZX’s cognitive functioning identified by Dr Ince as attributable to the presence of a neurodevelopmental disorder, including not only poor impulse control but also impaired working memory, inattention, difficulties with planning, cognitive flexibility, and emotional regulation. The judge asserted at paragraph 114(6) that these features “would certainly apply where he was involved in sexual activity and there was an absence or withdrawal of consent by the other party”. That is not a sufficiently clear causative nexus between what the judge found to be an inability to use or weigh the information and ZX’s neurodevelopmental disorders. I agree with Ms Butler-Cole that there is no sufficient analysis in the judgment of what other features of ADHD and ZX’s other disorders, aside from impulsivity, resulted in his being unable to make a decision despite understanding and retaining all the relevant information about engaging in sexual relations.*

67. *The judge’s failure to focus on the need to establish a clear causative nexus between ZX’s inability to use or weigh information needed to make a decision to engage in sexual relations and an impairment of, or a disturbance in the functioning of, his mind or brain leads me to conclude that there is force in the assertion in the first ground of appeal that he applied the wrong test and proceeded on the basis stated in the judgment that “there must be a connection between the disturbance in the functioning of the mind or brain and using and weighing of the relevant information” (emphasis added). “A connection” is insufficient. The presumption of capacity can only be rebutted if there is a clear causative nexus between the inability to make a decision and an impairment of, or a disturbance in the functioning of, the mind or brain.*

Baker LJ took a different approach to the third ground, however. He endorsed the following concerns of Poole J in Re PN:

following JB, there may be a natural desire to protect those with whom P might want to have sexual relations, in particular in cases where P has a history of sexual offending. Lord Stephens repeatedly refers to the MCA 2005 protecting not just P, but others ...]. However, it seems to me, although the issue of the consent of others to sexual relations has entered the list of relevant information, the Court of Protection must not allow the desire to protect others unduly to influence a clear-eyed assessment of P’s capacity. The unpalatable truth is that some capacitous individuals commit sexual assault, even rape, but also have consensual sexual relations. An individual with learning disability, ASD, or other impairment, may act in the same way, but it is only if they lack capacity to make decisions about engaging in sexual relations that the Court of Protection may interfere. If P would otherwise have capacity, then the court should not allow its understandable desire to protect others to drive it to a finding that P lacks capacity, thereby depriving P of the right they would otherwise have to a sexual life. The Court of Protection should not assume the role or responsibilities of the criminal justice system.

However, Baker LJ was not “*persuaded by [the Official Solicitor’s] argument that the judge took wider issues relating to the protection of the public into account when determining whether ZX had capacity to engage in sexual relations.*”

71. Plainly the judge was deeply concerned about the risk posed by ZX to vulnerable people. This is evident from the transcript of Dr Ince’s evidence and from the judgment (including, for example, his expression of shock in paragraph 39 of the judgment quoted above). At paragraph 64 of his judgment, citing the passage from PN quoted above, he stated that requirement (2) in JB “leads to the somewhat odd conclusion that one should allow those the Court is considering to be able to commit serious sexual offences unless they lack the capacity to understand that the other person’s consent to sexual activity is needed.” I am satisfied, however, that, although he remained concerned about the risk posed by ZX, he did not allow these concerns to influence his decision about capacity. At paragraph 114(12) of his judgment, he said:

“I have to avoid what has been called the protection imperative. I must not tailor my formulation of the capacity assessment to ensure a particular outcome”.

The Court of Appeal could not, itself, determine ZX’s capacity and instead:

73. [...] There must be a fresh psychiatric or psychological assessment, which will be further informed by the recent finding by his treating psychologist that that ZX meets the criteria for intellectual disability or learning disorder. The assessment should be conducted on the basis of the principles set down by the Supreme Court in JB. As part of that, it would be helpful in this case if the assessor could attempt to establish whether ZX has the ability to use information about consent “in the moment”, that is to say when he is engaged in sexual activities with another person, relevant to the decision whether to engage in sexual relations.

Comment

As Neil and Alex have discussed in chapters they have contributed to in a recent [book](#), sexual capacity remains an area of almost impossible legal and ethical complexity. This judgment shows that the Court of Appeal is very live to the need to ensure that the Court of Protection does not become an arm of the criminal justice system, but it is very clear that it is going to continue to have an uneasy relationship with it going forward. It is also very clear that public authorities aware of sexual risks posed by those for whom they have statutory responsibilities will continue to have to steer a very careful line – and (a line to which recourse to human rights arguments unfortunately makes no clearer or broader.

The judgment is also of importance for reinforcing the need for clarity in explanation as to precisely how a person’s inability to make a decision is caused by the relevant impairment or disturbance in the functioning of their mind or brain.

Best interests decision-making as an aspect of good clinical governance

NHS North Central London Integrated Care Board v Royal Hospital for Neuro-Disability & Anor [2024] EWCOP 66 (T3) (Theis J)

Best interests – medical treatment

Summary²

This is the most recent in a sequence of decisions given by the Vice-President, Theis J, regarding best interests decision-making in the context of CANH. It concerned, again, delay in best interests decisions being made arising out of a lack of an effective system for such decisions being made at the Royal Hospital for Neurodisability. These were considered by Theis J in *NHS North West London Integrated Care Board v AB & Others* [2024] EWCOP 62. The particular feature of XR's case was that he had not been visited since 2018 and had no known family or friends who could provide details as to his wishes, feelings, values and beliefs.

Theis J noted that:

66. I agree with the submissions of all parties that in the particular circumstances of this case the court should not make any inferences on the limited information it has about XR regarding his wishes and feelings. To do so would bring with it a high risk of speculation. The reality is that despite the extensive efforts made by the RHN and the Official Solicitor little reliable information is known as to what XR's wishes and feelings would be regarding the decision the court is faced with now. I am satisfied no further enquiries can or should be made and this is one of those relatively rare cases where it is not possible to ascertain or assess XR's wishes, feelings, beliefs and values under s4(2) and (6) MCA or those of his family or friends.

67. Whilst I recognise and carefully weigh in the balance the strong presumption in favour of preserving life I am satisfied when considering the evidence as a whole that it is not in XR's best interests to continue to be in receipt of CANH. This is because the benefits of such treatment continuing are significantly outweighed by the considerable burdens for XR caused by the daily care interventions, of which there is detailed evidence, that are required to continue in the context where there is no prospect of any change in XR's diagnosis or prognosis. I accept the evidence of both Dr Hanrahan and Professor Wade of a trajectory of decline in XR's position where the burdens of such treatments and interventions are likely to increase. For the reasons set out above XR's wishes and feelings are unknown and, as a consequence, cannot be factored in the court's consideration of what is in his best interests. The issue between Dr Hanrahan and Professor Wade as to whether XR can experience pain is considered in the context of there being a risk of the possibility that XR may experience pain but it can be no higher than that and in the light of the other considerations that factor, in the circumstances of this case, does not have a material bearing on the balancing exercise undertaken by the court in reaching a decision as to what is in XR's best interests.

68. I am satisfied this case was rightly the subject of an application to the Court of Protection. The decision maker, Dr A, considered the position to be finely balanced. Even though others took a different view that clinical decision and judgment should be respected. It is important that having properly considered the relevant Guidelines/Guidance clinicians should not feel under pressure either way regarding decisions that they have reached. Having said that, it remained unclear what system, if any, was in place for seeking disclosure of XR's records, who was undertaking that, and what role the IMCA played. In this case it is right to record that the Official Solicitor was able to gain more information about XR through the third party disclosure orders made once these proceedings were commenced. In the end it made no difference to the information that was available, although

² Note, Katie having been involved in the case, she has not contributed to this note.

it could easily have done, and if the application had not been made would have risked relevant information not being available in reaching a best interest decision.

An issue arose as to whether the court could or should give guidance as to what should happen “where those charged with making a best interest decision considered it to be finely balanced due to the lack of information about a patient’s likely wishes, feelings, beliefs and values” (paragraph 69). The Official Solicitor urged the court to issue such guidance; on the application of the RHN, permission was given for a draft of any proposed guidance to be sent to Professors Turner-Stokes and Wade in their capacity as the Chair and co-chair of the 2020 RCP PDOC Guidelines. In a letter dated 27 October 2024 they informed the court and the parties that the RCP is already in dialogue with the British Medical Association (BMA) and the General Medical Council (GMC) and is convening an appropriate multi-agency sub-group to develop updated supplementary guidance to address issues raised in recent cases. The letter cautioned against issuing any guidance based on a single case with the views limited to those involved in the case.

This meant, in turn that Theis J took the following position:

89. Not without some hesitation, I am, at this stage, going to decline the invitation for judicial guidance as I recognise the robust process referred to by Professor Turner-Stokes and Professor Wade has been started. The message from this judgment is for that to take place without undue delay, and for a timetable and framework for that review process to be published as a matter of urgency so that any revised Guidelines can be in place sooner rather than later and there is transparency about the timeframe for when that will take place.

90. Pending that, this case and AB provide an important timely reminder to any facility responsible for a patient in PDOC to carefully and proactively consider the relevant Guidelines/Guidance (both the 2020 RCP PDOC Guidelines and the Vice President’s Guidance), to ensure there is a rigorous process for best interest decisions in operation by those responsible for that patient’s care which is in accordance with the relevant Guidelines/Guidance, and that any decisions for applications to the Court of Protection are, if required, promptly brought before the Court without undue delay or drift.

91. It is also important in the relatively unusual cases such as this, where the wishes and feelings of the patient are not readily available, to have clarity about who is responsible for making enquiries and seeking records about that person to avoid delay and ensure there is consistency in approach to obtaining this important information. In such circumstances a relevant part of the decision whether to make an application to the Court of Protection could involve the power of the court to make third party orders for disclosure and the rigorous support the Official Solicitor can provide to ensure that is done.

Theis J also emphasised that:

*92. In my judgment the ICB has an important, critical role to play. As the Clinical Lead for the ICB set out in her statement ‘The ICB will undertake as a minimum an annual review of the care commissioned to **ensure that the care package remains appropriate to meet the service user’s assessed needs**’ (emphasis added). For these reviews to be an effective mechanism they should include active consideration by the ICB at each review to be vigilant that the care package includes*

an effective system being in place for best interest decisions to be made in these difficult cases so that drift and delay is avoided. The ICB should not just be a bystander at these reviews.

93. As Hayden J stated in GU:

[103] '...where the treating hospital is, for whatever reason, unable to bring an application to the court itself, it should recognise a clear and compelling duty to take timely and effective measures to bring the issue to the attention of the NHS commissioning body with overall responsibility for the patient.' And

[105] 'Regular, sensitive consideration of P's ongoing needs, across the spectrum, is required and a recognition that treatment which may have enhanced the patient's quality of life or provided some relief from pain may gradually or indeed suddenly reach a pivoting point where it becomes futile, burdensome and inconsistent with human dignity. The obligation is to be vigilant to such an alteration in the balance'.

94. *The wholly unacceptable delays in GU, AB and now this case send out a blunt but clear message that such delays in effective best interest decision making are unacceptable and wholly contrary to the patient's best interests which there is a clear statutory obligation on the responsible care providers to protect.*

Comment

Whilst the Royal Hospital is under the judicial microscope, and understandably, we are very aware that there are a much larger number of people in PDOC who are receiving CANH in other hospitals and, above all, nursing homes, where no proper best interests decision-making process has taken place. The message from Theis J therefore applies as much to those providers – and ICBs – as it does to the Royal Hospital.

Best interests, wishes and feelings: a worked example in an imperfect world

Aberdeenshire Council v SF (No 4) (Residence) [2024] EWCOP 67 (T3) (Poole J)

Best interests – residence

Summary

This is the most recent in a long-running series of decisions concerning SF, a Scottish woman in her 40s with moderate intellectual disability, autism spectrum disorder, associated periods of severe anxiety, and a diagnosis of difficult to treat schizoaffective disorder (bipolar type). In June 2023, Poole J held that SF was habitually resident in Scotland, notwithstanding that she had been living in England and Wales for a number of years, first as a patient detained in hospital under the Mental Health Act 1983 and then, from 2022, in a supported living placement in the community. At the time of that judgment, because of her condition and the circumstances of her care, SF was not integrated in a social or family environment in England. In a second judgment, Poole J held that a Scottish Guardianship Order made on 16 June 2021 (the SGO) which authorised SF's mother, the Second Respondent, EF, to consent to the deprivation of SF's liberty, should not be recognised and enforced in this jurisdiction. In a third, ex tempore judgment given on 27 June 2024 (not available online), Poole J held that SF had

then become habitually resident in the jurisdiction of England and Wales. He considered that she had made “astonishing progress” at her current community placement and had become integrated into a social environment in England.

After years of searching for suitable accommodation and care in Scotland there was now available to SF a choice of residence and carers but, because Poole J held that she did not have capacity to make the decision for herself, he had to make the decision in her name and in her best interests:

4. There are two options: SF can either remain in her current placement, "X", in the Northeast of England, or she can be moved to a new placement, "Y", nearer to her family in the Northeast of Scotland. She has been at X for over two years now. After an initially difficult period of settling in at X, she has made considerable progress. All agree that she has benefitted hugely from the care at that placement, provided by Orbis. However, her mother, aged 74 and with health problems, finds it increasingly difficult to make the long journey from her home in Northeast Scotland to visit SF at X and SF is also located far from her brother and the rest of her family and old friends who live in the same area as her mother. If she remains at X, SF will be likely to continue to receive excellent care and to live a life of activity far beyond what was imaginable just two years ago but contact with her family would be likely to diminish. If she were to move to Y, she would be much closer to her mother, brother and the rest of the family, but there would have to be a carefully managed transition period and it cannot be known how she will settle in and progress at Y. All accept that SF would struggle with the change. The offer at Y is of accommodation, provision of care, and the availability of activities similar to those at X, but SF would be in the hands of a new and unfamiliar team in new accommodation. The connections she has made at X would be lost and she would have to start over again. There would be a risk that she would not respond well to the new carers and environment.

As Poole J identified:

5. There are risks, benefits, and disadvantages from either option and neither choice is obviously the right one for SF. In approaching this difficult choice, the Court must apply the relevant statutory provisions under Mental Capacity Act 2005 (MCA 2005) s4, guidance from caselaw, and do its best to make a decision in SF's best interests.

Having set out the law and the evidence, Poole J made clear that:

28. A key issue is the wishes and feelings of SF. The evidence shows that she has expressed different wishes and feelings about moving back to Scotland at different times. The evidence also shows that she has been influenced by EF and GF [her parents] to express her wishes and feelings in favour of a move to Scotland. Having heard from EF and GF, I am sure that they sought to persuade SF to say that she wants to move to Y because they believe it is best for her. They have not acted maliciously but rather in what they believe to be her best interests. Nevertheless, their influence has been quite strong and has made it harder to discern SF's true wishes and feelings. Having given this matter very careful consideration I have concluded that:

- i) SF is conflicted - she loves living at X and being supported by the Orbis carers. She greatly enjoys the activities in which she participates in the community around X. She has a good life at X. She does not want to leave X. On the other hand she wants to see her mother and brother. She has been given to believe that she will see more of them if she moves to Scotland and may not see them if she remains in England. Naturally she wants to see them*

more rather than less. If she could both stay at X and see more of her family, that is what she would choose. She struggles to accept that she cannot have both.

- ii) Day to day, SF does not think about moving to Scotland. She does not pine for Scotland. She has some unhappy memories of living there.*
- iii) She can make plans for the future - as demonstrated by her saving up for her trip to Scarborough with the encouragement of staff - but largely she lives in the present. She does not ruminate on moving to Scotland or to Y. It is only when prompted that she applies her mind to the issue. She would like to see more of her family but when she does not see them, she gets on with the day and enjoys her life at X and in the community around X.*
- iv) SF is easily influenced and wishes to please her family. Before EF and GF sought to influence SF, she had consistently said she wanted to stay at X. I recognise that she might have been influenced by her carers at X and that at that time no-one around her was advocating for a move to Scotland, but there is no evidence that she was influenced in the way in which EF and GF have sought to influence her. My judgement is that SF's own wishes, before she was influenced to say otherwise, were to stay where she was living. She may not have appreciated the implications for contact with her family members, but she wanted to stay where she was.*

He made clear that:

29. Assessing all the evidence relating to SF's wishes and feelings, I find that SF's wish is to remain living at X and to be cared for by her current care team. She does not want to leave X but she does want to continue seeing her mother and brother there. She has no great desire to return to Scotland itself and is very happy living at X in England.

There were undoubtedly both risks and benefits to both SF staying in England & Wales, and going to the placement in Scotland, but ultimately, Poole J identified that:

35. I remind myself that the Court's role is not to do the best for EF or the family, but to make a decision on SF's behalf in her best interests. There is a loss to SF whichever choice is made. That has come about because of the need to transfer her care to England several years ago and the delays in finding a suitable placement in Scotland. Such an opportunity to move back to Scotland might not arise again for a number of years. Scotland is SF's home country and all her family live there; none lives in England. Nevertheless, SF does not want to leave X and she has no great desire to return to Scotland itself. The placement at X works very well for her and she is happy there. She may not be happy at the alternative placement, Y. She does not deal well with change, indeed it is liable to cause her distress. Until she settled in to X she was much more frequently agitated and distressed, and she frequently required restraint and seclusion. It may be that a change in medication has assisted her to achieve stability, but it is also quite clear that the excellent care she has received at X has been instrumental in transforming her life. The process of removing her from X and transferring her to Y risks a significant deterioration in her condition and her welfare. It cannot be known that the combination of factors that have so enhanced her life at X will be replicated at Y.

36. In her day to day life what matters most to SF is the place she lives, the people she has around her when she wakes up, when she eats, and when she goes out, the places she visits and the people she meets there. She has shown herself to be a sociable person who delights

in the company of her current care team and in activities out of the home. Her family mean an awful lot to her too and she loves seeing and spending time with them. I recognise the sacrifice of time with her mother and family that will be suffered by SF if she remains at X but in my judgement what is more important to her and to her welfare are the care, support, and experiences she has between visits - they are what give her life the character that it now has. It is a life that she enjoys and wants to continue. Placement X is working for SF and it would be contrary to her best interests to remove her from it. She has stability in her life for the first time for many years and the funding for her current placement is secure. I am satisfied that whilst this decision interferes with her right to a family life, it respects her right to a private life and that any interference with her right to a family life is proportionate and justified as being in her best interests.

Poole J concluded his judgment both by recognising that:

38. This decision will be hard for EF and GF to accept. I am sorry that there is no solution that suits them as well as SF's best interests.

39. I have written a letter to SF to explain my decision. She has written to me and we have met at her request. It is a courtesy to respond and by doing so I can give her my decision directly and in language suitable to aid her understanding.

Comment

Unlike in the earlier judgment about recognising and enforcing the Scottish Guardianship Order, this decision makes no new law. It is, however, an excellent worked example of a sensitive analysis of best interests where no option is ideal.

Anorexia and ketamine

Barnet, Enfield and Haringey Mental Health NHS Trust v CC & Ors [2024] EWCOP 65 (T3) (Hayden J)

Best interests – medical treatment

This case concerned a 21 year old woman, CC. Her clinicians were concerned as to her capacity to make decisions about medical treatment “*due to her overwhelming fear and distress, generated by her anorexia nervosa and compounded by her autism and depressive disorder.*” The independent expert, Dr Cahill:

9. [...] considered that CC lacked capacity to make decisions about her treatment concerning nutrition and her physical health. He emphasised that there are many "different facets and overlaps" to her condition. He observed that "to discuss capacity in general terms is impossible given the many different aspects of the case, likely comorbid psychiatric comorbidities and different clinical decision to be made". A great deal of effort and energy has been expended on identifying labels. I have been told that in clinical practice, it is widely recognised that females with ASD and disordered eating often present in an atypical way. CC, all agree, presents atypically. She does not believe that she truly has anorexia, she believes her central problem to be depression.

10. The labels are, to some degree, a distraction. Dr Cahill considers that CC has the ability to outline the advantages and disadvantages of particular facets of her treatment, but is, ultimately,

unable to use and weigh the information necessary to arrive at a decision. This is considered by Dr Cahill to be a consequence of her anorexic/ disordered eating/ ASD thinking. He considers that she is fixated on the "numbers" (relating to body mass index (BMI)) whether that be due to "a drive to be thin", i.e. anorexia, a need for control; a combination of anorexia and ASD; a desire to die; an emotionally unstable personality disorder (EUPD)/ ASD/ depression. Ultimately, CC is, in Dr Cahill's view, unable to make decisions about her nutrition. Dr Cahill was not convinced that CC's nutritional restriction is a facet of suicidal behaviour. He thought it more likely to be an expression of **"not wanting to feel as she does any longer"** (my emphasis) and her inability to articulate it. In addition, her poor physical health impedes her real insight into the seriousness of her current situation, and the desperation of her body's requirement for nutrition.

Having reviewed the law, Hayden J identified that:

25. It is important that I emphasise that CC told me that she believes that she has capacity to understand her medical treatment. When by way of example she was confronted with her vacillation on the question of her attitude to dying, she told me she contradicted herself, but asserted, rightly, that did not mean she was incapacitous. "We all contradict ourselves", she said. She was also able to summarise the full range and detail of her various conditions, in an impressive and eloquent manner. Despite what ultimately emerged as a consensus, amongst the psychiatrists, that CC lacked capacity, I have nonetheless given it a great deal of careful thought and consideration. Evaluating capacity in the context of eating disorders is a challenging process, which demands, to my mind, particular subtlety of thought. It is too easy to infer incapacity by focusing on the consequences for the patient of non-compliance with treatment. In this sphere, there is always, in my judgement, a pull towards paternalism. This requires to be resisted. The force is distinctly strong and stark when, as here, considering the risk to the life of such an obviously talented young person. The MCA does not require me to determine capacity on the balance of probabilities, rather, it requires me to apply that test in evaluating whether the presumption of capacity has been displaced. This is the statutory bulwark protecting personal autonomy.

26. Ultimately however, I agree with Dr Cahill that there is a distinction to be made between insight into a decision, and an ability to weigh the information surrounding it. The former engenders the decision, the latter is ultimately formulation of the question. The impact on CC of her ASD has, despite her efforts, eluded her understanding, in the way that Dr Cahill describes (see emphasis in paragraph 10 above). It is an important and integral element of her eating disorder. It is this inability to weigh and balance the impact of her ASD into the decision surrounding her treatment, that has, ultimately, robbed her of capacity on the issue. It is intensely frustrating to her, and profoundly distressing, not least because in this context, this, otherwise, impressively articulate young woman cannot identify the correct words to articulate her feelings.

What then followed was not, as might have been expected from other cases before the Court of Protection concerning anorexia, a decision as to whether continued force-feeding was in CC's best interests. Rather, it emerged that the real issue was whether she should undergo treatment with Esketamine. As Hayden J noted in relation to her treating psychiatrist, Dr W:

38. One treatment option which Dr W has advocated, enthusiastically, is Esketamine. This is a psychedelic drug and would require panel approval at the hospital. Dr W told me, in evidence, that he did not think there would be a problem in getting the approval of the panel. I was rather surprised at Dr W's confidence. Esketamine, as a treatment for resistant anorexia nervosa, has very little evidence base. There have been no trials in this country and, inevitably, no peer review. Dr W has had only one patient who he has treated in this way. The treatment, he tells me, was successful.

He has discussed Esketamine treatment with CC. She is immensely enthusiastic about it. Indeed, it has become the repository of all her hopes. She is so intensely invested in it, that a decision not to go forward is one she finds extremely difficult to contemplate. Dr W is acutely aware of all of this.

39. In his oral evidence, Dr W made a strong case for CC, in her quest to be treated with Esketamine. He was plainly concerned as to how CC might react if this treatment plan was not confirmed as being in CC's best interests. Dr W is very committed to his patient's care and anxious about her prognosis. I should also state that CC has been in the courtroom for most of the hearing. She has listened attentively.

Hayden J dug somewhat further into this:

42. In his oral evidence, Dr W said that he considered that he had a good working relationship with CC, and that she got on well with the eating disorder nursing team. He told me that Esketamine is a licensed drug which can be used in a psychiatric emergency. Its primary use is in anaesthetics, in which context, it has been used regularly for over 20 years. Dr W described it as "a safe drug". In the context of anaesthesia, I do not doubt that is an accurate description, but I consider it to be a bold claim, on the available evidence, for its limited use in treatment of resistant anorexia. Dr W said that he thought that its impact on CC might be to make her "giggly" and lightly "intoxicated". This, I took to be based on the response of his previous patient. Dr W amplified the range of likely responses. Esketamine, he told me, has a "dissociative effect" on patients, i.e. it alters consciousness. It can create a "lightness of the body", a sense of "floating". He also described what he termed "an enhanced feeling of being in the room". The drug "heightens the senses", "material may be felt more keenly against the skin", "smells will be experienced more strongly". Esketamine is a psychedelic drug and, as such, causes "visual distortions, hallucinations, and fragmented consciousness". Side effects may include psychological issues, a risk of future substance misuse (described by Dr W as theoretical), raised blood pressure, arrhythmia (thought to be a "remote" risk).

43. Whilst the hallucinations might be benign or even pleasant, it is also possible that they might be distressing and cause agitation. Both would require careful management and supervision. As Dr W reminded me, CC already has 1:1 supervision. Nonetheless, a pleasant hallucination might, he suggested, cause CC to want to go outside and she would have to be restrained to prevent her from doing so. An unpleasant experience would require her to be talked down by soothing words or, if necessary, by medication (benzodiazepine).

44. Alarming though all this sounds, it is not difficult to see why it might be worth trialling if the alternative is speedy deterioration and death. Neither would it be right to clothe this balance in ambiguous language. It requires to be confronted, as CC and her family have done.

Dr Cahill was considerably more cautious than Dr W:

45. In his review of CC's antidepressant medications, Dr Cahill considered that none of them had worked because there had not been sufficient focus on the impact of ASD (for all the reasons discussed above). In his evidence, he told me that nothing was likely to work unless the ASD was brought into sharper focus and with the assistance of an Occupational Therapist. He noted that there was no Occupational Therapist in place, and identified that as a key role, including in coordinating support. The Trust has immediately recognised this and has ensured that an

Occupational Therapist will soon be appointed and able to identify reasonable adjustments for CC to maximise therapeutic potential. I regard this as a key piece of evidence. Although we are dealing with a very different type of drug in Esketamine, if Dr Cahill is correct, it still runs a risk of failing, if the impact of ASD is not addressed in advance. That outcome has the potential to be catastrophic for CC. To invest so much hope in Esketamine, only for it to fail, would leave CC with no hope and no alternative plan that she could begin to contemplate. If Esketamine is to be tried, it must have the best possible opportunity to be successful. That is not the situation here. At the moment, there is a real risk that to move forward to such a treatment regime might be setting her up to fail.

In turn:

46. Ms Paterson KC, acting on behalf of the Official Solicitor, has been able to identify a properly convened medical trial of the use of Esketamine in resistant anorexia that is due to commence in London quite soon. I understand that approaches will be made to see if CC may be included within the trial. Dr Cahill considered that the Esketamine treatment was not, at this point, in CC's best interests. I agree. I also regard that conclusion as inevitable in the light of his reasoning.

Hayden J, however, wanted to make clear that he “signalled”:

47. [...] to CC, in very clear terms, that she must not perceive my decision as ideologically resistant to what may yet prove to be, and I hope will be, a progression in the treatment of this awful and insidious condition. Esketamine may well be an option for CC, perhaps even in the near future, but if it becomes an option, it must have the best possible chance to succeed, following the plan which Dr Cahill has suggested, and which I am persuaded is in CC's best interests. That plan is to be refined and considered further at a directions hearing in a few weeks.

Hayden J, finally, made a point of noting that:

48. [...] It is also important that I emphasise that she is surrounded by committed doctors and nurses. Nurse A gave evidence before me by video link at short notice and on CC's request. He had been on the screen for barely a matter of minutes before it became entirely obvious to me why CC had such confidence in, and affection for, him. He is plainly a crucial part of CC's support. His understanding of CC and his commitment to her care was extremely impressive. CC personally, and the system more generally, is lucky to have him. I indicated, at the conclusion of the evidence, that I wanted him to see the judgment in order that he could fully understand my decision and discuss it with CC if she wishes to do so.

Comment

In the context of concerns as to whether the Terminally Ill Adults (End of Life) Bill could encompass at least some with anorexia within its scope, this case is a useful reminder of the need to explore all treatment options in relation to the condition – even if it is also a useful reminder that such treatment options need to have a proper evidential grounding.

Short note: when there is no good birth option

The dilemma facing Cusworth J in *Mid Yorkshire Teaching NHS Trust v SC & Anor* [2024] EWCOP 69 (T3) was that neither option – natural or Caesarean section – was a good one for the woman at the heart of the proceedings. She had a very firm (but delusional) belief that she was carrying not one but

four babies. She made clear to the Official Solicitor's representative, Ms Coates, that "[i]f I have the c-section, I'll get 1 and they will take the other 3 away and sell them. That is what they want to do. I need more power more rights". Cusworth J was clear that she lacked capacity to make the decision about her birth arrangements, and that:

25. [...] I do take fully into account what SC has said to Ms Coates, her unhappiness and suspicions about the way that she has been treated by the staff who have seeking to care for her. I also remind myself, importantly, of the significance of the decision that the court is here being asked to make. As MacDonald J properly said in *North Bristol NHS Trust v R* (above) at [84]

'...for the court to authorise a planned Caesarean section is a very serious interference in a woman's personal autonomy and Art 8 rights. As the Vice President noted in *Guys and St Thomas NHS Foundation Trust & Anor v R*, Caesarean sections present particular challenges in circumstances where both the inviolability of a woman's body and her right to take decisions relating to her unborn child are facets of her fundamental freedoms.'

26. Notwithstanding that very important consideration, I am nevertheless satisfied that in these circumstances, it is very clearly in SC's best interests for the planned Caesarean to go ahead on Monday as the Applicant Trust and the Official Solicitor both agree. The views that she has expressed are I am clear very much influenced by her mental illness, and her delusional belief that she is carrying four small babies that can be delivered by her vaginally with no difficulty or risk. The increased risk of uterine rupture after having had two previous Caesarean sections is very real, which could cause real danger both to her life and that of her unborn child. The medical evidence in favour of a planned Caesarean is overwhelming.

27. Further, and whatever course is taken, the reality that SC is carrying only one child, and that the local authority plan to make an application for its removal from her, will no doubt have a devastating but unavoidable impact on her health and well-being. In those circumstances, any attempt at vaginal delivery, aside from being fraught with medical risk, may also be the cause of further trauma for SC if, even after coming through that procedure successfully for the first time, she is nevertheless unable ultimately to care for her child. Consequently, I am satisfied that the birth should take place in the safest and least traumatic circumstances for SC, so that her ability to recover in future is not further impaired by additional traumatic memories.

Short note: miracles and medical realities.

In refusing permission to appeal the decision of Arbuthnot J that continuation of life-sustaining treatment was no longer in the best interests of a woman identified as XY, the Court of Appeal has made some pertinent observations about when miracles have to give way to medical realities. In *XY (Withdrawal of Treatment)* [2024] EWCA Civ 1466, the two central grounds of appeal were that:

1. The judge failed to give sufficient weight to evidence presented by XY's family regarding her responsiveness to familiar voices and stimuli.
2. XY's identity as a person of faith, her belief in miracles, and her family's testimony about her desire to continue fighting for life were inadequately addressed.

Baker LJ addressed the first ground thus:

47. Turning to the first ground on which Mr Thomas concentrated his submissions, the judge was plainly fully aware of the extent of the evidence from family members about XY's responsiveness. As Mr Thomas emphasised, this evidence came not only from A but from other family members and friends. A number of them, in particular A herself, have been very regular visitors, spending several hours each day by her bedside. A was able to give evidence about specific incidents when she had seen her mother move in a way which suggested she was responding to stimuli. I do not, however, accept Mr Thomas' submission that this evidence before the judge was unchallenged. It may be that A was not cross-examined on her observations. But the challenge came from the unanimous evidence from the clinical and nursing staff that they had seen nothing to indicate any awareness in XY, and from the clinical and expert evidence that the evidence from CT scans and EEG recordings was indicative of a PDOC at the lowest end of the spectrum. Whilst it is likely to be true that nurses were not constantly present at the bedside in the way that A has been for many hours, there has been a high level of specialist nursing attendance, as is established procedure in an ICU.

48. The judge gave conspicuously careful attention to all of the evidence about this issue. Her decision to prefer the evidence of the clinical and nursing staff about the extent of XY's responsiveness, and the interpretation of the evidence advanced by Dr Bell and Professor Wade, was plainly open to her on the evidence. There is no real prospect of the Court of Appeal finding that she was wrong to reach that conclusion.

As to the second ground:

54. The judge was obliged to consider the family's clear evidence about XY's faith in the context of her present circumstances which, as Mr Mylonas submitted on behalf of the Trust, she could never have envisaged. As Ms Roper submitted for the Official Solicitor, the fact that she had a religious faith, and believed that it is God's choice when someone lives and when someone dies, does not lead to an inference that she would have wanted to continue treatment in these circumstances. There is also force in Ms Roper's further submission that the family's views about what XY would have wanted are situated in their belief, contrary to all the medical evidence accepted by the judge, that there is a prospect of recovery.

55. In those circumstances, there is no real prospect of the Court of Appeal concluding that the judge erred in her approach to XY's beliefs and values and wishes and feelings. On the contrary, she gave those issues particularly careful and sensitive attention. Although she did not recite the evidence about XY's religious faith in detail, I have no doubt that she had it in mind and took it into account. In the course of summarising submissions, she recorded A's case that "faith is a considerable component of who XY is" and that she "would choose life in these circumstances". In her final analysis, the judge acknowledged that XY was "a woman of faith". But in considering the weight to be given to her faith, and to the family evidence about her wishes and feelings, the judge made a number of pertinent observations. She observed that XY "has never stated her views about clinically assisted nutrition and hydration or on sustaining her life artificially in the circumstances where she is totally dependent on others". This led the judge to conclude that "we do not know how she would feel in the current situation that she finds herself in" and "we do not know how she would feel about the continued treatment when the specialists and experts say it is futile" and to "question whether this loving mother and grandmother would have wanted the burden of the treatment to continue." In these observations, the judge was plainly following Baroness Hale's observation in the Aintree case. XY's wishes might well have changed in the light of the stresses and strains of her current predicament.

56. This evaluation was plainly open to the judge on the totality of the evidence. The applicant and other members of the family remain convinced that, because of her faith, XY would have wanted the treatment to continue. I have no doubt that the judge took their strong views about XY's wishes and feelings into account, as she was required to do under s.4(7). But she was entitled to entertain doubts about what XY would have really wanted in these terrible circumstances.

The urban myth of DoLS

R (Ibrahim) v Nursing and Midwifery Council [2024] EWHC 2991 (Admin) (High Court (Administrative Court) (Richard Kimblin KC, sitting as a Deputy High Court Judge))

Article 5 – DoLS authorisations

R (Ibrahim) v Nursing and Midwifery Council [2024] EWHC 2991 (Admin) is a case which shows how the Deprivation of Liberty Safeguards are still not well understood. It concerned an appeal by a Registered Mental Health Nurse against the decision of the Nursing and Midwifery Council imposing a 12-month Conditions of Practice Order with a review. The NMC imposed this after an event 2017 when he prevented a patient from leaving her room at University College London Hospital. The patient in question, 'Patient A', had CNS lymphoma, suffered from paranoid schizophrenia and was on a palliative care pathway. The nurse "accepted that he prevented Patient A from leaving her room for 1-2 minutes somewhere between 2:45am and 4am. He did so because Patient A had thrown a yoghurt at him and was moving towards him in anger" (paragraph 31). The NMC found that the appellant's actions amounted to misconduct, and that his fitness to practise was impaired.

The submissions made to the High Court on the appeal attacked the NMC's order on the basis that:

- a. *The patient was a proven physical risk to herself and others and was at risk of absconding;*
- b. *The patient was subject to a Deprivation of Liberty Safeguards ("DOLS") assessment that permitted deprivation of liberty under the Mental Capacity Act 2005;*
- c. *The DOLS order required 2:1 care as a condition of that order;*
- d. *Shortly before the Registrant's shift, Colleague C unilaterally downgraded Patient A's care to 1:1 without adherence to the proper procedures;*
- e. *The patient had no care plan;*
- f. *The Registrant was informed of (a) and (b), but not of (c), (d), or (e) when he came on shift;*
- g. *The Registrant was therefore in a position where he could not leave the patient in order to remedy any of the above matters, had little support from other overworked staff. He prioritised the safety of his patient and of those around her.*

In reaching his conclusion that the NMC panel erred, Richard Kimblin KC (sitting as a Deputy High Court Judge) noted that:

39. It is also of obvious significance that the Appellant was placed in the sole care of Patient A, contrary to the level of provision which had been signed off by an experienced and expert body of medical professionals in the DOLS. In my judgment, this is a circumstance of such clear materiality that it had to be fully grappled with in the Panel's decision. The DOLS is a carefully considered and reasoned document which has a statutory basis. While this case is not directly concerned with a departure from the DOLS in that the charges do not allege that any party was in error for allowing circumstances to exist in which the care provision was reduced from 2:1 to 1:1, it is an authoritative statement which plainly should have been followed unless and until it was varied. The Appellant was correct to rely on it.

40. Still further, it is relevant that the Appellant was new to the ward and had no care plan from which to work. These matters show that the Appellant was put into a challenging situation with arguable systemic failings which were not of his making.

41. Arguments arising from the above were clearly and cogently articulated on the Appellant's behalf via written submissions, as I have set out, and were supplemented orally. Given that the Appellant recorded absconding behaviour in the clinical notes and that is consistent with the similar absconding behaviour referred to the DOLS notes, which the Appellant had not seen when he made his entry, the Panel had to engage with the reality of what the Appellant faced and the extent to which that was a situation which, arguably, he should not have had to face, alone.

42. It is a matter of fact that the Panel did not mention these arguments in their findings section. The Panel had to grapple with them. The Appellant is entitled to know why such important arguments, on which his defence rested, were apparently rejected.

43. In order to find the NMC's allegations proved, the Panel was required to decide whether the Appellant had clinical justification for keeping the patient shut in her room. I find that it is not possible to see how the Panel could have made a fair and rational decision while omitting to address the terms of the DOLS order, the inadequacy of staffing, and the patient's history of dangerous and aggressive behaviour.

The factual findings were therefore quashed; Richard Kimblin KC also found that the panel had failed to grapple with the appellant's case as regards impairment. He declined to remit the case for reconsideration and quashed all the material parts of the order, as well as ordering the NMC to pay the appellant's costs.

Comment

The case provides a revealing snapshot of what life is all too often like on wards in acute hospitals. The reference in the appellant's case (then picked up by the High Court) to the DoLS making 2:1 care a 'condition' of the DoLS authorisation is, however, more than a little unlikely – what is much more likely is that the authorisation was recognising that, at the point that the authorisation was sought, the hospital considered that 2:1 care was necessary. That is very different to a requirement that 2:1 care be imposed. Indeed, earlier in the judgment was a reference noting that the DoLS authorisation provided that "the Managing Authority (UCLH) was to consider lessening the care to 1:1 'if Patient A becomes more settled'" (paragraph 32). The local authority granting the authorisation was expressly recognising that it was a matter for clinical judgment as to whether Patient A could be cared for in a less restrictive way. Indeed, it would also be a matter for the hospital whether Patient A could or should

be discharged altogether; the hospital would not need to go back to the local authority to release her from the authorisation.³ In other words, and as should always be remembered, a DoLS is not a warrant to detain which must be obeyed by the care home or hospital, but rather a recognition that a set of circumstances amount to a deprivation of liberty which is permissible for so long it is necessary and proportionate.

³ Separate questions would arise as to whether other bodies would need to be involved in the discharge decision, depending on where Patient A would have gone to next: see further [here](#).

PROPERTY AND AFFAIRS

Thank you and goodnight to Simon

Our longstanding property and affairs correspondent, Simon Edwards, is standing down with effect from this issue. Worse (for us), he is, in fact, retiring from practice at the end of the year. Simon has been the conscience of Chambers' Court of Protection team for many years, and not just the Report editors, but the team more broadly thank him for his quiet wisdom over many years, and wish him all the best for a very well-deserved change of pace.

Deputyship updates

In a [letter](#) sent out on 18 November 2024, HMCTS has confirmed that Court of Protection Practice Direction 9H has been updated to confirm that from 2 December legal professionals must submit applications for Property and Affairs Deputyship applications via the [digital submission portal](#) on gov.uk.

The letter notes that:

In support of mandation, in respect of any Property and Affairs Deputyship applications made on paper after 4th December by professionals, it is unlikely that authorisation to recover costs of making the application from the estate of P will be granted.

Although litigants in person are encouraged to submit digitally, mandation of the submission portal will only apply to professional court users.

From 2 December, it has also been possible to submit a digital application to replace a deputy following the same process.

PRACTICE AND PROCEDURE

Flight risk and the threshold for the court's involvement

Hywel Dda University Health Board v P & Anor [2024] EWCOP 70 (T3) (Morgan J)

Court of Protection jurisdiction and powers – interface with inherent jurisdiction – undue influence

Summary

This private hearing, without notice to P or her mother due to a flight risk, was to determine whether, in the absence of a capacity assessment, there was reason to believe that P lacked capacity to make the relevant decisions and, if not, whether the inherent jurisdiction was available. P was 18 and lived with her family. She had global developmental delay, autism and likely learning disability. She had only ever been away from her home once for a 24-hour period in hospital, and the application was to seek her removal from the family home to undertake a series of capacity, treatment, and needs assessments.

Morgan J held that s.48 MCA 2005 required no gloss and although there was reason to believe that P was unable to make the relevant decisions, in the absence of a capacity assessment the causal nexus with her mental impairments had not been established, even on a 'reason to believe' basis. However, P was a vulnerable adult and there was reason to believe she was unable to decide because of the coercive control or constraint of her mother. This was demonstrated by the lack of response to clinicians during periods of difficulty, refusal to allow community learning disability nurses to enter the family home, declining assistance and visits, and reported changes in P's own presentation from open and polite to hostile and refusing to engage.

In terms of case management, Morgan J noted that the flight risk must be seen in the light of the resources available to her mother to put any such plan into effect and the injunctive steps the court could take to ameliorate that risk. She very much loved P and, despite having previously fled with her children when they were much younger, it could not be assumed the same would happen now that two of them were adults and the third a late teenager. Moreover, public transport in West Wales was not plentiful, and her mother was reliant on state benefits.

Accordingly, exercising the inherent jurisdiction, injunctive orders were made to enable entry to the family home, access to P for assessment purposes in that setting, and prevention of P's removal from the home by her mother or others on her instruction. The capacity assessment was the most pressing and a short return date was listed which would be on notice to all parties.

Comment

Court of Protection orders are routinely made under s.48 MCA 2005 pending further capacity evidence because "*there is reason to believe that P lacks capacity in relation to the matter*" and "it is in P's best interests to make the order, or give the directions, without delay". This decision transposes the *obiter* of *DP v London Borough of Hillingdon* [2020] EWCOP 45 into its legal reasoning.

Although both judges agree that s.48 requires no gloss, at paragraph 62(vi) of *DP*, Hayden J observed that "*The exercise required by Section 48 is different from that set out in Section 15. The former requires*

a focus on whether the evidence establishes reasonable grounds to believe that P may lack capacity, the latter requires an evaluation as to whether P, in fact, lacks capacity.” Whether this description of the threshold mirrors the wording in s.48 is not necessarily a moot point, given – as was noted in DP at paragraph 57 – “under the aegis of s.48, there may be significant infringements imposed on people’s civil liberty.”

This judgment reflects the importance and relevance of the statutory principles when considering the s.48 threshold. Section 2(5) provides that “In proceedings under this Act or any other enactment, any question whether a person lacks capacity within the meaning of this Act must be decided on the balance of probabilities.” Whether this only applies to s.15 or holds true when considering whether “there is reason to believe that P lacks capacity” for s.48 purposes remains to be seen. *Somerset NHS Foundation Trust v Amira* [2023] EWCOP 25 at paragraph 54 would suggest the former, as does *Barnet Enfield And Haringey Mental Health NHS Trust & Anor v Mr K & Ors* [2023] EWCOP 35, albeit that, perhaps, it ends up being a distinction without a difference:

the language of section 48 needs no gloss and that the court need not be satisfied, on the evidence available to it, that the person lacks capacity on the balance of probabilities, but rather a lower test is applied. Belief is different from proof. Section 48 requires: 'reason to believe that P lacks capacity.' Section 2 requires: 'whether a person lacks capacity within the meaning of this Act must be decided on the balance of probabilities'. That being said in a case of this nature, where medical treatment is being considered which the patient does not consent to, the court must be satisfied there is evidence to provide a proper basis to reasonably believe the patient lacks capacity in respect of the medical decision.

This case was before a judge who was able to exercise the inherent jurisdiction. Where there is real cause for concern about a person’s capacity which cannot be properly assessed, similar injunctive orders may be required in the High Court in undue influence cases so as to determine whether the Court of Protection can then exercise its statutory jurisdiction.

Coercion, control and powers of attorney

Re CA (Fact finding – capacity – inherent jurisdiction – injunctive relief) [2024] EWCOP 64 (T3) (Arbuthnot J)

Lasting powers of attorney – revocation

Summary

This is a decision which is very helpfully summarised in the case title. In summary terms, it involved the court having to decide what to do, and how to do it, to secure the interests of CA, a 79 year old woman with dementia. Her daughter, DA, held lasting powers of attorney in respect of her mother’s property and affairs and health and welfare.

Arbuthnot J found, after conducting a fact-finding hearing, that:

63. Overall as I look at the evidence as a whole, I find that DA fails to make any allowances for her mother’s age and frailty. She is hoping that by force of her personality she can keep her mother

healthy and able to look after herself. There is no doubt in my mind that mother and daughter love each other deeply and DA has certainly cared for her mother as much as she is able to.

64. I am concerned too that DA has persuaded her mother that she is lazy and stubborn and that her failure to look after herself better is her own fault. I consider that that view has arisen from what CA has been told repeatedly by DA in the same way that CA's fear that she will be moved into a care home comes from her daughter and indeed EA on 20th November 2023, when the court and the local authority have been at pains to make it clear that that was not – and is not – the intention.

65. To that end, DA bullies and forces her mother to do the things that she believes will keep her alive for longer. When she force-feeds her it is because her mother is not eating enough and she has had anorexia. Their relationship of verbal abuse is mutual, but CA is ageing and getting increasingly frail and deserves a different approach from an adult daughter.

66. I am no expert, but after seeing DA in court in the four-day hearing and on other occasions before this, it is the daughter's personality issues that lead her to treat her mother in the way she does. She lacks self-control and in particular she is unable to control her anger at times. CA describes her daughter as bullish and brutish, and I agree with that description. It is a dysfunctional, volatile relationship with a mother and daughter who are enmeshed and depend on each other emotionally.

67. I have carefully considered DA's argument that the local authority are "out to get her" (my words, not hers). This is simply not the case. The safeguarding concerns originated from the hospital where any number of different staff reported DA's concerning behaviour towards her mother. These complaints then continued via the care agency. The social work team have primarily gathered the information together to get a picture of the relationship and the way this elderly lady is treated by her daughter.

68. There is no protection for CA from other members of the family. EA leads his own life and to the extent he steps in, he has swallowed his daughter's story that the local authority is prejudiced against her and wants to put her mother in a home. CA's son has only a limited involvement with his mother, and I suspect is only too glad to leave everything to his sister. DA's partner is one step removed from CA, but there is no evidence he would mistreat CA.

69. Finally, at times CA has told the court that her daughter did not force-feed her. Indeed, in court on 2 October 2024, she said the force-feeding had not happened, but in the near past including to Dr Barker on 20 August 2024, she was less certain and has complained of her daughter pulling her hair. I certainly do not consider her accounts help me to determine either way the truth or otherwise of these allegations.

70. It was clear that CA is subject to the undue influence of her daughter in a number of different ways. One example is above, what CA said in court on 2 October 2024 when her daughter was next to her, it is clear (and on a number of other occasions) that CA says what she thinks her family would like her to say.

71. On the balance of probabilities, I find the allegations proved.

The question of CA's capacity in the material domains was one that both the expert instructed and Arbuthnot J clearly found somewhat difficult, but ultimately she reached the conclusion that CA lacked capacity to conduct proceedings and to make decisions concerning her care and her property and

affairs. Indeed, ultimately, neither CA's daughter nor CA's ex-husband (the third respondent) contested these conclusions. The conclusion as to whether CA had capacity to make decisions about unsupervised contact was more finely balanced, but ultimately Arbuthnot J agreed with the expert that,

124. [...] applying the presumption of capacity, CA was making unwise but capacitous decisions about contact with DA. It is a relationship that is of great importance emotionally to CA and although DA is as CA says "brutish" and "bullish" she is doing her best to keep her mother alive and as healthy as she can persuade her to be. CA recognised the relationship had negatives but considered the positives, outweighed these. I found in this finely balanced case that she had capacity to decide on unsupervised contact.

Arbuthnot J also found that CA had capacity both to enter into and to revoke an LPA for health and welfare. She then, therefore, had to change her judicial headgear to wear the hat of a High Court judge exercising its inherent jurisdiction over the capacitous but vulnerable. She found that CA was clearly within the scope of the jurisdiction, and that there was no other statutory scheme which could be used to protect her from the contact risks posed by her family. This therefore meant the inherent jurisdictions was in play:

138. The test which must be met before the inherent jurisdiction could be engaged to regulate contact is whether the proposed intervention, here supervised contact, is necessary and proportionate.

139. I heard evidence from Ms Haverson, NCC's Adult Team Leader. She provided a graph which showed that DA's behaviour towards her mother had improved markedly in recent months since their contact had been supervised, since proceedings had been on-going and since allegations of breaches of undertakings DA had given had been made.

140. The risks of future harm to CA remain at present. CA needs to be protected from the harm particularly from DA but also from EA, CA's ex-husband. Another risk to CA is from DA's misuse of the LPA for health and welfare. As Mr Lewis observed in his position statement on behalf of NCC, such was the extent to which DA sought to exercise control over CA, that she purported to make best interests decisions for DA as health welfare during a long period of time when DA believed CA had capacity to decide on her care, knowing that she had no lawful authority to make these decisions.

141. The proportionality of any proposal had to be considered. I noted that the number of times that DA and EA can see CA and the time they spend with her is not limited in any way. There are no restrictions on DA's partner's contact with CA. The continuation of supervised contact is the least intrusive measure commensurate with the risks I have found in CA's relationship with DA.

142. It should not remain in the long term but I have decided to direct the parties to jointly instruct an independent psychological expert to consider the family relationships and how they can be managed so that CA remains safe when she sees her family. It may then be possible for unsupervised contact to take place. Using the inherent jurisdiction to impose a supervised framework around contact is a temporary way of ensuring that CA can be safe. All contact that CA has with DA and/or EA will accordingly be supervised by one of CA's professional carers, but, at NCC's suggestion supported by the Official Solicitor, I will impose no limit as to frequency or duration.

As regards the question of what to do with the LPA:

143. In terms of the LPA, Mr Lewis for NCC submitted that there were three approaches that could be taken by the Court now the Court had found that CA had capacity to make and revoke the LPA. The Court could revoke the instrument which he contended would be the "smoothest and clearest remedy". It would avoid arguments between DA and NCC when DA was constantly suspicious of NCC's motives and thought she was in a battle with the local authority and would avoid the risk of satellite litigation about the terms of an injunction.

144. The second route would be for the Court to "edit" the instrument itself and direct the Office of the Public Guardian to register the Court's amendments. This would be analogous to the powers in section 23 of the Mental Capacity Act 2005 concerning LPAs and which are most commonly deployed when the attorney is, for example, directed not to sell P's house.

145. The third route was the Official Solicitor's preferred route and in the event the Court's. The instrument would be left intact, but a series of injunctive directions would be made against DA. Mr Lewis relied on a case where similar circumstances, elder abuse by a son against his parents had led to this happening: *DL v A Local Authority* [2012] EWCA Civ 253. Theis J's approach was approved by the Court of Appeal, although it was noted that there was no LPA in that case.

Arbuthnot J noted that:

148. Mr Chisholm for the Official Solicitor, supported the third route (namely the making of injunctive orders) but on the basis that the injunctions could and should be made under section 16(2) of the Act to support best interests decisions relating to DA's care, the Court having found that DA lacks capacity to make decisions concerning her care needs.

149. It seemed to me the third route respected CA's wishes for DA to be her LPA, and having found that CA had capacity to make or revoke the LPA, I did not consider that the inherent jurisdiction could or should be used to revoke the LPA. The injunctive directions which were discussed by the parties and for the most part agreed would protect CA from further physical and emotional harm. These were a proportionate response to the risks CA faces.

She also found that:

150. The use of the inherent jurisdiction to impose the continuation of supervised contact between CA and DA/EA in circumstances where CA has capacity pursuant to the MCA 2005 decide on contact with others, was compatible with Article 8 of the European Convention for the Protection of Human Rights and Fundamental Freedoms 1950 (the European Convention), namely the family's rights to respect for private and family life. The interference with the Article 8 rights was justified to protect CA.

151. In the circumstances, the injunctions would allow DA to continue to be health and welfare attorney under the LPA whilst her use of it would be compatible with ensuring CA's safety.

Comment

This was a very complex case, as can be seen by the range of tools that the court had to deploy to respond to the situation. Of particular, wider, interest was the dilemma posed by the fact that CA had

capacity to revoke the health and welfare LPA (and although the judgment did not say this in terms, was clearly not choosing to do so), but lacked capacity to make decisions in relation to her care. One issue that could perhaps have been teased out a little more in the relevant section of the judgment was whether the real concern was:

- (1) Whether DA would use her powers as attorney in such a way as might harm her mother – in which case, directions under s.23(2) would have seemed the right course of action.
- (2) Whether DA would act towards her mother in such a way as to compromise her mother's best interests, in which case directions under s.23(2) could not assist.

Logically, it would appear that the real concern must have been (2), and hence the s.16(3) injunction route was the right course to adopt.

CoP user group minutes

The minutes of the general CoP user group meeting of 16 October 2024 have now been published.

Points of particular interest include an exchange between Vicki Cook of TSF Assessments Ltd and Senior Judge Hilder as to whether capacity assessments had to be conducted face to face. Senior Judge Hilder:

clarified that the purpose of the assessment is to satisfy the decision maker that the threshold of jurisdiction has been reached. The Court will want to know that P has been given the best opportunity for assessment. Remote assessments were permitted during the pandemic but should not be regarded as a standard expectation. If an assessment is conducted remotely, the report should include a clear explanation as to why and set out the support provided to P. If you do not agree with a direction for further assessment, a rule 13.4 application may be made.

On the subject of capacity assessments, Julian Partridge of Devon County Council noted that:

We have received 3 directions orders in the last few weeks and each one is asking for a formal diagnosis on the COP 3 despite a full explanation of P's impairment being contained within the COP3 ..is this a new requirement? We haven't experienced this before....what if there is no formal diagnosis ?

[Senior Judge Hilder] advised that there is no formal diagnosis requirement. A decision maker may request more information if they are not satisfied with the evidence provided. Again, the R13.4 reconsideration may be used where considered necessary.

MENTAL HEALTH MATTERS

Mental Health Bill update

The Mental Health Bill had its second reading on 24 November 2024. An excellent summary of the debate by Tim Spencer-Lane can be found [here](#). Alex has created a specific [page](#) on his website gathering together relevant resources relating to the Bill. It includes a walkthrough of the MHA 1983 as it would be as if amended by the Bill.

The MHA, ‘detainability,’ and judicial scrutiny (and the real underlying problems of children with complex needs)

Re SB [2024] EWHC 2964 (Fam) (High Court (Family Division) (Keehan J))

Article 5 ECHR – deprivation of liberty

Summary

At the heart of this case was the ongoing crisis in supporting children with complex needs. Those issues are discussed in detail in chapter 14 of the Law Commission’s [consultation paper](#) on disabled children’s social care needs, and have been highlighted in detail by (amongst others) the [Nuffield Family Justice Observatory](#) and the [Children’s Commissioner for England](#). Continuing work started by the [previous Government](#), the Labour Government has announced [steps](#) including “[u]ndertaking joint work with NHS England to develop integrated, multi-agency community provision to provide care and/or treatment where restrictions that amount to deprivation of liberty can be imposed.”

In the meantime, SB’s case is grim, but not unusual. It concerns a 15 year old diagnosed with autism and learning difficulties. As Keehan identified at paragraph 11:

In 2020, her parents separated and the mother left the family home. These events greatly distressed SB who felt she had been abandoned by her mother. This distress was considerably exacerbated when SB became aware that her mother had given birth to a baby. Overlaying this was the alleged sexual abuse that SB had suffered by an older male relative which had repeatedly taken place since she was 12 years of age. The perpetrator was arrested in May 2024 and is the subject of an ongoing police investigation.

In turn:

4. Since April 2024 SB has been exhibiting increasingly challenging and extreme behaviour which has placed herself and others at very real risk of very serious harm and, potentially, leading to her death or the death of others. She has been the subject of repeated referrals to the local authority, local psychiatric services, and the police.

5. SB is currently placed in a General Adolescent Unit located at the North Wales Adolescent Service (‘NWAS’) subject to a DoL. Betsi Cadwaladr University Health Board (‘the health board’) is responsible for caring for SB during her admission to NWAS. It was joined as the fourth respondent to these proceedings on 13 August 2024.

6. An issue has arisen between the local authority and the health board as to which statutory body is responsible for the care and treatment of SB and under what legal framework. This issue culminated in the local authority seeking a declaration and ancillary orders from this court, in short form, that because SB was detainable under the provisions of the Mental Health Act 1983 ('the 1983 Act'), the court did not have jurisdiction to grant a DoL pursuant to the inherent jurisdiction. In practical terms, the thrust of the local authority's case was that it was the responsibility of the health board, pursuant to the provisions of the 1983 Act, to make provision for the care and treatment of SB, and not the responsibility of the local authority even with the benefit of a DoL, if authorised by the court.

7. The health board strongly opposed the position of the local authority. It asserted that this court had no jurisdiction to determine whether SB was detainable in a hospital pursuant to the 1983 Act; it had no jurisdiction to exercise a reviewing or supervisory role of the decisions made by clinicians and professionals under the 1983 Act; and that for the court to make a declaration or findings as to whether SB was detainable under the 1983 Act put pressure on the health board to change its position, or otherwise, was an abuse of process.

As Keehan J identified:

53. In support of the proposition that this court can properly analyse and determine whether the 1983 Act is an available scheme, the local authority relied heavily on the decision in the case of *Manchester University NHS Foundation Trust v JS & Others (Schedule 1A Mental Capacity Act 2005)* [2023] EWCOP 33. [...] The essential issue in the case was whether the 17 year old patient was ineligible to be deprived of their liberty pursuant to the provisions of the Mental Capacity Act 2005 ('the 2005 Act').

54. Schedule 1A of the 2005 Act establishes that certain categories of people cannot be deprived of their liberty under that Act. Schedule 1A sets out five situations ('cases') when a person is ineligible if they are "(a) within the scope of the Mental Health Act, but (b) not subject to any of the mental health regimes" (para 2 of Schedule 1A) and they object to being a mental health patient, or to some or all of the mental health treatment (para 5(4) of Schedule 1A).

55. Paragraph 12(1) of Schedule 1A defines the term "within the scope of the Mental Health Act" as:

"P is within the scope of the Mental Health Act if –
An application in respect of P could be made under s.2 or s.3 of the Mental Health Act; and
P could be detained in a hospital in pursuance of such an application, were one to be made."

56. The meaning of the word 'could' in paragraph 12(1) of Schedule 1A was considered by Charles J in the case of *GJ v The Foundation Trust* [2009] EWHC 2972 (Fam). He concluded as follows at paragraph 80:

"So, in my judgment the construction urged by the Secretary of State is the correct one, namely that the decision maker should approach paragraph 12(1) (a) and (b) by asking himself whether in his view the criteria set by, or the grounds in, s. 2 or s.3 MHA 1983 are met (and if an application was made under them a hospital would detain P)."

The Health Board came out swinging:

57. *In the health board's skeleton argument, it was submitted that the JS case was distinguishable as it was limited to a discrete ability of the Court of Protection to determine ineligibility of detention under the 2005 Act for case E patients (i.e., those not already detained under the 193 Act), and did not extend to children below the age of 16, such as SB, within proceedings before the Family Division. In the local authority's skeleton argument, it was submitted that (i) by parity of argument with the ineligibility provisions of Schedule 1A of the 2005 Act, (ii) the interpretation of paragraph 12(1) of Schedule 1A endorsed by Charles J in GJ (above) and (iii) the approach taken by HHJ Burrows in the JS case (above), this court could and should find and declare that SB is detainable under s.3 of the 1983 Act. Accordingly, there is no lacuna for the inherent jurisdiction to deprive SB of her liberty in hospital where she is currently placed or in another placement.*

Perhaps slightly surprising, given the vigour with which the arguments had been put:

58. *[...] at the conclusion of the health board's oral submissions and the court indicating that (i) the case of JS was distinguishable from the legal framework and factual matrix pertaining in this case, and (ii) did not provide material assistance to the court in respect of the issue to be decided in this case, the local authority did not oppose the submissions made by the health board and did not pursue its application for a declaration. No other party, in particular the children's guardian, sought to make any oral submissions in support of or in opposition to the case originally advanced by the local authority.*

Keehan J did then wonder whether he should give a judgment, given that there was no longer any dispute, but decided to do so, and set out his analysis thus:

59. *The leading authorities are abundantly clear that this court has no role to supervise or review decisions which have been entrusted by Parliament to another public authority. The 1983 Act is an obvious example where Parliament has provided for a statutory code in respect of the detention of people with a mental disorder for treatment in hospital.*

60. *Schedule 1A of the 2005 Act makes statutory provision for finding that a person is ineligible from being deprived of their liberty under the 2005 Act, where in case E, they could be detained under the provisions of the 1983 Act. This express statutory provision enables the Court of Protection to consider and determine the question of whether a person could be detained under s.2 or s.3 of the 1983 Act. It is limited to the exercise of determining the specific question of whether a person is ineligible to be detained under the provisions of the 2005 Act. I cannot see any basis for concluding that this provision is to be read as having a wider application, and, in particular, to permit the court to determine whether a person is 'within the scope of the Mental Health Act' when exercising its powers under the inherent jurisdiction.*

61. *There is no authority for the proposition that a court contemplating the exercise of the inherent jurisdiction to deprive a person of their liberty had jurisdiction to encroach upon the issue of whether a person was detainable or could, or would, be detained in a hospital under s.3 of the 1983 Act. In the absence of clear authority, I am satisfied that for this court to make findings and/or declarations about whether SB was detainable under s.3 of the 1983 Act would be to exercise an impermissible supervisory or review function of the clinicians and mental health professionals acting pursuant to the provisions of the 1983 Act. This court has no jurisdiction to make such findings or orders.*

Keehan J was also concerned as to the practical point of making a declaration that SB was detainable:

*62. Further, and in any event, even if this court did find favour with the opinions of Dr Vaidya over those of Dr Hales and made a finding that SB was detainable under s.3 of the 1983 Act what would that achieve? It would not, of itself, lead to SB being detained in a hospital for treatment under the 1983 Act. It might lead to the clinicians and professionals charged with making the decision to detain her under the 1983 Act, to change their professional opinions and decisions. However, to make orders in these circumstances would, as Hoffman LJ set out in *ex p T* (above), be an abuse of process.*

63. If the court did make such a finding, and then went on to make the declaration initially sought by the local authority that the court could not then exercise the inherent jurisdiction to authorise the deprivation of liberty, SB could find herself in a position where she was not afforded protection by being detained for treatment in a hospital nor afforded the protection of being deprived of her liberty in a safe place. This would be an intolerable and unconscionable state of affairs.

Keehan J made clear that he did not “intend any criticism of the local authority in making their applications” in refusing their application for declarations as to the detainability of SB, but:

68. By reason of the above, the court will continue to authorise SB’s deprivation of liberty at NWS pursuant to its inherent jurisdiction. Such an order is both necessary and proportionate having regard to the aim that is sought to be achieved, namely, to prevent SB, in the interim, causing harm to herself or others, pending her imminent discharge into a community placement.

Comment

Many people, we suspect, would be more troubled by the underlying facts of SB’s case, and the lack of appropriate support for her (driven, no doubt, as much by lack of resource as anything else) than by the procedural minutiae of the judgment. It is, however, clearly right, although subject to an important nuance. Paragraph 59 could not be right to the extent that it is suggesting that the High Court cannot consider the lawfulness of decisions of those discharging duties under the MHA 1983. It is self-evidently the case that the High Court can judicially review decisions made by clinicians in relation to treatment: see, for instance, *R (Wilkinson) v Broadmoor Hospital, Responsible Medical Officer & Ors* [2001] EWCA Civ 1545 (in relation to decision-making in respect of treatment).⁴

Further, in *Surrey County Council v MB* [2007] EWHC 3085 (Fam), Charles J considered arguable judicial review proceedings against both doctors and the local authority responsible for (what would now be called) the AMHP in respect of a refusal to make an application under the MHA 1983 in a complex interface case. He noted that:

49. It is acknowledged that a challenge to a decision under the Mental Health Act, being a clinical and professional decision, at public law is a difficult one to establish. However, in my judgment the

⁴ There is a separate question about whether the possibility of judicial review really meets the requirements of Article 8 ECHR as regards the requirement that patients have the ability to challenge decisions in relation to involuntary treatment. That was a matter addressed by the Independent Mental Health Act review, and has led to proposals in relation to tighten up safeguards around such treatment in the [Mental Health Bill](#).

grounds of challenge that are put forward in the judicial review claim to the decisions of both doctors for whom and for which the first defendant in the judicial review proceedings takes responsibility, and of the social worker, which is the reason for the second defendant being in the proceedings, are arguable.

The case did not, in fact, ultimately proceed to a substantive hearing, and it is important to note that Charles J was not proceeding on the basis that he might be making a determination, himself, that MB was 'detainable,' but it does confirm that such decision-making is not beyond review by the courts.

Right Care, Right Person

NHSE has published [guidance](#) on Right Care, Right Person. It might be considered striking that the guidance was published in November 2024, when the agreement itself was published in July 2023, and the approach is being vigorously implemented by the police around the country. It is particularly striking that the guidance, itself, recognises that:

NHS England has been clear that implementation of the NPA:RCRP needs to put people's wellbeing and safety first, ensuring they do not fall through the gaps between services. We recognise that no additional funding has been provided for RCRP delivery, yet it involves the health service taking on significant additional activity. Therefore, it is critical that the timelines for each phase of delivery are agreed on the basis that there is a safe pathway in place, and if this is not the case, we support local systems seeking to agree slow timelines for delivery. It is also vital that RCRP implementation is underpinned by strong partnership working across agencies – health, children's and adults' social care, VCFSE organisations, and the police. Importantly, it cannot be delivered without involving people with lived experience in co-producing changes to these services. This includes the involvement of people from racialised and ethnically diverse backgrounds, as set out in NHS England's [Patient and Carer Race Equality Framework](#) (PCREF).

In December 2024, the Home Office produced a [review](#) of the implementation so far, and the King's Fund published a [report](#) of a rapid research project exploring the view of health and care staff on the impact of implementing RCRP (in the period December 2023 – February 2024). The report identifies in several places the lack of NHSE guidance as a problem. More broadly, and as the summary notes:

The publication in 2023 of the National Partnership Agreement (NPA), a collective national commitment to roll out RCRP, has altered the response to mental health crises in England. Health and social care providers generally welcomed the shift, acknowledging a previous over-reliance on the police. This is, however, an important and substantial policy change, and our interviews reveal numerous barriers to implementation, resource needs, and concerns around potential future impacts.

Across the phases of implementation, health and care organisations are working productively with local police forces to develop policies in response to the RCRP changes. We heard several examples of good practice, clear communication, and strong multi-sector partnerships. This was not, though, the experience of all our interviewees, with some reporting strained relationships, particularly early in the implementation process. Key challenges reported include the over-rapid implementation of RCRP, constraints in health and care providers' capacity and capability, differences in perceived risk, and misunderstandings around legal powers, which risk unlawful

actions. Amended timescales and 'soft transitions' have improved health and social care providers' initial impressions of RCRP, and in most instances adapted implementation plans have been based on local needs.

Our participants reported concerns about escalation procedures and differing perceptions of risk and thresholds for police involvement, which can exacerbate problems of timely response and raise safety concerns. Some interviewees believed that the policy shift has changed some police officers' approach to mental health, with some interpreting RCRP as a blanket approach of "anything to do with mental health, we're not doing it." This has resulted in strained relationships between sectors, and we heard examples of inadequate police response, including refusals to respond when there were incidents outside RCRP's scope, even including a risk to life. We heard reports of families, patients, and members of the public being redirected to other services when seeking police support to situations involving people with mental ill-health, and frequently expressed concerns about how patients may 'fall through the gaps' in service provision.

Our interviewees suggested a need for national guidance, produced jointly by health and police authorities, to enable a shared understanding of how different agencies could respond within the limits of their own legal powers and workforce constraints. They indicated that this should include consideration of risk and thresholds for intervention, clear approaches to escalating incidents which need police involvement and joint training to avoid misuse of legal frameworks.

Improvements in data collection and further robust evaluative research, analysing the impact of this policy on patients, carers, health, care, and police staff, are necessary to inform policy longer term.

THE WIDER CONTEXT

Assisted dying / assisted suicide⁵

In Westminster, Kim Leadbeater MP's Terminally Ill Adults (End of Life) Bill passed its second reading by 330 votes to 275. As a Private Member's Bill, it has not had Government support to date (unlike the position in Jersey, where the work leading to the implementation of a regime there is being led by the Government).⁶ However, we now understand that the Government will start to work on such matters as impact assessments.

We will keep readers updated as matters move forward into Committee stage, which Ms Leadbeater has committed to making more extensive than is usually the case with Private Member's Bill. To this end, Alex has set up a [resources page](#) on his website.

One matter that readers of this Report will no doubt be particularly interested to see unfold is as to whether the approach to capacity remains as set out in the Bill, namely a bare reference to the Mental Capacity Act 2005. This and other complexities relating to capacity are explored in the evidence submitted by Alex and other members of the Complex Life and Death Decisions research group to the Health and Social Care Select Committee's inquiry into assisted dying / assisted suicide. And some may well also be interested to see this [video](#) where Alex explores with Dr Kevin Ariyo the research that he led on as to the ways in which the courts have sought to address the role of interpersonal influence in decision-making capacity.

One final point at this stage in relation to the role of judges, put forward as a safeguard. Whatever "the High Court" is intended to mean in the Bill (a matter which is no doubt going to be teased out in Committee), it cannot mean the Court of Protection. This is a separate, statutory, court, established under the Mental Capacity Act 2005.

Capacity, hospital discharge and possession orders – a checklist and a gap in the court's powers?

Northampton General Hospital NHS Trust v Mercer [2024] EWHC 2515 (KB) (High Court (King's Bench Division) (HHJ Tindal, sitting as a Deputy High Court judge))

Other proceedings – civil

Summary

This case concerns the challenge of delayed discharge from hospital and, specifically, when the delay to discharge comes from the fact that the patient considers that they cannot leave. The judgment, reflecting (no doubt) the frustration of the hospital Trust involved, talks of 'bed-blocking' and 'refusal,'

⁵ We are conscious that language evokes strong emotions here, with very strong feelings from both 'sides' as to the correctness of identifying what is being proposed in Ms Leadbeater's Bill. Recognising that strength of feeling, we use "assisted dying / assisted suicide" here.

⁶ For a comparison between the approaches in England & Wales, Scotland, Jersey and the Isle of Man, see the [slides](#) and the accompanying table from the webinar held in Chambers on 20 November.

but it might be felt that the facts disclosed a slightly more complex picture than that. As (deliberately) described in relatively short terms by HHJ Tindal, sitting as a Judge of the High Court:

3. Ms Mercer is aged 34 and has several disabilities. She is wheelchair-dependent and requires support with her personal care and medication, but also has diagnoses of Autistic Spectrum Disorder and Emotionally Unstable Personality Disorder. She has lived in residential accommodation for most of her adult life. Before she was admitted to Northampton Hospital ('the Hospital') on 14th April 2023 for cellulitis of her right leg, she had lived at a home called St Matthews for nine years. She was transferred to the Claimant Hospital's Willow Ward for treatment to her leg and on 25th April 2023 she was declared medically fit for discharge. The original plan was for her to return to St Matthews, but that fell through because of a dispute between it and Ms and Mrs Mercer. Despite placement searches by the Adult Social Care team at North Northamptonshire Council ('NNC'), she has been in the Hospital ever since, mostly on Willow Ward. However, a placement has been now found which the Hospital and NNC believe will meet Ms Mercer's needs: 24-care in a Supported Living placement.

4. This would be an entirely new lifestyle for Ms Mercer and she is extremely anxious. She and her mother feel she may hurt herself or others there. Therefore, she refuses to move and wants a placement in residential accommodation, either St Matthews or a similar care home closer to her mother. But she has been assessed as not needing that. So, after a year of accommodating Ms Mercer whilst NNC tried to find a suitable placement to accept them, the Hospital have decided that enough is enough and on 14th August 2024, sought this possession order.

The application for a possession order was plagued with procedural deficits. Ms Mercer was not represented at the hearing, but was assisted by her mother. HHJ Tindal ultimately granted the order, but used the opportunity both to review the (relatively limited) case-law on this area, and to set out a checklist for future cases. Of particular interest is what HHJ Tindal had to say in relation to the MCA 2005:

28, Turning to the MCA, it is imperative that a hospital contemplating a possession claim considers whether there is reason to believe the patient may lack mental capacity. This was not discussed in detail in H, Price, or even MB, where the hospital had assessed the patient as having capacity to make all relevant decisions and to litigate (which was not disputed by her lawyers: see [40]-[41]). Moreover, even if the patient has capacity to litigate, or the possession or injunction proceedings, they may still be a 'vulnerable party' requiring 'participation directions' under CPR PD1A (which could include a remote hearing).

i) Firstly, with a MHA informal patient fit for discharge but refusing to leave, the complex interface between the MHA and MCA contains several tripwires for a hospital which might make a possession order inappropriate. As discussed in this article: [948](#), psychiatrists may assume that applying the 'least restrictive principle' in the MHA Code of Practice and also under s.1(6) MCA points towards use of 'Deprivation of Liberty Safeguards' ('DOLS') arrangements in a community placement rather than MHA detention in a hospital, but that does not necessarily follow. M shows 'DOLS' is not available through a CTO and whilst the Court of Protection can 'co-ordinate' with a Tribunal to move an incapacious patient from discharge under the MHA to authorisation of DOLS under the MCA (MC v Cygnet Behavioural Health [2020] UKUT 230 (AAC)), DOLS is unavailable if the patient is 'ineligible' under Sch.1A MCA. They will be if still subject to a MHA treatment regime in hospital, in the community under a CTO/Guardianship and even if not but are still 'within scope'

of the MHA, like an informal mental health patient: *Manchester Hospitals v JS* [2023] EWCOP 12^[7]. In practical terms, if a discharged MHA patient is refusing to move from hospital to a community placement which would be a deprivation of liberty under Art.5 ECHR, that requires authorisation by the Court of Protection under the MCA, pending which a High Court possession order may well be inappropriate and which it may therefore refuse.

ii) Secondly, a patient with no history of MHA detention or admission may still lack capacity to make decisions about where they should live under ss.2-3 MCA. It is true that s.1 MCA states there is a 'presumption of capacity' and that people should not be assumed to lack capacity because they make unwise decisions and/or without all practicable steps to enable capacity. However, failure to undertake a capacity assessment if there is any 'reason to believe the patient may lack capacity' would breach NHS guidance, so may justify refusal of a possession order (c.f. *Barber*) because the consequences are so serious either way. If a hospital do not take reasonable steps to assess a patient's capacity and treats them as not having capacity to consent to treatment or discharge when in fact they do have it, the hospital will not have a defence under ss.5-6 MCA to otherwise tortious acts like medication or restraint, even if clinicians believed those acts were in the patient's best interests, like the *Police in ZH v CPM* [2013] 1 WLR 3021 (CA). Conversely, if a hospital fails to assess capacity of a patient and assumes they do have it when they do not, they cannot consent to leaving hospital, which therefore requires a best interests decision under s.4 MCA, if there is objection by the Court of Protection under ss.16-17 MCA, or if not by the hospital under s.5 MCA (only dispute requires Court involvement: *NHS v Y* [2018] 3 WLR 751(SC)). If a hospital fails to comply with the MCA in discharging an incapacious patient to an unsuitable placement, they can be liable in tort for resulting injury, as in *Esegbona v King's NHST* [2019] EWHC 77 (QB).

iii) Thirdly, s.2 MCA states that 'a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain' and s.3 MCA states the person is unable to make a decision if unable to understand, retain or use the information relevant to the decision (or to communicate it). As explained in *A Local Authority v JB* [2021] 3 WLR 1381 (SC), this means 'capacity' under the MCA is 'issue-specific' and 'time-specific', so someone can have mental capacity to make one decision (e.g. to see their relatives) but lack capacity about another (e.g. to manage their financial affairs or where they should live). The 'relevant information' under s.3 MCA which must be understood for capacity to consent to treatment (*Hemachandran v Thirumalesh* [2024] EWCA Civ 896) is slightly different than for capacity to consent to discharge from hospital, which is in turn slightly different than for capacity to consent to living at a particular placement – see *Wiltshire CC v RB* [2023] EWCOP 26. In *RB* itself, a patient fit for discharge from hospital objected to her return to accommodation where she had suffered trauma and was held to have been wrongly assessed as lacking capacity as the assessment elided issues of discharge and placement. Moreover, as also stressed in *RB*, an individual's capacity to litigate (e.g. to defend a possession claim by a hospital) is a separate issue of capacity again. If a patient lacks capacity to defend a possession claim by a hospital, under CPR 21 they require a Litigation Friend and without

⁷ Although not relevant for the purposes of the case, it is important to note that it is possible to be both on a CTO and a DoLS. The ineligibility for DoLS arises if the DoLS authorisation purports to relate to a place other than identified on the CTO as the place that the person is required to reside: see Case C in the appallingly drafted Schedule 1A to the MCA 2005, and this [shedinar](#).

it the order would be invalid and may be set aside: Dunhill v Burgin [2014] 1 WLR 933 (SC). Moreover, service of proceedings must be on an Attorney, Deputy, or carer – see CPR 6.13.⁸

HHJ Tindal also made some important observations as to the Equality Act 2010:

29. Indeed, finally turning to the EqA, at the first hearing I raised the absence of not only assessment of Ms Mercer’s litigation capacity, but also evidence of the Hospital’s compliance with the Public Sector Equality Duty (‘PSED’) under s.149 EqA and evidence relevant to a potential public law EqA disability discrimination defence. Again, there are three key points about EqA ‘mental disabilities’:

i) Firstly, a patient may fall outside the scope of the MHA, also have capacity under the MCA to make all relevant decisions, yet still have a ‘mental impairment with a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities’ amounting to a disability under s.6 EqA. A ‘mental disability’ has a ‘long-term effect’ if it has lasted or is likely to (in the sense of ‘may well’) last for at least 12 months (para.2 Sch.1 EqA), whereas mental capacity under the MCA relates to the ability to make a particular decision at a particular time, so a person may lose and regain capacity from time to time: see MOC v DWP [2022] PTSR 576(CA). Therefore, a MCA capacity assessment may not necessarily reveal a EqA ‘mental disability’.

ii) Secondly, as Chamberlain J analysed in MB at [61], a hospital is a ‘service-provider’ under s.29 EqA, which can be liable for disability discrimination if it fails in its duty under ss.20-21 EqA to make reasonable adjustments for a disabled patient before seeking possession (or an injunction to exclude). Of course, as in MB, if a hospital has taken all reasonable steps (and complied with national guidance and its own policy), there will be no breach. However, it does not appear the patient’s lawyers in MB raised s.15 EqA, which provides that a service provider or landlord discriminates against a disabled person if it ‘treats them unfavourably because of something arising in consequence of their disability (if they were or ought to have been aware of it) and cannot show the ‘treatment is a proportionate means of achieving a legitimate aim’. If a hospital seeks possession (‘unfavourable treatment’) because of a patient’s refusal to leave hospital (‘something’) due to a known mental disability, it will have to prove possession would be proportionate. In Aster v Akerman-Livingstone [2015] 2 WLR 721(SC), Lady Hale explained s.15 EqA has a higher onus of proof than the ‘proportionality test’ for possession under Art.8 ECHR and a summary possession order is not a given. But it may be more likely for a hospital against a patient than a landlord against a tenant, providing all reasonable lesser alternatives have been tried but not succeeded in the patient leaving.

iii) Finally, quite aside from actual disability discrimination under ss.15 or 20-21 EqA, a hospital is a ‘public authority’ owing the PSED to ‘have regard’ to the needs ‘to advance equality of opportunity’ for disabled people and to take different steps for them than for non-disabled people under s.149 EqA. On one hand, this is a duty of substance not form, which can be complied with without explicit reference to s.149 EqA (McDonald, MB). On the other, such cases of inadvertent compliance are rare and a public authority would generally be wise to carry out and record a specific, open-minded and conscientious consideration of the impact of possession on the disabled person and whether that can be safely managed, though breach of the PSED will not defeat possession if highly likely

⁸ Although CPR 6.13(2)(b) also provides that, if there is no attorney, deputy or carer, for service on an “adult with whom the protected party resides or in whose care the protected party is.”

it would have resulted even if the PSED had been complied with (Luton Housing v Durdana [2020] HLR 27 (CA) and Metropolitan Housing Trust v MT [2022] 1 WLR 2161 (CA)).

Drawing the threads together, HHJ Tindal suggested that:

30. [...] the following may be a helpful checklist for a hospital seeking possession (or a injunction in more complex cases e.g. with risks to staff), in relation to a patient whose refusal to leave hospital may be affected by a mental health or mental capacity issue. (However, I do not suggest a failure to take any or even all of these steps will necessarily bar such orders):

(i) Has there been full and holistic preparation of the patient for discharge?

- Has NHS guidance / local policy on 'patient involvement' been followed?*
- Has there been sufficient liaison with the relevant local authority if it will be responsible for accommodation and/or care provision and funding?*
- Has it been explained to the patient and carer: how ongoing medical/care needs will be met, who is responsible for meeting them and what the patient or carer can do if they are unhappy about the provision?*

(ii) Have there been all necessary mental capacity assessments of the patient?

- Does the patient have capacity to consent or object to (1) discharge and/or (2) placement (as opposed to treatment)? If not, an application to the Court of Protection may be required if there is any dispute.*
- If both, do they have capacity to defend possession/injunction proceedings? If not, a suitable Litigation Friend will need to be found (who may be the person required to be served with the claim under CPR 6.13).*
- Either way, if the patient would struggle to attend or participate physically and is a 'vulnerable party' under CPR 1A, the claimant hospital could suggest to the Court a remote hearing and facilitate it from hospital.*

(iii) Has the proportionality of possession (or an injunction) been assessed?

- Is the patient's refusal to leave in consequence of a mental disability?*
- Have all reasonable lesser alternatives to possession or an injunction been tried but not succeeded in the patient leaving the hospital voluntarily?*
- Can the physical and psychological impact on the patient of being removed from hospital home or to the proposed placement be safely managed?*

I emphasise that whilst the few cases so far suggest possession or an injunction has been ordered after a patient has been fit for discharge for around a year, that particular quantity of time is less important than the quality of the evidence on those issues justifying possession or an injunction.

On the facts of the case before him, HHJ Tindal proceeded thus:

31. *Prior to the first hearing, the Claimant Hospital had evidenced much of this. Dr Baratashvili's statement proved Ms Mercer had been medically fit for discharge since April 2023. Ms Mallender's first two statements proved the Claimant had complied with the national NHS guidance and the Hospital's own policy. I reject Ms and Mrs Mercers' allegations that Ms Mallender has 'lied', which stem from their misunderstanding (e.g. they thought reference to past case-law breached confidentiality). Ms Mallender has showed why Ms Mercer's return to St Matthews broke down in May 2023 (due to a dispute between it and Ms Mercer) and how Ms Mercer had been assessed as the responsibility of the local authority NNC. It had investigated almost 120 different placements for Ms Mercer and found a Supported Living placement specialising in working with those with Ms Mercer's disabilities, initially with 2:1 care day and night during transition, before reducing to 1:1 care with 2:1 at specific times, meeting all her care needs.*

32. *However, even aside from Ms Mercer and her mother being unable to participate effectively at the last hearing, there was relatively little information about Ms Mercer's undisputed and long-term diagnoses of Autistic Spectrum Disorder ('ASD') and Emotionally Unstable Personality Disorder ('EUPD') relevant to both disability under the EqA and capacity under the MCA. The Claimant Hospital had provided assessments from Dr Ur-Rehman of Ms Mercer's capacity to consent or object to her discharge and placement, but there was no assessment of her capacity to litigate. Moreover, there was no Equality Impact Assessment ('EIA') addressing the proportionality of possession and whether all lesser alternatives had first been explored. This was in part why I adjourned the first hearing.*

33. *By contrast, at the adjourned hearing, not only was Ms Mercer able to attend remotely (although as I said, preferred her mother to speak for her), the Hospital and Ms Mercer herself had between them filled those gaps in the evidence. There were EIAs from NNC giving more details about the proposed placement and from Ms Mallender explaining that possession was proportionate because Ms Mercer did not need to be in the Hospital, which urgently needed her bed. Dr Ur-Rehman had assessed Ms Mercer as having capacity to defend the proceedings and as Mr Sinnatt said, that view was underlined by Ms Mercer providing medical assessments about her ASD and EUPD. Moreover, Mrs Mercer accepted Ms Mercer could understand discharge, placement and possession. I am entirely satisfied Ms Mercer had mental capacity in all relevant areas.*

34. *Nevertheless, at that adjourned hearing, I listened to and considered Ms Mercer's concerns, articulated clearly by her mother and indeed by her social worker, Ms Sgoluppi. After all, Ms Mercer has been in institutional care all her adult life, St Matthews for 9 of the last 10 years and the Hospital for the last 18 months. As Ms Sgoluppi said, Ms Mercer has clearly become institutionalised and that in combination with her ASD and EUPD has led her to severe anxiety over the proposed move to a Supported Living placement for the first time. Mrs Mercer fears her daughter will self-harm, hurt her carers, or even attempt suicide. I do understand and entirely sympathise. It is sad and ironic that NNC's assessment of Ms Mercer's care, in seeking to find the least restrictive option (consistently with the MHA, MCA and CA, as well as proportionality under the EqA), has caused Ms Mercer more anxiety than a more familiar institutional placement.*

35. *However, that is NNC's assessment of her needs for care and support and if Ms Mercer wishes to challenge it, she must do so with NNC in the first instance, then by complaint to the Ombudsman, or by claiming Judicial Review of NNC's assessment. What she cannot do is continue to avoid her departure by remaining in the Claimant Hospital when she does not need a bed there (and has not done for over a year) but other patients do. More positively, the proposed placement will initially*

have 2:1 care available day and night to help Ms Mercer, which will be reviewed before it reduces to 1:1 care. NNC assesses that as enough to keep Ms Mercer safe and her social work team will review her progress closely. I understand from NNC's EIA that Mrs Mercer has already met the care team (although still has concerns). Moreover, the Hospital also agreed to my suggestion of deferring possession for a week to help Ms Mercer prepare. So, at the hearing, I was satisfied possession was a proportionate means of achieving a legitimate aim even if s.15 EqA (and Art.8/14 ECHR) were engaged and that the Hospital had complied with the PSED. There was no arguable public or private law defence, so I granted summary possession. We must hope the transition goes smoothly.

Comment

Cases involving discharge from hospital where individuals have potentially impaired capacity, even in the context of those who are not in some way seen as objecting to their discharge, can be very complicated. Alex has set out a set of slides for those seeking to think through how the MCA operates in this context [here](#). One point made there, and also in our comment on the [Wiltshire](#) case referred to by HHJ Tindal, is that talking of 'consent' to discharge is perhaps inapt, because the decision whether or not to stay in hospital is – as this case shows – not ultimately in the patient's gift. Rather, the decision in question is whether or not to leave hospital, to match the language that would be used in relation to a person whose decision-making capacity is not in question. It would be interesting to know whether, applying that test, Ms Mercer had or lacked the relevant decision-making capacity.

And notwithstanding the obvious care with which HHJ Tindal approached matters, some might wonder whether this was not a case in which an independent report on Ms Mercer's capacity was warranted, given its importance (including to the availability of any public law defence to the possession proceedings). Casting no aspersions on those at the hospital providing reports upon Ms Mercer's capacity, it might be thought that there was a distinct systemic nudge at play towards finding her to have capacity; similarly, whilst her mother undoubtedly was her champion, that is different to being able to assess her capacity. The case might well be thought to throw up, in fact, a serious limitation with the powers of civil courts at present, as they have no equivalent power to the Court of Protection to direct a report from a Special Visitor under s.49 MCA 2005. This limitation and its consequences for considering litigation capacity are discussed in the Civil Justice Council's [recent report](#), but it might equally be thought that a situation like this is one where the court would also benefit from independent evidence as to capacity to make the decision(s) in issue.

Book Reviews: NHS Law and Practice (2nd edition) and Making Lawful Decisions (1st edition)

Legal Action Group have recently sent me two books to review, one very long, and the other very short. This review can be short. They are both excellent.

In slightly greater detail, the long (1114 pages) book is the second edition of [NHS Law and Practice](#) (£95.00), with a revised author team led by David Lock KC, Leon Glenister and Hannah Gibbs. I should come clean immediately and say that, thanks to their kindness, I had early access to it when working on the chapter on the intersection between social care and healthcare when leading on the Law Commission's consultation paper on disabled children's social care law. I knew that I

could rely upon it as an authoritative, clear and and straightforward guide to a world that is anything but clear and straightforward. They saved me a huge amount of time, and they will equally save anyone – whether they be patient, family member or professional – huge amounts of time trying to navigate the maze of primary and secondary legislation, statutory guidance, non-statutory guidance, case-law and (on occasion) urban myth in this area. The authors are to be thanked and congratulated, and encouraged to start girding their loins again for a new edition.

The short (188 pages) book is an entirely new work, that of colleagues in Chambers, Steve Broach KC and Victoria Butler-Cole KC (together with other contributors). Called *Making Lawful Decisions* (£45.00), it tackles a topic which is should be of interest to everyone. In short chapters covering all stages of the decision-making process, as well as compliance with the Human Rights Act 1998 and the Equality Act 2010, it packs in a huge amount of supremely practical wisdom and has the potential to save everyone industrial quantities of time, money and heartache by ensuring that decisions are made lawfully first time around. The chapter on remedies in the Law Commission consultation paper I noted above could have been cut by at least half, if not more, had this book been published and been followed years ago. The authors – all of them – have done a real public service in pulling this work together. I hope that a second edition will not be needed, even if the reality is that it may well be in due course.

Note: I am always happy to review books in the field of mental capacity, mental health and healthcare law (broadly defined).

Alex Ruck Keene

Mental capacity in civil proceedings – the final report of the Civil Justice Council working group

At its July 2022 meeting, the Civil Justice Council (CJC) approved the creation of a working group to look at a procedure for determining mental capacity in civil proceedings. The working group (of which Alex was a member) has now published its [final report](#). We reproduce the executive summary below (footnotes omitted), although this is no substitute for reading the whole report:

1.1 The issue of whether an adult party to court proceedings has the mental capacity to conduct the proceedings (“litigation capacity”) is one of fundamental importance. Under the Civil Procedure Rules (CPR) a person who lacks litigation capacity is a ‘protected party’ and must have a ‘litigation friend’ appointed to conduct the litigation on their behalf. If it is wrongly decided that the party lacks capacity, the appointment of a litigation friend to take decisions on their behalf will represent a significant infringement of their personal autonomy. If it is wrongly decided that the party has capacity and can conduct the proceedings for themselves, they may be denied meaningful access to justice.

1.2 Although CPR Part 21 sets out the procedure applying to protected parties, neither the CPR nor its Practice Directions (PDs) set out any procedure for determining whether a party lacks litigation capacity. The Court of Appeal recommended more than 20 years ago that consideration be given to addressing this gap, but that does not appear to have happened and no action has been taken.

1.3 Where the party whose litigation capacity is in doubt is legally represented, the issue can usually be resolved without the involvement of the court. The Working Group does not seek to propose any changes in relation to such cases.

1.4 However, in many other cases the issue can be much more difficult to resolve and will require the involvement of the court. Such cases include unrepresented parties and represented parties who dispute the suggestion that they lack capacity and/or will not cooperate with any process of assessment. In the absence of any clear provision in the CPR, for many years judges, parties and legal representatives have been forced to come up with ad hoc solutions. This has led to inefficiency, inconsistency of practice, and actions being taken without a clear legal basis.

1.5 One 'ad hoc' solution that many respondents to the consultation referred to was the practice of having an 'informal' litigation friend in place prior to the issuing of a claim. It seems to be common for arrangements to be made for such a person to assist a claimant and for this person to attend hearings to approve settlements. Given the extent of work undertaken prior to issue, often resulting in settlement, particularly in personal injury and clinical negligence claims, the view was expressed that the appointments of litigation friends prior to the issuing of a claim be formalised. The CJC supports this.

1.6 It is the strong view of the Working Group, and the almost unanimous view of the judges and practitioners whom it consulted, that there should be clear provision and guidance on the procedure for the determination of issues of litigation capacity. This should principally be set out in the CPR and/or a new PD, to ensure that there is a single, easily identifiable, and authoritative source. In relation to some of the issues identified, other measures may be needed, such as professional guidance, judicial training and even legislation.

1.7 Given the huge diversity of civil cases and the wide range of issues that may arise, a single procedure, to be applied in all cases, would be inappropriate. Instead, courts should be provided with a 'menu of options' together with guidance as to the relevant principles to be applied, to ensure an appropriate approach can be adopted in each case, giving effect to the overriding objective.

The key principles and recommendations can be summarised as follows:

a. In dealing with issues of capacity, the court must take into account, in particular (i) the fundamental importance of the issue; (ii) the right for those with capacity to conduct their own litigation; (iii) the need to protect the interests of the party who may lack capacity, at a time when they are unable to protect their own interests; (iv) the need to protect the interests of other parties to the substantive proceedings; and (v) proportionality.

b. The court's role must be a quasi-inquisitorial one, in which the court is responsible for ensuring that it has the evidence it considers necessary to determine the issue, albeit that the work of gathering such evidence will necessarily be delegated to others.

c. Issues of litigation capacity should be identified and determined at the first available opportunity.

d. Although the presumption of capacity is an important starting point, it must not be used to avoid proper determination of the issue where it arises, even where it may be difficult to obtain evidence.

e. The determination of a party's current litigation capacity is not generally one in which other parties have a right to be heard, although in some cases it may be so inextricably interlinked with the substantive issues that they must be given a right to be heard.

f. However, all parties (under the overriding objective) and their legal representatives (as part of their professional ethical duties) have a responsibility to assist the court in identifying and determining issues of litigation capacity.

g. Where the party whose capacity is in doubt is legally represented, the legal representatives should carry out the work of investigating the issue. In other cases, a range of options should be available to courts for the delegation of this work. This would include existing options and may also require the introduction of further options, based on procedures currently available in the Court of Protection (COP).

h. There should be a clear power for the court to order disclosure of evidence relevant to the issue of litigation capacity, together with guidance to ensure that this is only used where it is necessary and proportionate.

i. Generally, once the court has decided that an issue of litigation capacity requires determination, it should direct that no further steps be taken in the proceedings, and that existing orders be stayed, pending determination of the issue. However, this should be subject to a power to order otherwise, based on a 'balance of harm' approach.

j. In relation to hearings to determine the issue of a party's litigation capacity, the court should consider what measures are necessary to protect the party's rights to privacy, confidentiality, and legal professional privilege. Open justice and the need for transparency are of crucial importance in civil court proceedings. However, in order to protect legal professional privilege, confidentiality and privacy, the court should have the power to (i) hold all or part of the hearing in private; (ii) exclude other parties to the substantive proceedings; (iii) make anonymity orders and/or impose reporting restrictions, where those measures are unavoidably necessary.

k. A party who is found to lack litigation capacity must have a right of appeal, which may require modifications to usual appeal procedures to ensure that it is effective.

l. Proper funding must be made available for the investigation and determination of issues of litigation capacity, including the creation of a central fund of last resort.

1.9 Ultimately, this report is only a first step in what may well be a long journey to achieving a system for determining issues of litigation capacity which is fit for purpose. Some improvements can be made quickly, simply and at little or no cost. Others will require further detailed consideration, further funding and/or legislative intervention and so may take some time. However, given the importance of the issue and the current absence of provision, it is not an option to simply ignore the issue.

Litigation friends in the immigration tribunals

Mr Justice Dove and Judge Plimmer, the presidents of the Immigration and Asylum Chambers of the Upper Tribunal and First-tier Tribunal, have issued [guidance](#) on the appointment of litigation friends. This joint presidential guidance is published following consultation with users of the tribunal and will be reviewed after six months. It applies in England and Wales.

Capacity, “capability” and consent – a complication concerning surrogacy

R & Anor v A & Anor [2024] EWFC 341 (Family Court) (Judd J)

Other proceedings – family (public law)

This is a very sad case involving surrogacy. It was an application for a parental order by Mr and Mrs R, with respect to a 6 month old boy – in other words an order providing for the boy to be treated as their child. The surrogate mother, Ms A, suffered from respiratory arrest during the course of a caesarean section when giving birth. This left her with a hypoxic brain injury and cognitive impairment. Every other condition for the making of a parental order was satisfied, but Ms A was in consequence of her brain injury thought to be unable to give the consent of the surrogate normally required by the Human Fertilisation and Embryology Act 2008, s.54(6) of which provides that:

The court must be satisfied that both –

- (a) the woman who carried the child, and*
- (b) any other person who is a parent of the child but is not one of the applicants (including any man who is the father by virtue of section 35 or 36 or any woman who is a parent by virtue of section 42 or 43)*

have freely and with full understanding of what is involved, agreed unconditionally to the making of the order.

However, s.54(7) provides in material part that:

Subsection (6) does not require the agreement of a person who [...] is incapable of giving agreement.

The question for the court, therefore, was whether Ms A was “*incapable of giving agreement.*” Judd J identified that counsel before her had been unable to find any case in which this had been addressed. Section 1 of the Adoption and Children Act 2002 also applies to the making of parental orders, so that the child’s welfare throughout their life is the court’s paramount consideration. Judd J noted that:

27. *S52(1) of the ACA 2002 provides that:*

“The court cannot dispense with the consent of any parent or guardian of a 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.”

28. *It can therefore be seen that the provisions of the HFEA and the ACA are different with respect to consent/agreement. Mr. Powell points out that the Mental Capacity Act was brought into force after the ACA, and that s52(1)(a) was amended to include reference to it. The HFEA came into force afterwards but no reference was included*

29. *Although the two Acts clearly have similarities (and s1 of one is imported into the other), there is a clear difference when it comes to the issue of consent. There is no provision by which consent can be overridden under the HFEA on the basis of the child's welfare. I am satisfied that the question as to whether the relevant person is incapable of giving agreement pursuant to s54(7) is a question of fact to be determined by the court, giving the words their ordinary meaning, and that the capacity concerned is wider than that defined in the Mental Capacity Act 2005. The court is likely to wish to consider the person's ability to understand the information relevant to the decision, to retain it, to use and weigh it, and to communicate it, but may take into account other issues too. (emphasis added)*

On the facts of the case, Judd J had little hesitation in concluding that Ms A was “incapable” of giving the relevant consent, and that the parental order should be made.

Comment

It is perhaps a little unfortunate that Judd J did not have drawn to her attention a straightforward reason why the HFEA 2008 talks of the person being incapable of giving consent, whereas the ACA 2002 talks of the person lacking capacity for purposes of the MCA 2005. The former applies across the United Kingdom (and, specifically, Scotland, where the test for capacity is different, and set out in the Adults with Incapacity Act (Scotland) 2000); it could not therefore simply refer to the MCA 2005 test. The ACA 2002 (for these purposes) only applies in England and Wales, and can therefore refer to the MCA 2005.

In this regard, it would perhaps have been helpful had Juud J drawn to her attention the recent joint report of the Law Commissions of England & Wales and Scotland on surrogacy. This provides (at 10.27) that:

There has not been a reported decision where the surrogate has been found unable to consent due to a lack of capacity. In England and Wales, the Mental Capacity Act 2005 sets out the conditions under which a person will be held to be lacking capacity for these purposes. In Scotland, in terms of the rules of court, the reporting officer is required to ascertain whether the person suffers or appears to suffer from a mental disorder within the meaning of section 328 of the Mental Health (Care and Treatment) (Scotland) Act 2003.

Even if, strictly, the MCA 2005 can only apply when the statute provides,⁹ Occam's Razor might be thought to apply so as to remove the need in England & Wales to consider whether 'wider factors' than those contained in the MCA 2005 should apply when considering capability to consent for purposes of the HFEA 2008.

The draft Bill put forward by the Law Commission proposed a continuation of the same terminology of “incapability” as contained in s.54 HFEA 2008. It may be that in light of this decision it would be prudent for any legislation ultimately brought forward to make clear that the term is to be construed by reference to the relevant legislation in the different jurisdictions (even if the Northern Irish legislation is not yet fully in force by then, there is still a statutory test which could be applied for these purpose). In the interim, and with respect, it is suggested that Judd J's decision on the law is one that is open to

⁹ See, in this regard, this [discussion](#) of the application of the MCA 2005 in the context of the retrospective assessment of testamentary capacity.

doubt, albeit that there is no reason to consider that on the evidence before that her decision on the facts of the individual case was incorrect.

European Court of Human Rights

A Strasbourg shot across the bows for the MCA 2005

ET v Moldova [2024] ECHR 858 (ECtHR, Second Section)

CRPD

Summary

This decision is one with ramifications extending significantly beyond Moldova. It concerned the inability of the applicant, who had been declared totally incapacitated owing to her mental illness, to bring a court action aimed at restoring her legal capacity and the alleged discrimination against her on the basis of her intellectual disability. "Incapacitation" is a phenomenon which is still relatively widespread, by which a court declares that a person is (in effect) a non-person legally, such that their actions have no legal consequences.

It is a matter which greatly concerns the Committee on the Rights of Persons with Disabilities, who have regularly challenged states in which such frameworks exist. In *ET*, the ECtHR made a specific point of referring to the Committee's [General Comment 1](#) on Article 12 (on the right to legal capacity).

Article 6

At the time that the material events occurred in Moldova, Moldovan law did not provide for any intermediary solutions in respect of varying degrees of incapacitation, i.e. by reference, for instance, to the degree of the person's cognitive impairment. It only provided for total incapacitation. As the court noted:

46. Aside from the negative effect on a person's rights under Article 8 of the Convention (see Shtukurov v. Russia, no. 44009/05, § 95, ECHR 2008), such a rigid rule not allowing the domestic courts to take into account the degree of a person's incapacitation also resulted in the total limitation of his or her access to a court. "

This clearly engaged Article 6, on the basis that proceedings for restoration of legal capacity are directly decisive for the determination of "civil rights and obligations" (paragraph 42).

The Strasbourg court noted that:

47. It is true that the right of access to a court is not unlimited. In particular, there may be relevant reasons for limiting an incapacitated person's access to a court, such as for the person's own protection, the protection of the interests of others and the proper administration of justice (see Nikolyan, cited above, § 91). However, the importance of exercising these rights will vary according to the purpose of the action which the person concerned intends to bring before the courts. In particular, the right to ask a court to review a declaration of incapacity is one of the most important rights for the person concerned since such a procedure, once initiated, will be decisive for the exercise of all the rights and freedoms affected by the declaration of incapacity (see Shtukurov,

cited above, § 71). The Court therefore considers that this right is one of the fundamental procedural rights for the protection of those who have been partially deprived of legal capacity. It follows that such persons should in principle enjoy direct access to the courts in this sphere (see *Stanev*, cited above, § 241), which was not the case in the Republic of Moldova at the time of the events (see paragraph 16 above, notably Article 308 of the Code of Civil Procedure).

48. The State remains free to determine the procedure by which such direct access is to be realised, while ensuring that the courts are not overburdened with excessive and manifestly ill-founded applications. This problem may be solved by other, less restrictive means than automatic denial of direct access, for example by limiting the frequency with which applications may be made or introducing a system for prior examination of their admissibility on the basis of the file (*ibid.*, § 242).

49. The Court also notes the importance which international instruments for the protection of people with mental disorders attach to granting them as much legal autonomy as possible (see paragraphs 22 and 23 above). In particular, a growing trend has been the replacement of systems based on depriving a person of all legal capacity in his or her “best interests” with a system of supported decision-making which is capable of taking into account the person’s own will and preferences. In this connection, it is to be noted that in the present case the applicant argued that she had had strained relations with her guardian. The latter may have experienced a conflict of loyalties between, on the one hand, the applicant’s former husband in supporting his application to deprive her of legal capacity and, on the other hand, the applicant in supporting her wish to recover her capacity (see *Ivinović v. Croatia*, no. 13006/13, § 45, 18 September 2014). Nevertheless, the applicant had no direct means to initiate court proceedings to recover her capacity and the courts rejected the court action brought by the lawyer whom she had authorised (see paragraph 11 above).

The court also noted that the Moldovan Constitutional Court had, itself found that the domestic legal provisions limiting the right of access to a court by incapacitated persons to be unconstitutional as well as amendments to the legislation improving the situation. It is therefore not entirely surprising that it then found *ET*’s Article 6 rights to have been breached.

Articles 8 and 14

Interestingly, the Strasbourg court then went on to consider the applicant’s complaint that she had “been discriminated against as compared with other persons temporarily unable to understand their actions but whose legal capacity remained intact” (paragraph 53). It found that there had been differential treatment:

65. The Court notes that under Article 20 of the Moldovan Constitution [...] all persons have the right of access to justice. However, as the law stood at the time of the events, one category of persons – those affected by intellectual disability – could be deprived of their legal capacity and as a result completely lose their right of defending in court their rights, such as those protected under Article 8. The Court considers that this shows the existence of a difference of treatment of this category in comparison to all other persons.

It found that this differential treatment had been based on an identifiable characteristic, “namely the state of mental health of the individual, which is to be considered as a form of “other status” within the

meaning of Article 14 of the Convention" (paragraph 66). This then meant it had to consider whether there was an objective and reasonable justification for this treatment:

68. In this connection, the Court reiterates that there is a European and worldwide consensus on the need to protect people with disabilities from discriminatory treatment (see Glor v. Switzerland, no. 13444/04, § 53, ECHR 2009).

69. It accepts that mental illness may be a relevant factor to be taken into account in certain circumstances, such as when assessing parents' capability of caring for their child (see Cînța, cited above, § 68). In view of the obligation mentioned above, the Court finds that the domestic authorities had the power, and even the obligation to take action which was aimed at protecting the interests of such persons, notably through ensuring reasonable accommodation to their needs. There are, therefore, valid reasons for treating differently persons with mental illnesses, always with the aim of offering additional protection to them, to the extent that they need such protection, and while ensuring that taking into account their will and preferences remains at the heart of any arrangements made. Accordingly, the Court concludes that the reasons advanced by the Government – of protecting the rights and interests of persons affected by intellectual disabilities – constitute an objective and reasonable justification for the measure taken.

That was, however, not the end of the story, because the court had to consider whether the methods used were proportionate to the aim of protecting the rights and interests of persons with intellectual disabilities:

71. In the present case the applicant found herself in a situation where she could no longer decide even in respect of the smallest matters or most intimate aspects of her life and was never heard in order to find out whether she had any wishes or preferences.

72. Furthermore, although the applicant had a home in which she had lived before T.A. [her former husband] had applied to have her declared incapacitated, she was moved elsewhere without being asked. Even though the Government submitted that the Cocieri centre in which the applicant had been treated had not prevented anyone from leaving, they did not comment on the applicant's argument that in practice, patients had not been properly informed of their right to leave. In view of the especially vulnerable situation of persons with intellectual disabilities, such information was essential for them to have any realistic chance of exercising their right to leave.

73. It is also apparent that the applicant was not only prevented from deciding on where to reside, but also on with whom to live. Under the law in force at the time, she were to live with her guarantor M.M., but the latter asked that the applicant be admitted in a specialised institution. Moreover, after being declared incapacitated, she was separated from her two daughters, without any additional judicial review of the need for such a separation (see Cînța, cited above, § 76). Although T.A. argued before the court that the applicant had been aggressive with her daughters, no specific evidence was relied on to confirm the existence of such aggressiveness. During her internment, the applicant could not realistically hope to conduct other social relations, except with other persons being treated at the hospital.

74. In this context, the Court refers to General Comment No. 1 of the Committee on the Rights of Persons with Disabilities, which interpreted Articles 12 and 19 of the United Nations Convention on the Rights of Persons with Disabilities (the CRPD) as requiring, inter alia, that a person with

disabilities should be able to express his or her will and preferences, including in respect of such issues as where to live and with whom (see paragraph 23 above).

75. It is to be noted that the States Parties to the CRPD, including the Republic of Moldova, were invited as early as in 2014, that is, before the time frame of the present case, to replace substitute decision-making regimes (whereby a person with intellectual disability is placed under guardianship and the guardian has the power to take all decisions concerning that person) with supported decision-making (see paragraph 23 above). By choosing to continue with a substitute decision-making regime, the Moldovan authorities allowed the most serious interference with the applicant's rights by depriving her of all legal capacity and thus of any participation in decision-making processes concerning every aspect of her life. The Court finds that this failure on the part of the domestic authorities amounted to disproportionate measures stemming from the legislation itself. It is apparent that less drastic steps were possible, as exemplified by the new protection system introduced by the Republic of Moldova in 2017 and 2018 (see paragraph 20 above).

The conclusion was therefore perhaps inevitable:

76. The Court finds that the Moldovan authorities deviated from what was required to ensure the reasonable accommodation of the applicant's needs in the form of supporting her in the decision-making process, by denying her any role in organising her own life (see paragraphs 59 and 60 above). The domestic court's decision of 22 July 2015 (see paragraph 11 above) was based exclusively on the criterion of her mental health status, without any consideration to her actual abilities. The law allowed an interference with the applicant's rights that was not only not impossible on any other category of persons, but also did not permit the domestic courts to take into consideration the varying levels of intellectual disability and the possibility that, at least in some respects of their lives and with proper assistance, persons in such situations could both understand and take meaningful decisions. Moreover, in the absence of periodic review of the applicant's capacity to comprehend, the measure taken in her respect could be considered as being taken for an indefinite period of time.

77. With the passage of time, the initial measure taken has become increasingly burdensome on the applicant, causing her discomfort in her daily life while at the same time preventing her from being able to obtain directly in court the right to take at least some decisions on her own, unlike other persons (see paragraphs 59 and 60 above). In the face of this disproportionate means of achieving the otherwise acceptable aim of protecting the rights of persons with disabilities, the Court finds that the measure taken amounted to discriminatory treatment.

Comment

CPRD "absolutists" will no doubt find the judgment in ET to be problematic, given that (in effect) the Strasbourg has adopted a CRPD-lite approach, recognising, as it has done previously, that (in English legal terms) concepts such as capacity and best interests are valid, and also by interpreting "supported decision-making" as respecting, rather than being directed by the person's will and preferences. Others might find that Strasbourg has sought to interpret the provisions of the ECHR through the prism of what the CRPD actually requires.

In any event, it may be thought that "legal incapacitation" is something that is irrelevant in England & Wales, as no-one is ever incapacitated in the way ET was. However, such would be a brave assertion, as the appointment of a deputy (whether for property and affairs or for health and welfare) might be

thought to come very close. So paragraphs 71-75 of the judgment in this case make required reading for anyone who blithely asserts that all is rosy in the garden of the MCA 2005. What they may clear is that anyone acting as a deputy must (not just to comply with the MCA 2005, but also with Article 8 read together with Article 14):

1. Take all practicable steps to support that person to make their own decisions in relation to the relevant matters, and revisit the question of their capacity on an ongoing basis.
2. Pay close attention to the person's known wishes and feelings (in CRPD language, their will and preferences) when determining what course of action to take in their best interests in respect of any given decision.

Similarly, anyone relying on the "informal incapacitation" that occurs when s.5 MCA 2005 is relied upon to provide care and treatment must equally be mindful of the same factors. And those who might be required to assist individuals access the Court of Protection in the context either of deputyship (to challenge the appointment or scope of appointment of a deputy) or of DoLS (to challenge the de facto incapacitation inherent in the authorisation process) need to be astute to observations made about the vital importance of being able to access a court to be able to exercise their rights under Article 6 ECHR.

Discrimination and the dismissal of complaints by those with cognitive impairments – a strong statement from Strasbourg

Clipea & Grosu v Moldova [2024] ECHR 867 (ECtHR, Second Section)

CRPD

Summary

This case concerned two individuals with intellectual disabilities who were periodically undergoing treatment at a psychiatric hospital, on what was said to be a voluntary basis. Their application concerned: (1) whether the conditions to which they were subjected at the hospital gave rise to Article 3 ill-treatment; and (2) whether the fact that their complaints were dismissed without investigation gave rise to discrimination contrary

The ECtHR noted that:

*63. [...] the applicants were hospitalised on a voluntary basis. This distinction between voluntary and involuntary hospitalisation is an important factor in assessing the scope of the State's obligations under the Convention. Voluntary patients are generally presumed to have consented to treatment and to retain a greater degree of autonomy than those who are involuntarily detained. However, this voluntary status does not relieve the State of its duty to protect persons in vulnerable situations. Mental health patients, even when admitted voluntarily, may still be in a fragile state due to the very nature of their illness. In this connection, albeit in the context of the States' obligations under Article 2 of the Convention (see *Fernandes de Oliveira v. Portugal*[GC], no. 78103/14, § 124, 31 January 2019), the Court has previously held that:*

“There is no doubt that as a person with severe mental health problems A.J. was in a vulnerable position. The Court considers that a psychiatric patient is particularly vulnerable even when treated on a voluntary basis. Due to the patient’s mental disorder, his or her capacity to take a rational decision to end his or her life may to some degree be impaired. Further, any hospitalisation of a psychiatric patient, whether involuntary or voluntary, inevitably involves a certain level of restraint as a result of the patient’s medical condition and the ensuing treatment by medical professionals. In the process of treatment, recourse to further kinds of restraint is often an option. Such restraint may take different forms, including limitation of personal liberty and privacy rights. Taking all of these factors into account, and given the nature and development of the case-law referred to ... above, the Court considers that the authorities do have a general operational duty with respect to a voluntary psychiatric patient to take reasonable measures to protect him or her from a real and immediate risk of suicide. The specific measures required will depend on the particular circumstances of the case, and those specific circumstances will often differ depending on whether the patient is voluntarily or involuntarily hospitalised. Therefore, this duty, namely to take reasonable measures to prevent a person from self-harm, exists with respect to both categories of patient. However, the Court considers that in the case of patients who are hospitalised following a judicial order, and therefore involuntarily, the Court, in its own assessment, may apply a stricter standard of scrutiny.”

64. Bearing in mind the above considerations, the Court notes that in the present case neither of the applicants was formally subjected to involuntary treatment, which required a court decision. However, there is nothing in the case file to confirm that the applicants signed any documents giving their free and informed consent to their treatment at the hospital (see paragraphs 5 and 37 above; see also Article 25(d) of the CRPD, cited in paragraph 39 above, and Article 5 of the Oviedo Convention, cited in paragraph 40 above). Assuming that such documents were signed, it is unclear whether the applicants had benefitted from any assistance in fully understanding their situation, at a time when their state of mind required their urgent hospitalisation into a psychiatric hospital, so as to express a truly informed consent.

65. In any event, as noted by the Court (see paragraph 63 above) and as pointed out by the Council of Europe Commissioner for Human Rights (see paragraph 56 above), hospitalisation of a psychiatric patient, whether involuntary or voluntary, inevitably involves a certain level of restraint. Even persons who are admitted to psychiatric treatment voluntarily often lose control over their treatment choices once they enter the system, with institutional and coercive logic taking over. Patients in such situations often have no means of challenging these practices.

Turning to the specifics of the case:

65. [...] This appears to have been the case with the applicants, since they were denied access to outside walks and, as the first applicant alleged, he was sometimes tied to his bed and force was used against him (see paragraphs 9, 14 and 15 above). He had to submit to an injection of a sedative or face possible use of force (see paragraph 16 above). The testimony of another patient (V.B., see paragraph 13 above) and of one of the doctors (V.F., see paragraph 15 above), confirms that there was a general policy of restricting certain rights, such as taking walks in the fresh air because of a lack of staff. The practice of assigning code numbers to patients, which restricted their rights to varying degrees was unofficial, unrecorded and therefore not open to challenge in any way (*idem*). The closed nature of the institution is also illustrated by the inability of a State authority specialising in the protection against discrimination to assess the conditions in the hospital after having informed it in advance of its visit (see paragraph 7 above). Finally, it is noted

that the Government have not provided any evidence that the applicants were informed of their right to leave the hospital at their own discretion.

66. Given the findings above, the Court concludes that, even assuming that the applicants were admitted to the relevant hospital voluntarily, there were sufficient elements of coercion so as to treat their subsequent stay and treatment there as being de facto involuntary.

The court found that Article 3 was breached as regards the way in which their complaints were investigated. In respect of the first applicant's complaints as to the conditions at the hospital, the Government made the somewhat bold argument that "*nobody would voluntarily return to an institution where conditions were inhuman,*" to which the Strasbourg court responded:

76. [...] In this regard, the Court refers to its finding that although the applicants' treatment at the hospital was voluntary, they could not be considered to have given their consent to continue their treatment completely freely (see paragraph 65 above). It also notes that during his treatment at the hospital, it was considered that the first applicant might try to escape, even when accompanied by his mother, and this was the reason for advising her not to take him out for a walk in the fresh air (see paragraph 9 above). The "escape" or departure from the hospital of a voluntary patient in control of his or her state of mind would not be an event worth warning somebody about. It follows that the hospital doctors considered that the first applicant was a danger to himself and/or others while he was treated there. In such circumstances, his mother had no real choice but to consent to his treatment. Moreover, the Government did not show that in the event of an emergency such as a crisis necessitating a quick response, a person in the applicants' situation would have had a real option to choose which specialist institution the ambulance would take them to. Since both applicants were treated at the same hospital on a regular basis, they would presumably usually be taken there instead of to other institutions. Similarly, the second applicant's last hospitalisation was requested by the police with her mother's consent, since she was irritable and had attacked her mother (see paragraph 34 above). It is finally worth mentioning that the Chişinău Clinical Psychiatric Hospital was the only such institution in the city.

77. The Court finds that the unavailability of walks in the fresh air and the poor sanitary conditions of the bathrooms and toilets in the relevant units, lasting each time three to four weeks and when viewed in the light of the applicants' particular vulnerability, exceeded the minimum threshold of applicability of Article 3 (see paragraph 60 above).

78. There has accordingly been a violation of Article 3 of the Convention in respect of the material conditions in which the first applicant was treated.¹⁰

Not least because of the way in which the investigation had been conducted, the Court could not draw a conclusion as to whether the first applicant was subjected to ill-treatment by the staff and/or other patients in the hospital.

In relation to the applicants' complaints about the way in which their complaints had been addressed by the Moldovan authorities, the court noted that, whilst the core element of each is the alleged failure of the authorities to take sufficient measures to protect the applicants' physical integrity and dignity,

¹⁰ Although this section of the judgment does not refer to the second applicant, it is clear from the end that her complaint in this regard was also upheld.

this failure was said not to be an isolated occurrence but “was due to the general stereotypes held by the Moldovan authorities in respect of persons with intellectual disabilities,” and therefore fell to be considered separately (para 87).

As the court went on to note:

91. Having regard to the arguments advanced by the applicants, the Court notes that the alleged difference in treatment of persons with intellectual disabilities in the Republic of Moldova did not result from the wording of any statutory provisions, but rather a de facto policy by State agents. Accordingly, the issue to be determined in the instant case is whether the manner in which the legislation was applied in practice resulted in the applicants’ being subjected, on grounds of disability or of perceived disability, to different treatment without objective and reasonable justification.

92. The Court notes that in the initial phase of the investigation both the prosecution service and the courts relied on the applicants’ diagnosis in order to uphold the discontinuation of the investigation. In particular, they found that the applicants were “persons with limited legal capacity, [who] in these circumstances, ... [were] not always able to fully and correctly understand the things that happen[ed] in certain circumstances” (see paragraphs 23 and 32 above).

The Strasbourg court was clear that:

*93. [...] the reasoning given by the judicial authorities reveals a difference in treatment between the applicants and other alleged victims of inhuman and degrading treatment (“the comparator”, see *T.H. v. Bulgaria*, no. 46519/20, § 109, 11 April 2023). That difference was based on the applicants’ intellectual disabilities and was one of the reasons for rejecting their complaints as unfounded (the ground of the alleged distinction, *ibid.* § 109; *Fábián v. Hungary* [GC], no. 78117/13, § 96, 5 September 2017).*

As it went on to note:

94. The first phase of the investigation consisted of hearing, on the one hand, the applicants and, on the other hand, four heads of units at the hospital. No other investigative action had taken place before discontinuing the investigation (see paragraph 19-21 above). The prosecutor solved the resulting discrepancy in the versions submitted by the two sides by referring to the applicants’ psychological disabilities which, he found, prevented them from fully understanding the circumstances of their treatment at the hospital, and thus undermined the credibility of their claims. Their refusal to undergo a psychiatric and psychological examination to confirm or refute that conclusion was another major reason for discontinuing the investigation.

*95. This type of argument would apparently suggest that persons with intellectual disabilities are unable to understand and are thus unreliable witnesses (see, *mutatis mutandis*, *Luca v. the Republic of Moldova*, no. 55351/17, § 105, 17 October 2023), unless they prove their ability to comprehend by undergoing psychiatric and psychological examinations.*

The court was entirely unimpressed by this:

95. In the Court’s view, there was no objective and reasonable justification for rejecting the applicants’ complaints on the sole basis of their disability and in the absence of any investigative

actions other than hearing the party most interested in discontinuing the investigation. In Cînta, cited above, §§ 68 et seq.) the Court found that “relying on mental illness as the decisive element or even as one element among others may amount to discrimination when, in the specific circumstances of the case, the mental illness does not have a bearing on the [substantive issue in question]”. In the Court’s view, when ill-treatment happens, a victim’s intellectual disability cannot affect that objective fact. It is true that such a disability may distort an alleged victim’s perception of reality and cause that person to wrongly believe that he or she was ill-treated. However, as with other alleged victims, once a prima facie case is established indicating that inhuman treatment may have happened, any dismissal of such a complaint must be based on an objective analysis of all the evidence obtained as part of an effective investigation. In other words, the fact that a person complaining of such treatment has an intellectual disability is no reason for shifting the focus of the investigation from objectively verifying the facts to determining whether the person fully understands what happens to him or her. (emphases added).

The court had little hesitation in finding that there was a violation of Article 14 taken in conjunction with Article 3.

Judge Derenčinović (from Croatia), dissented, on the basis that the matters concerned of simply did not reach the threshold for Article 3 ill-treatment, but also that:

[T]he evidence presented before the Court seems insufficient to conclude that the applicants’ treatment was involuntary. The applicants did not rely on this assumption, as they did not complain of illegal detention or unlawful deprivation of liberty under Article 5 of the Convention. Moreover, this assumption has not been confirmed by the doctors and nurses at the hospital and remains unsubstantiated in the absence of court documents pertaining to the applicants’ legal capacity or guardianship. The argument based on the inherently restraining nature of the treatment cannot be accepted as the pivotal factor that changes hospitalisation or treatment from voluntary to de facto involuntary. This would mean that all treatment and hospitalisation become de facto involuntary unless accompanied by a court decision finding a lack in legal capacity, in which case treatment or hospitalisation would be de iure involuntary. This would effectively render the distinction between voluntary and involuntary treatment meaningless and create significant complications for the States’ obligations towards hospitalised persons and margin of appreciation. It would also undermine a person’s freedom to make individual and informed choices about his or her (mental) health, such as choosing to undergo or terminate voluntary treatment or rehabilitation.

Comment

As with the decision in *ET v Moldova* [2024] ECHR 858, the Strasbourg court took an approach that would be regarded by the CRPD Committee as rather CRPD-lite, as it did not move from concluding that the applicants were not in the hospital voluntarily to finding that that was, per se, a violation of their rights under the ECHR (which would have been the position the CRPD Committee would take in relation to the CRPD). It also side-stepped the proposition advanced before it by the Council of Europe’s Commissioner for Human Rights that “coercion could no longer be taken for granted in psychiatry; the free and informed consent of the persons concerned had to be the basis for decisions taken in relation to them” (paragraph 56). However, its observations about the thin line between formal and informal patients and the shadow of coercion are powerful ones. In the English context, they might be thought to reinforce the importance of the proposal in the Mental Health Bill to extend the provision of

Independent Mental Health Advocates to informal as well as formal patients (as already happens in Wales).

Equally powerful are the court's very clear conclusions as to the unacceptability of simply dismissing complaints by those with cognitive impairments on the basis that the person has an impairment. There are so many situations in which those with responsibility for acting on complaints (whether – in the UK – they be NHS bodies, local authorities or the police, depending on the nature of the issue) do, indeed, not seek objectively to verify the facts, but simply start examining whether the person is a reliable or a credible witness. This judgment makes crystal clear just how unacceptable that is.

SCOTLAND

Kirsty McGrath steps away

Kirsty McGrath's career, originally with Scottish Executive from 1999 and thereafter with Scottish Government, has continuously spanned the whole lifetime to date of the Adults with Incapacity (Scotland) Act 2000. For long she has been the principal civil servant practically dealing with all aspects of increasingly necessary and urgent law reform, in particular over the decade from publication in October 2014 of Scottish Law Commission's Report No 240 on "Adults with Incapacity" with draft legislation for remedying the serious failures by Scottish governments, and collectively the Scottish Parliament, to comply with its obligation under Article 5 of the European Convention on Human Rights to provide a human rights-compliant regime for what would otherwise be unlawful deprivations of liberty.

Since then, Kirsty has consistently displayed the finest qualities of a true civil servant: employed by government, working in accordance with governments' successive policies, yet the servant of society, and the citizenry of her country, as a whole: a most challenging place to be, standing between the increasing pressures of all those in Scotland concerned to remedy the perceived increasing disrespect of government for the fundamental rights of citizens with mental and intellectual disabilities, and her loyalty to governments as her employers. She has met that challenge with openness and honesty, accumulating an outstanding knowledge and understanding of the whole range of issues both in principle and in detail; and as matters have progressed, being as clear as she properly could be about what to expect from government. It is notable that progress by government towards essential law reform progressed too slowly for some of us, yet it did progress, through comprehensive rounds of consultation in 2016 and 2018, and follow-up upon that last round of consultation, but halted in 2019 when she was transferred to the role of supporting the Scottish Mental Health Law Review ("the Scott Review"). Eventually, following publication of the Final Report of the Scott Review, she transferred back to the mainstream work of Scottish Government, exposed again to a crescendo of all the same fundamental challenges. Among all those challenges, the diversity of views, and the resulting disagreements, Kirsty personally has maintained the highest standards of competence, understanding and integrity.

She left Scottish Government on 20th November 2024, vacating the post of Head of Unit, Mental Health and Incapacity Law, within the Mental Health Directorate of Scottish Government. She leaves, one can be sure, with the personal respect, thanks and best wishes of all with whom she has interacted over that career, however robust some of those interactions may have been. One has to hope that, in one way or another, her knowledge, experience and personal qualities will not be lost altogether from the wide community of all those in Scotland committed to the rights and welfare of the most vulnerable people in our society.

Adrian D Ward

Council's reasons for care plan inadequate

In *CM (attorney to AM) v Western Isles Council*, [2024] CSOH 103, an attorney (CM) to an adult (AM) successfully asserted, by way of judicial review, that a local authority (Western Isles Council) ought to

have given adequate reasons for the terms of a proposed care plan, and had failed to do so. The attorney also successfully resisted an argument by the Council that the matter ought not to have been brought to court when the alternative of referring it to the Public Services Ombudsman was available. The case was decided by Lady Haldane, whose decision was issued on 15th November 2024.

The attorney has financial and welfare powers. He resides in the south of England. The adult lives in the Western Isles. He is aged 89. His circumstances were summarised by Lady Haldane as follows:

"[4] ... He has lived in his home for around 40 years. He has no spouse and no children. Until December 2023 he lived with his brother CM. CM moved at that point to a nursing home in the Western Isles. He has recently sadly passed away. AM has lived alone since his brother moved into the nursing home. His home has two floors and has a Rayburn coal stove in the kitchen, which is the only source of heat in the home. This stove can heat two radiators in the living room and there are, in addition, a number of electric and oil fired radiators in the house. The bathroom has a bath with an over bath shower. There is no walk in shower in the property. AM suffers from a number of symptoms of advanced old age including restricted mobility, unsteadiness on his feet, a tendency to fall, and he walks with the aid of a walking stick. He has oedema (swelling) in his legs, ankles and feet. His hearing is impaired but he finds wearing hearing aids uncomfortable. Since his brother moved out, AM has become depressed and anxious. He does not leave his home other than to attend medical appointments. He has recently been diagnosed with a build-up of fluid in his lungs which is suspected to be cancer. He is not considered fit for further exploratory examination or treatment due to his age, frailty and the distress this would cause him.

"[5] As a consequence of the foregoing circumstances AM has difficulty in attending to his personal needs. In the period prior to the respondent's first assessment he was unable to step into the bath or shower or stand to wash. He was unable to prepare meals and hot drinks safely or collect his medication. He has suffered from incontinence and has increased laundry needs as a result. He was and is heavily reliant on neighbours, in particular a Mr and Mrs C, and other friends and family for support with his care needs. Mr and Mrs C both work and have an adult son with learning difficulties and his own care needs. The petitioner visits his uncle as often as he can, approximately every six weeks, from his home in the South of England. AM's cousin, IM, arranges for coal to be delivered and provides further assistance and maintenance services."

The attorney made a referral to the Council for an assessment of the adult's care needs under the Social Work (Scotland) Act 1968 (as amended). A first assessment was carried out on or around 28th February 2024. The resulting report, dated 7th March 2024, assessed the adult's needs as "critical". A care package was provided to the adult at home. The first assessment was reviewed during April and May 2024. A report on that second assessment was dated 21st May 2024. The adult's needs were downgraded to "substantial". A care package at home remained in place.

The attorney challenged both assessments, on the grounds that both were irrational. He sought reduction of the decision not to provide a residential care place to the adult, which is what the adult desired. He sought declarator that the adult's needs required residential care, and an order requiring the Council to provide a residential place at one of three named establishments. In the alternative, he sought declarator that both reports were inadequately reasoned, and an order requiring the Council to carry out a fresh assessment of the adult's care needs.

Lady Haldane identified the issues as being whether the Council had a duty to provide reasons for its decisions, and if so the basis and nature of that duty; whether the Council's decision was irrational, or alternatively inadequately reasoned; and whether the court should decline to provide a remedy because the potential for review by the Scottish Public Services Ombudsman amounted to an effective alternative remedy. Her decision narrates a full exploration of those issues, with citation of all relevant authority.

Factors that she noted included that the Council had found that the adult "requires support with his laundry and household duties", and with shopping, provided only by neighbours who were finding that difficult and felt that they were no longer able to support the adult with his needs. The adult consistently expressed views that his needs could only be met in a residential setting, but the Council had simply stated that, having noted his views, his needs would be met by providing a care package in his home – which, as Lady Haldane pointed out, in isolation did not make sense. It appeared that his needs were not being met, or perhaps could not be met, through community care services. There was a gap in reasoning as to why needs for care being required had been identified; friends, family and neighbours were unwilling to continue addressing those needs; and the Council was unable to facilitate required services, when the identified needs were not being met, or perhaps could not be met, through community care services.

Having considered the arguments and authorities, Lady Haldane concluded that:

"[70] Drawing all of these strands together, the respondent has a statutory duty to assess needs, and to decide what services to provide to meet those needs. The respondent is afforded a discretion in the discharge of that duty, but where a need has been identified in respect of which a community care service is not to be provided, then the individual affected is entitled to know why that is so. In the present case, such an explanation is absent. Accordingly the submission that the reasoning for the decisions reached in each of the assessment and review documents is inadequate, is well founded."

She held that the threshold for a finding of irrationality had not been reached, but that the Council's decisions were inadequately reasoned.

On whether the court should decline to provide a remedy because of the potential for review by the Scottish Public Services Ombudsman, after careful consideration Lady Haldane held that there was no reason to disapply the "ouster" clause in section 7(8) of the Scottish Public Services Ombudsman Act 2002, which is in the following terms:

"... 7(8) The Ombudsman must not investigate any matter in respect of which the person aggrieved has or had –

...

"(c) a remedy by way of proceedings in any court of law, unless the Ombudsman is satisfied that, in the particular circumstances, it is not reasonable to expect the person aggrieved to resort or have resorted to the right of remedy".

She pronounced an order requiring the Council to undertake a reasoned assessment of the adult's needs of new.

There was no discussion, presumably because it was considered unnecessary, as to whether international human rights requirements should be taken into account, or required implementation.

Article 19 of the UN Convention on the Rights of Persons with Disabilities is headed: “Living independently and being included in the community”. The introductory paragraph refers to rights of all persons with disabilities to live in the community, and the right to full inclusion and participation in the community. It is generally founded upon by those seeking to live in community settings rather than residential settings. This case would have given rise to consideration as to whether it might also apply to moves in the opposite direction, given the explicit obligation upon states to ensure that: (b) “Persons with disabilities have access to a range of in-home, residential and other community support services ...”, and (a) “Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement”.

The UN Disability Convention is not binding, but the European Convention on Human Rights is, and may be interpreted having regard to the UN Convention. A recent example of how the European Court on Human Rights is increasingly doing that is the case of *ET v Moldova* discussed in the Wider Context section of this Report.

Consideration of Article 8 of the European Convention, regarding the right to respect for private and family life, in conjunction with the right under Article 3 not to be subjected to, *inter alia*, “inhuman or degrading treatment ...” could have given rise to a question whether those Articles might be violated, not by removing someone against their wishes from circumstances such as those in which the adult in this case was living, but by effectively forcing him to remain in those circumstances, where needs assessed in the first assessment were described as “critical” (no reasons having been given for the downgrading to “substantial”).

Adrian D Ward

What is happening?

Over the last three months we have covered the accelerating pace of adults with incapacity reform. The “Adults with Incapacity Amendment Act: Consultation”, on which we reported in September, seemed to envisage a continuing leisurely pace, despite the urgent need for legislation across – as a

minimum – the various areas where necessary reform is long overdue. The consultation sought “thoughts on proposals for reform” to the Adults with Incapacity (Scotland) Act 2000, with a closing date of 17th October 2024. Then, still almost six weeks before expiry of that consultation, Scottish Government announced that an Adults with Incapacity (Amendment) Bill would be introduced by Scottish Government into the Scottish Parliament during the current 2024-25 parliamentary session. We covered that announcement in the [October Report](#).

[Last month](#) we reported with increasing anxiety that we still had nothing of substance on which we might report further, but we outlined our understanding of the extraordinarily tight timescale that appears to be necessary to enact even the significant volume of minimum necessary reforms prior to the Scottish Parliament elections in 2026, when any Bills that had not completed their parliamentary passage will be lost. At that stage, we understood that necessary consultation might well be at short notice, and we warned our readers accordingly.

For this last Report before the seasonal break we had fully expected to require substantial space to cover at least some of the public communication and consultation necessary to ensure that deadlines are met. Regrettably, we have to leave that space unfilled. Speculation is rife, but lacks sufficient substance – because none is yet available – to justify describing it in the Report.

Adrian D Ward

[Editorial note – the blank spaces around this article are deliberate, as space had been left aside for the detailed coverage that we had anticipated would be possible]

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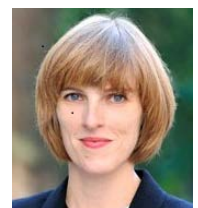
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Conferences

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

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

Peter Edwards Law have announced their autumn online courses, including, Becoming a Mental Health Act Administrator – The Basics; Introduction to the Mental Health Act, Code and Tribunals; Introduction – MCA and Deprivation of Liberty; Introduction to using Court of Protection including s. 21A Appeals; Masterclass for Mental Health Act Administrators; Mental Health Act Masterclass; and Court of Protection / MCA Masterclass. For more details and to book, see [here](#).

Advertising conferences and training events

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

Our next edition will be out in 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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