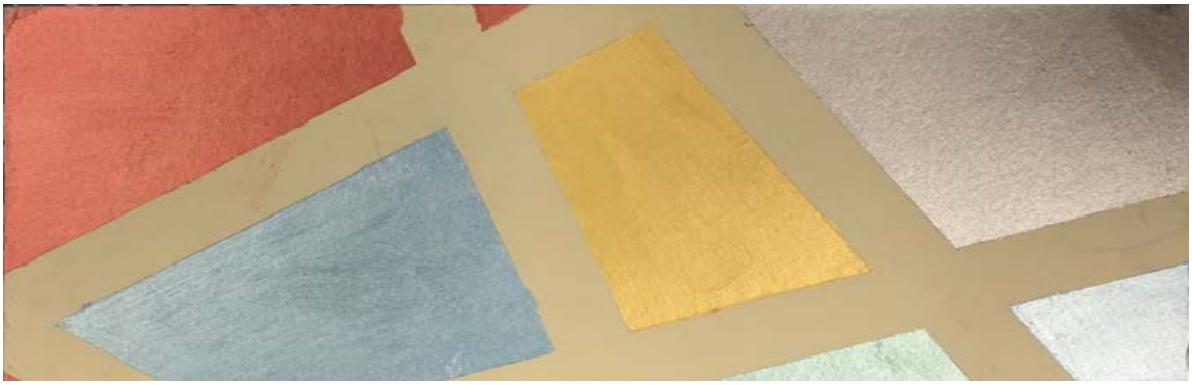

Welcome to the December 2024 Mental Capacity Report. Highlights this month include:

(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.

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.

Contents

Assisted dying / assisted suicide[1]

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).[2] 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

[1] 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.

[2] 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.

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,' 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[3]. 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

[3] 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.

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 patent lacks capacity to defend a possession claim by a hospital, under CPR 21 they require a Litigation Friend and without 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.[4]

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'.

[4] 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."

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). Oh 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 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 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, [5] 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 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 decisions 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

[5] See, in this regard, this discussion of the application of the MCA 2005 in the context of the retrospective assessment of testamentary capacity.

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 Shtukaturov 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 Shtukaturov, 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 imposable 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 the 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 Chișinău 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.*[6]

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, this failure was said not to be an isolated occurrence but "was due to the general stereotypes held by the Moldovan

[6] 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.

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 factopolicy 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 Cînța, 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.

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Alex has been in cases involving the MCA 2005 at all levels up to and including the Supreme Court. He also writes extensively, has numerous academic affiliations, including as Visiting Professor at King's College London, and created the website www.mentalcapacitylawandpolicy.org.uk. To view full CV click here.

Victoria Butler-Cole KC: vb@39essex.com
Victoria regularly appears in the Court of Protection, instructed by the Official Solicitor, family members, and statutory bodies, in welfare, financial and medical cases. She is Vice-Chair of the Court of Protection Bar Association and a member of the Nuffield Council on Bioethics. To view full CV click here.

Neil Allen: neil.allen@39essex.com
Neil has particular interests in ECHR/CRPD human rights, mental health and incapacity law and mainly practises in the Court of Protection and Upper Tribunal. Also a Senior Lecturer at Manchester University and Clinical Lead of its Legal Advice Centre, he teaches students in these fields, and trains health, social care and legal professionals. When time permits, Neil publishes in academic books and journals and created the website www.lpslaw.co.uk. To view full CV click here.

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Arianna practices in mental capacity, community care, mental health law and inquests. Arianna acts in a range of Court of Protection matters including welfare, property and affairs, serious medical treatment and in inherent jurisdiction matters. Arianna works extensively in the field of community care. She is a contributor to Court of Protection Practice (LexisNexis). To view a full CV, click here.

Nicola Kohn: nicola.kohn@39essex.com
Nicola appears regularly in the Court of Protection in health and welfare matters. She is frequently instructed by the Official Solicitor as well as by local authorities, CCGs and care homes. She is a contributor to the 5th edition of the *Assessment of Mental Capacity: A Practical Guide for Doctors and Lawyers* (BMA/Law Society 2022). To view full CV click here.

Katie Scott: katie.scott@39essex.com
Katie advises and represents clients in all things health related, from personal injury and clinical negligence, to community care, mental health and healthcare regulation. The main focus of her practice however is in the Court of Protection where she has a particular interest in the health and welfare of incapacitated adults. She is also a qualified mediator, mediating legal and community disputes. To view full CV click here.

Nyasha Weinberg: Nyasha.Weinberg@39essex.com

Nyasha has a practice across public and private law, has appeared in the Court of Protection and has a particular interest in health and human rights issues. To view a full CV, click here

Simon Edwards: simon.edwards@39essex.com

Simon has wide experience of private client work raising capacity issues, including *Day v Harris & Ors* [2013] 3 WLR 1560, centred on the question whether Sir Malcolm Arnold had given manuscripts of his compositions to his children when in a desperate state or later when he was a patient of the Court of Protection. He has also acted in many cases where deputies or attorneys have misused P's assets. To view full CV click here.

Adrian Ward: adrian@adward.co.uk

Adrian is a recognised national and international expert in adult incapacity law. He has been continuously involved in law reform processes. His books include the current standard Scottish texts on the subject. His awards include an MBE for services to the mentally handicapped in Scotland; honorary membership of the Law Society of Scotland; national awards for legal journalism, legal charitable work and legal scholarship; and the lifetime achievement award at the 2014 Scottish Legal Awards.

Jill Stavert: j.stavert@napier.ac.uk

Jill Stavert is Professor of Law, Director of the Centre for Mental Health and Capacity Law and Director of Research, The Business School, Edinburgh Napier University. Jill is also a member of the Law Society for Scotland's Mental Health and Disability Sub-Committee. She has undertaken work for the Mental Welfare Commission for Scotland (including its 2015 updated guidance on Deprivation of Liberty). To view full CV click here.

Conferences

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

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

Adrian will be speaking at the European Law Institute Annual Conference in Dublin (10 October, details here).

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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