



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

(1) In the Health, Welfare and Deprivation of Liberty Report: the Court of Appeal on belief and capacity, and both sexual and medical complexities before the courts;

(2) In the Property and Affairs Report: a guest post updating deputies and attorneys on important responsibilities;

(3) In the Practice and Procedure Report: which decisions are for doctors, and which for the courts; jury-rigging Article 5(4) compliance in community DoL cases, and transparency under the spotlight;

(4) In the Mental Health Matters Report: a Mental Health Bill on the way, the hard edges of the MHA 1983 and the CQC and Valdo Calocane;

(5) In the Wider Context Report: the limits of Article 3 in the context of the inherent jurisdiction, the CQC and covert medication and Lord Falconer's Assisted Dying Bill;

(6) In the Scotland Report: the Scottish Government consults on legislative measures to respond to the Scott Review and a report from the World Congress on Adult Care and Support.

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](#).

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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

### Belief and mental capacity – the Court of Appeal decides

*Re Sudiksha Thirulamesh (dec'd)* [2024] EWCA Civ 896 (Court of Appeal (King, Singh and Baker LJJ))

*Mental capacity – assessing capacity*

#### Summary<sup>1</sup>

The Court of Appeal has made very clear how to approach the situation in which a person appears not to believe their doctor. We can do no better by way of summary than reproduce the opening paragraphs of the judgment of King LJ (giving the sole reasoned judgment, with which Singh and Baker LLJ agreed):

1. *Sudiksha Hemachandran (“Sudiksha”) died on 12 September 2023. She was 19 years old. She was born with a rare mitochondrial disorder known as Mitochondrial Depletion Syndrome RRM2B (“RRM2B”), a chronic degenerative disease with no known cure.*

2. *On 20 July 2023, the University Hospitals Birmingham NHS Foundation Trust (“the Trust”) made an emergency application to the Court of Protection asking the court to approve a palliative care plan for Sudiksha and for her life sustaining treatment to be withdrawn.*

3. *The issue which came before the late Roberts J (“the judge”), namely Sudiksha’s capacity to make decisions in relation to her medical treatment, was both unusual and difficult and is central to this appeal. Whilst the medical evidence was overwhelming that Sudiksha was in multi-organ failure and nearing the end of her life, she was fully conscious and able to communicate through a voice box. She was adamant that she wished to have the opportunity to be considered for experimental nucleoside treatment in America or Canada. She wanted to “die trying to live”.*

4. *On 7 August 2023, the judge made a declaration that Sudiksha lacked capacity “to give or withhold her agreement to medical treatment including palliative treatment”.*

5. *The court having decided that Sudiksha lacked capacity to make decisions about her medical care, the case was listed to be heard on 23 October 2023 with a time estimate of two days in order for the court to “determine [Sudiksha’s] best interests in terms of medical treatment”.*

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<sup>1</sup> Alex, Neil and Tor having been involved in this case, and given the commitments of other editors this month, the commentary on this case is very short.

6. In the event, no best interests decision was ever made by a court as Sudiksha died only 35 days later. Her end of life care was provided under the terms of a treatment plan ("the treatment plan") without any judicial intervention. The plan had been agreed with Thirumalesh Chellamal Hemachandran and Revathi Malesh Thirumalesh ("the parents") some months previously in May 2023.

7. On 5 October 2023, Sudiksha's parents (who had been the 2<sup>nd</sup> and 3<sup>rd</sup> Respondents in the capacity proceedings) issued an Appellant's Notice seeking permission to appeal against the declaration of incapacity. Notwithstanding that Sudiksha's death meant that the appeal was academic, I granted permission to appeal and in due course, also permission for MIND to intervene.

8. Mr Bruno Quintavalle represented the parents, Katie Gollop KC and Olivia Kirkbride represented the Official Solicitor, Vikram Sachdeva KC, Catherine Dobson, and Isabella Buono represented the Trust and Alex Ruck Keene KC and Neil Allen represented MIND.

9. Having heard extensive submissions from the parties and from MIND, I would allow the appeal. It follows that the declaration made by the judge on 7 August 2023 that Sudiksha lacked the capacity to give or withhold her agreement to medical treatment, including palliative treatment, will therefore be set aside. That being the case, the presumption of capacity contained in section 1(2) Mental Capacity Act 2005 ("MCA") means that Sudiksha is presumed to have had the capacity to give or withhold her agreement to medical treatment, including palliative treatment, at all times leading up to her death.

10. In reaching that decision, I should be clear that I make no criticism of the judge who demonstrated the same care and compassion in this case as she did in every case she heard during her time as a High Court Judge before her untimely death. The decision she reached was in part at least, influenced by an established legal approach to the relevance of a patient's belief in their illness and prognosis. That approach is, for the reasons set out in this judgment, wrong and contrary to Court of Appeal authority.

Breaking matters down more, however, at first instance, Roberts J had found that Sudiksha was:

93. [...] unable to make a decision for herself in relation to her future medical treatment, including the proposed move to palliative care, because she does not believe the information she has been given by her doctors. Absent that belief, she cannot use or weigh that information as part of the process of making the decision. This is a very different position from the act of making an unwise, but otherwise capacitous, decision. An unwise decision involves the juxtaposition of both an objective overview of the wisdom of a decision to act one way or another and the subjective reasons informing that person's decision to elect to take a particular course. However unwise, the decision must nevertheless involve that essential understanding of the information and the use, weighing and balancing of the information in order to reach a decision. In [Sudiksha's] case, an essential element of the process of decision-making is missing because she is unable to use or weigh information which has been shown to be both reliable and true."

Further, Roberts J had held:

98. As to the nature of the impairment of, or disturbance in the functioning of, the mind or brain which prevents [Sudiksha] from understanding, using and weighing the information which she has been given, it is accepted that [Sudiksha] does not suffer from any recognised psychiatric or

psychological illness. Dr Mynors-Wallis struggled to identify precisely how to 'label' [Sudiksha] condition. His evidence was that her beliefs, which he accepted to be false, did not amount to a delusion because there was an understandable basis for her views which derived from, or coincided with, the views held by those she loved and trusted. His concern about making the causal nexus between a lack of ability to make a decision and the impairment in question was that none of the treating clinicians had identified a physical problem in her brain or that her recent respiratory arrests had affected her the functioning of her brain. That much is agreed.

On the appeal, and identified by King LJ, the central question for the Court of Appeal, was as to the relevance of Sudiksha's belief in her illness and prognosis. The Trust's position in writing was that:

*"where there was an objectively verifiable medical consensus as to the consequences of having, or not having, treatment, a person must believe, or accept as true, the information which informs the matter in order to understand it for the purposes of section 3(1) MCA". Mr Sachdeva argued that the requirement of belief was not an attempt to add a gloss to the statute, but rather that it followed from the ordinary reading of the requirement of section 3(1) MCA that a person must understand information relevant to a decision about medical treatment. Relevant information, he submitted, includes information as to the consequences of having or not having medical treatment. If a person does not believe relevant information that is objectively true, then the person will proceed on the basis of incorrect information and will, under section 3(1)(a) be unable to make a decision for him or herself.*

The Trust's position relied on the observations made by Munby J (as he then was) in *Local Authority X v MM* [2007] EWHC 2003 (Fam); [2009] 1 FLR 443 ("Re MM") to the effect that:

*81. [...] If one does not "believe" a particular piece of information then one does not, in truth, "comprehend" or "understand" it, nor can it be said that one is able to "use" or "weigh" it. In other words, the specific requirement of belief is subsumed in the more general requirements of understanding and of ability to use and weigh information."*

That observation (pre-dating the MCA 2005) had led the courts to proceed on the basis that "in order to 'understand' information for the purposes of section 3(1)(a) MCA, the patient concerned must believe that information" (paragraph 55). Unfortunately, however, King LJ noted (at paragraph 54), Munby J had founded himself upon a passage in an earlier judgment in *Re MB (Medical Treatment)* [1997] 2 FLR 426 which did not, in fact, say what he had identified it as saying. Rather, Butler-Sloss LJ in *Re MB* had been saying that a lack of belief in the relevant information may indicate that the person does not have capacity to make the decision.

As King LJ noted:

*57. During the course of submissions, Mr Sachdeva, having heard the submissions of the other parties and in discussions with the Court as they looked together with him at Re C and at the use of the word may by Butler-Sloss LJ in Re MB, refined his submissions, so that his final position on behalf of the Trust was that:*

*"Where there is objectively verifiable medical consensus as to the consequences of not having medical treatment, if a person does not believe or accept that*

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*information to be true, it may be that they are unable to understand it and/or unable to weigh it for the purposes of the MCA.”*

58. *This approach dovetails with that of both the Official Solicitor and of MIND (Mr Quintavalle on behalf of the appellants, chose not to concentrate to any extent on this aspect of their grounds of appeal). The Official Solicitor submitted that a person who does not believe relevant information, whether it be factual or opinion, may lack capacity, but equally they may not. The meaning of each of the words “understand”, “use” and “weigh” is, she submits, different from the meaning of the word “believe.” The statutory language Ms Gollop submits is complete in meaning: there is no missing meaning, and no implicit or subsumed meaning that needs to be made explicit and no addition or embellishment is required. I agree.*

59. *As McFarlane LJ said in PC and NC:*

*“37. The central provisions of the MCA 2005 have been widely welcomed as an example of plain and clear statutory language. I would therefore deprecate any attempt to add any embellishment or gloss to the statutory wording unless to do so is plainly necessary.”*

60. *Nothing in the recent approach of the Supreme Court (in JB) would appear to indicate anything to the contrary.*

61. *It follows that in relation to the judgment with which I am concerned, in order to understand and/or to use and weigh up the relevant information, Sudiksha’s belief as to her prognosis and the likelihood of her receiving effective nucleoside treatment was relevant, but not determinative as to whether she was able to make a decision under section 3 and therefore satisfy the functional test.*

King LJ then undertook a detailed analysis of the evidence before Roberts J and the way in which Roberts J had approached that evidence, before drawing the threads together in respect of this aspect of the appeal as follows:

123. *As discussed above in my judgment from paragraphs [48] to [60] above, there is no specific requirement of belief, whether subsumed into the general requirement of understanding or in the ability to use and weigh information or otherwise. In as much as this Court is influenced by any of the pre-MCA cases, in my view the proper approach is that of Butler-Sloss LJ in Re MB: an absence of belief may but not inevitably will, on the facts of a particular case, lead to a clinician or a court to conclude that the functional test in section 3(1) is not satisfied and that the person in question does not have the ability to make the decision in question.*

124. *All that is required is an application of the statutory words without any gloss. “Does this person have the ability to understand?”, “Is this person able to use and weigh this information?” The danger is that the introduction of the word “belief” is either the same as the statutory test, in which case it is otiose or, if that is not the case, there is the risk that by introducing a hard-edged requirement of ‘belief’ people will look for something different from the statutory test which is wrong in law. All that is required is the application of the words of the statute.*

125. *Unsurprisingly, both the judge and Dr Mynors-Wallis approached the case on the basis that Sudiksha’s inability to believe that she was going to die soon and that nucleoside experimental treatment was not going to help, led inexorably to the conclusion that she was unable to satisfy the functional test as she did not understand the information and was unable to weigh and use it.*



126. The judge at [93] agreed with Dr Mynors Wallis that Sudiksha was “unable to make a decision for herself in relation to her future medical care, because she does not believe the information she has been given by her doctors, absent that belief, she cannot use or weigh that information as part of the process of making the decision”.

127. She then moved on to consider (essentially by reference to Dr Mynors-Wallis’ first report) whether Sudiksha was unable to make a decision in relation to her medical treatment because of an impairment of mind. The judge’s approach at [103] (paragraph [114] above) to belief/acceptance again fed into this critical issue: “her complete inability to accept the medical reality ... is likely to be the result of an impairment of mind”.

128. Whilst the wording of Ground 6 is somewhat confusing, the appeal has been argued by all parties on the basis that the alleged error of law on the part of the judge was in relation to her approach to the statutory test in saying that Sudiksha’s refusal or inability to believe the ‘information’ alone resulted in her failing the functional test in section 3(1) MCA. It follows in my judgment that the appeal must succeed on this ground as, for the reasons set out above, the judge made an error of law in regarding the absence of belief as determinative of the functional test. This was an error made through no fault of her own given that she was applying the test as set out by *Munby J in Re MM*.

129. It follows that the Trust’s concession was well made. The proper application of the statutory test does no more than reflect that, where there is an objectifiable verifiable medical consensus as to the consequences of having or not having medical treatment, if the patient does not believe or accept that information to be true, it may be that they are unable to understand and or use and weight the information in question.

King LJ went on to note that it was not necessary for the Court of Appeal to determine whether “upon the application of the less absolute test in relation to belief, the court would have still concluded that Sudiksha was unable to make a decision for the purposes of the functional test” (paragraph 130). This was because the Court of Appeal found that Roberts J had fallen into further error by rejecting the unanimous expert evidence as to capacity. She started with the important proposition:

132. That judges are entitled to disagree with an expert witness needs no rehearsing. In *AB v BG (Re G and B (Fact -Finding hearing) [2009] EWCA Civ 10, Wall LJ (“AB v BG”) said at [17] that that proposition has an “equally obvious corollary”. There must, he said, be “material upon which the judge in question can safely found his or her disagreement, and he or she must fully explain the reasons for rejecting the expert’s evidence.”*

133. Turning once again to *Kings College, MacDonald J* said:

“39. Finally, whilst the evidence of psychiatrists is likely to be determinative of the issue of whether there is an impairment of the mind for the purposes of s 2(1), the decision as to capacity is a judgment for the court to make (see Re SB [2013] EWHC 1417 (COP)). In *PH v A Local Authority [2011] EWHC 1704 (COP)* Baker J observed as follows at [16]:

*‘In assessing the question of capacity, the court must consider all the relevant evidence. Clearly, the opinion of an independently-instructed expert will be likely to*

*be of very considerable importance, but in many cases the evidence of other clinicians and professionals who have experience of treating and working with P will be just as important and in some cases more important. In assessing that evidence, the court must be aware of the difficulties which may arise as a result of the close professional relationship between the clinicians treating, and the key professionals working with, P.”*

134. Mr Quintavalle in oral argument, sought to go significantly further than either *AB v BG* or *Kings College*. He submitted that a judge cannot disagree with the opinion of an expert absent there being available to the court other alternative expert medical evidence in support of the judge’s view. In other words, Mr Quintavalle appeared to submit that a judge may not disagree with a unanimous view of experts, but may only decide as between more than one opposing expert view. That cannot be right, although it is undoubtedly the case that where the judge disagrees with a unanimous view which has been expressed by appropriate experts, a reader will look carefully to understand the judge’s “full explanation” for having rejected that common view and for the identification by the judge of the material upon which their disagreement is based.

135. In the present case, the judge was faced with; the united view of Dr Bagchi and Dr Mynors-Wallis, the endorsement of the Official Solicitor (who had the advantage of having ascertained Sudiksha’s wishes) and of Dr Tunnicliffe’s virtual concession that his ‘delusion’ position was not sustainable and that what he was in reality concerned about was the right best interests decision for Sudiksha.

136. Critically also, the judge’s reasons for rejecting the views of the experts who (notwithstanding their error in relation to belief) were of the view that Sudiksha had capacity, had to be considered and explained against the statutory presumption of capacity, the principle of autonomy and the fact that an unwise decision is not an incapacitous decision.

137. In my judgment, the judge fell into error in her approach which was essentially to adopt Dr Mynors-Wallis’ first report with no analysis as to why it was to be preferred to his second report which had been written having seen and assessed Sudiksha and which dovetailed with Dr Bagchi who had had the advantage of seeing her on a number of occasions including in the absence of her family.

138. Once one displaces an absolute requirement for “belief”, then, where a 19-year-old young woman, fully conscious and suffering no identifiable mental illness or loss of brain function and with the full support of her close knit family, refuses to accept that her death is imminent but says loud and clear to two psychiatrists that she wants to “[d]ie trying to live”, it will take a great deal to displace the principle of autonomy and the presumption of capacity, no matter how unwise her decision to eschew palliative care may have seemed to a more mature mind.

139. It follows that against that backdrop, the judge in my judgment, failed to give sufficient reasons for disagreeing with the unanimous view of the experts that Sudiksha had capacity to make decisions as to her medical treatment.

At paragraph 140, the Court of Appeal took the other grounds of appeal shortly. Ground 4 was entirely specific to the facts of the case, so I do not set out here.

i) Ground 3: professional diagnosis of an impairment of the mind:



*Re D (Children) [2015] EWCA Civ 749 did not, as implied in this ground, say that a professional diagnosis of an impairment of mind is required before it can be said to have been established. In Re D at [30], I simply said that the diagnostic test<sup>2</sup> will require evidence from a suitably qualified person, which will usually be a person with medical qualifications. This was said in the context of a case where it was agreed that the person in question suffered from significant learning difficulties. In case there is any room for misunderstanding, I make it absolutely clear that I endorse the approach of MacDonal J in North Bristol that no formal diagnosis of impairment is required.*

[...]

iii) Ground 5: Application of Re JB to the present case:

*Mr Quintavalle submitted that the test in JB did not apply because in JB, unlike the present case, there was no doubt that the patient concerned had an impairment of mind and the issue there was as to whether, notwithstanding that impairment, the patient could consent to treatment. Mr Quintavalle drew the attention of the Court to the Mental Capacity Act 2005 Code of Practice (“the Code”) which stipulates the two-stage test of capacity, the first stage (at 4.11) being to establish whether someone has an impairment i.e. the diagnostic test. In this context he draws the attention of the court to section 42(5) MCA which requires the Court to “take into account” the Code. Responding to this submission, Mr Sachdeva rightly drew the Court’s attention to Lawson, Mottram and Hopton, Re (Appointment of personal welfare deputies) [2019] EWCOP 22; [2019] 1 WLR 5164 at [16] which makes it clear that it is the wording of the statute as authoritatively interpreted by the Court which must prevail over the Code. In my judgment, this and indeed any court, is in any event, bound by the Supreme Court decision in JB namely that questions under section 2(1) MCA should be first as to whether P is unable to make a decision for themselves by reference to section 3(1) the functional test. If they are not so able, consideration is given at the second stage to whether that inability is because of an impairment of, or a disturbance in, the functioning of the mind or brain (section 2(1), the diagnostic test).*

*I should say for completeness sake, that the Code with which the Court is concerned was first published in 2007. A consultation ran between March and July 2022 in relation to the proposed updating and revision of the Code. The Consultation said that the Code was to be revised because: “the existing Code guidance needs updating in light of new legislation and case law, organisational and terminological changes, and developments in ways of working and good practice”. The draft new Code, dated June 2022, adopts the JB approach to assessment of capacity at chapter 4.*

## Commentary

Given the clarity of the judgment (which is not being appealed), it might be thought that there is not a great deal to say by way of commentary, save to note that the Court of Appeal were not ruling out the relevance of (dis)belief altogether, as some seem to have suggested. An apparent lack of belief in what is being said is undoubtedly a legitimate reason to consider whether the person has capacity to make

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<sup>2</sup> King LJ had earlier noted the submission made on behalf of Mind that, rather than “diagnostic test,” “a more appropriate term would be to refer to the ‘impairment test rather than the diagnostic test given that [...] no diagnosis of mental illness is required in order to satisfy the test (see *North Bristol NHS Trust v R* [2023] EWCOP 5 (“*North Bristol*”) at [48])” (paragraph 40).

the relevant decision. What the Court of Appeal has made crystal clear is that that lack of belief cannot, itself, serve as a legally defensible conclusion that the person lacks capacity.

### The Court of Appeal, life-sustaining treatment and ‘covert consciousness’

Re PC [2024] EWCA Civ 895 (Court of Appeal (Bean, King and Baker LJJ))

*Best interests – medical treatment*

#### Summary

The Court of Appeal has refused permission to appeal the decision of Cusworth J in *NHS North Central London ICB v PC et al* [2024] EWCOP 31. The case concerned a 31 year old woman, who suffered a cardiorespiratory arrest and collapsed at home. A lack of cardiac output for about 30 minutes led to her brain being deprived of oxygen, which caused a severe hypoxic ischaemic injury. She was left in a Prolonged Disorder of Consciousness (‘PDOC’), at the low end of the spectrum of awareness, for four years and was now 35. An application was made by the ICB, who commissioned her inpatient hospital care, that it was not in her best interests to continue clinically assisted nutrition and hydration in circumstances where there was a lack of agreement from some members of her family. A paper prepared by the second opinion doctor required by the RCP PDOC guideline process, Professor Wade, was circulated shortly before the hearing, indicating, as King LJ put it, that:

*50. Professor Wade's position had evolved from a view that it is unlikely that a person in PDOC will experience pain but that it "cannot be excluded", to "we have no convincing evidence that an unconscious person cannot experience pain". What the judge knew and was entitled to take into account was that PC was and is exhibiting significant and distressing (for all concerned) pain behaviours in the form of crying, groaning and grimacing which behaviours appear to respond to pain relieving medication. Further, that so far as expert understanding is concerned, the level of uncertainty about how pain is experienced, if at all, by people in PDOC is such that current policy is to treat people who exhibit pain behaviours in ways designed to minimise and control pain.*

However, Professor Wade’s:

*51. [...] evolving view about this issue had no impact upon his evidence as to PC's diagnosis, level of awareness or need for further assessment of her condition, all of which remained constant throughout, as did that of Dr B and Dr A.*

PC’s mother sought permission to appeal on four grounds.

*Ground 1: The decision not to adjourn to obtain expert medical evidence was unfair in circumstances where the only evidence was from a second opinion doctor who fundamentally reversed his opinion on the key point in the case (PC's experience of her life) while giving evidence.*

*Ground 2: The Court conducted its own assessment of PC's experience of pleasure, contrary to authority.*

*Ground 3: Failing to determine the relevance of "covert consciousness" to the assessment of people in a persistent disorder of consciousness.*

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*Ground 4: It was an error, and contrary to authority, to decide that it was appropriate to cease treatment for someone with a low burden of care and no expressed wishes not to have care. That decision failed to pay lawful respect to the sanctity of life and PC's right to life.*

Grounds 2 and 3 were dismissed crisply:

*92. So far as Ground 2 is concerned, the extensive independent evidence gathered over a number of years was that PC derived no experience of pleasure. The judge summarised the evidence before him accepting it, as he was bound to do absent any evidence to the contrary. He did not conduct his own assessment. Permission to appeal on this ground is refused.*

*93. So far as Ground 3 is concerned, Mr Lawson's exploration of the discrete issue of 'covert consciousness' in cross examination was very limited and was in the context of an academic paper by Professor Adrian Owen called "The Search for Consciousness". This brief paper explores technological developments whereby using functional magnetic resonance imaging ("fMRI") there may be demonstrated, in certain cases, residual cognition and covert awareness at some deep level. It remained however impossible to establish any form of traditional communication at the bedside. The paper records that the use of fMRI "with entirely physically non-responsive patients is still very much in its infancy" although the paper says, it has the potential to improve diagnosis.*

*94. Mr Lawson did not suggest that fMRI should or could be conducted on PC. This means that the judge and any other expert could only properly base their conclusion as to whether there was a correct diagnosis on the evidence available which was already before the court. The judge was entitled to conclude that PC was in a state of PDOC and that her level of awareness had been established by appropriately qualified experts. It was therefore unnecessary to have dealt expressly with 'covert consciousness' when all the evidence collected following full assessment in compliance with the PDOC Guidelines, and specifically relating to her current presentation, did not raise any clinical uncertainty. It follows that permission to appeal is also refused on this ground.*

On ground 1, King LJ reminded herself that:

*96. Pursuant to r.15.3(1) Court of Protection Rules 2017, the Court of Protection has a duty to restrict expert evidence to that which is "necessary to assist the court to resolve the issues in the proceedings". Those representing MC had to satisfy the judge that, notwithstanding the overwhelming evidence in relation to the diagnosis of PDOC and as to PC's level of awareness, further neurological evidence was necessary in order to resolve the proceedings. Far from answering that question, those representing MC had not complied with r.15.5 (2) and (3). No expert had been identified, there was no draft letter of instruction, no indication of the issues to which expert evidence would relate or the questions which the expert would be requested to answer. The grounds in support of the application to adjourn simply stated that "it is appropriate to carry out further investigations of [PC's] awareness".*

*97. In his helpful oral submissions, Mr Lawson focused on: (i) the issue that there had not been adequate assessment of PC, and that both Professor Wade and the nursing home had been in breach of the PDOC Guidance, and (ii) that Professor Wade's evidence as to 'pain' was a central point and that having changed his view on PC's ability to experience pain, it was unfair on the parties not to enquire into both that change of evidence and her awareness.*

98. Mr Lawson submitted that there had been a departure from the PDOC Guidance in that there had wrongly been no full assessment of consciousness for some years. There was, he said, sparse evidence of the level of PC's consciousness and there was accordingly a need for a repeated assessment 4 years down the line. There was he said an "uncertainty as to diagnosis" which required further investigation.

99. So far as 'pain' was concerned, Mr Lawson said that it was unfair of the court to proceed on the basis of "shifting sands". Professor Wade's views on pain were, Mr Lawson said, central to the decision the court had to make, and an acceptance of his new position was not a satisfactory basis for decisions as to PC's best interests.

100. An appeal against a decision to adjourn a final hearing is a case management decision which has to be considered by an appeal court on the basis of whether the decision is fair. In *Re P (A Child)(Fair Hearing)*[2023] EWCA Civ 215, Peter Jackson LJ distilled twelve key principles from a range of appellate and ECHR authorities concerning the issue of whether it is fair to adjourn proceedings. It is not necessary to rehearse those principles here, although it is worth noting that Peter Jackson LJ followed his itemisation of the propositions at [46] by saying that: "[t]he essential touchstone is fairness and the weight to be given to any individual proposition or other relevant factor must be a matter for the judgment of the court in the case before it".

101. It should be borne in mind that the PDOC Guidance is just that, guidance, but in any event on an analysis of the guidance, there is in my judgment no basis whatsoever for the submission that the Integrated Care Board were in breach of the PDOC Guidance by not having repeated a full multidisciplinary assessment since PC moved to the nursing home, or that the annual reviews were inadequate. It is abundantly clear that there was no evidence of any improvement or increase in awareness on PC's part by the demonstration of pleasure. On the contrary, the only significant change was the increase in her crying and distress behaviours which was appropriately investigated.

102. As was acknowledged by the judge at [40], the evidence of Professor Wade as to PC's likely awareness of pain evolved during the hearing and it is undoubtedly the case that his view as to whether PC may suffer pain has changed. Significantly however, his evidence as to PC's diagnosis, her level of awareness and the need for further assessment of her condition was unaffected by his change in view with regard to her likely experience of pain. It was therefore wrong for it to be asserted on behalf of MC that Professor Wade had "fundamentally reversed his opinion on the key point in the case". In my view, as was submitted by Mr Hadden on behalf of the Integrated Care Board, Professor Wade's expanded definition of pain and his recognition that PC may have some experience of 'pain' should not be conflated with any change in his opinion regarding PC's level of awareness or consciousness, an opinion that was on all fours with all the clinical evidence and the annual reviews carried out by reference to the WHIMs and CRS-R tests.

103. The judge was entitled to conclude on the evidence that so far as PC was concerned at [57] "there was no evidence of any enjoyment of life. The only evidence is of her exhibiting discomfort and pain".

104. Mr Lawson has neither at first instance nor on his application for permission to appeal identified an appropriate expert or told the court what difference expert neurological evidence

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would bring to the determination of PC's best interests. The judge had the benefit of all the assessments set out above. The Official Solicitor gave careful consideration as to what medical evidence was required and at her request, Professor Wade answered the various additional questions she had posed in addition to having conducted a full and formal assessment such as is required by the guidance when an application to the court for an order in relation to the withdrawal of CANH is contemplated.

105. In my judgment, there is no real prospect of a successful appeal against the judge's findings that: (a) no amount of further assessment would answer the question whether PC is capable of feeling pain; and (b) there is no evidence suggesting or indicating that PC is functioning at a higher level than all the previous assessments, or that this issue requires further investigation. Permission to appeal is refused on Ground 1.

King LJ did, however, note that:

106. I should say for completeness that whilst in this case it has not led to the granting of permission to appeal, I can understand that those representing PC felt 'wrong footed' by the late introduction of the Pain Paper which was, as I understand it, introduced other than by court direction or agreement between the parties. I would remind legal representatives who have the lead in the instruction of experts, that the filing of additional expert evidence should be done following an application to the court, which application can, no doubt, be dealt with on paper if the parties are in agreement.

As to ground 4, the case put to the court was that there was "a compelling issue of principle for this court to consider, namely whether it is right in any case where there was a low burden of care and no expressed wishes on the part of a patient not to have care for a judge to make an order that it is in the best interests of that patient to withdraw CANH." King LJ was clear that:

109. In my judgment, there is no need for this court to undertake such a task. The legal principles applicable to these cases are clear and well established. Whilst Mr Lawson seemed to suggest that the time might have come to update or clarify the principles set out in *Aintree Hospital NHS Trust v James* [2013] UKSC 67 ("*Aintree*"), Baroness Hale's judgment remains the lodestar which guides the courts when considering these anxious cases and it therefore remains the case that the sanctity of life is not absolute and that life sustaining treatment can nevertheless be withdrawn where it is not in the best interests of the patient. Time and again judges rightly have in mind [36] of *Aintree*:

"36. The courts have been most reluctant to lay down general principles which might guide the decision. Every patient, and every case, is different and must be decided on its own facts. As Hedley J wisely put it at first instance in *Portsmouth Hospitals NHS Trust v Wyatt* [2005] 1 FLR 21, "The infinite variety of the human condition never ceases to surprise and it is that fact that defeats any attempt to be more precise in a definition of best interests" (para 23). There are cases, such as *Bland*, where there is no balancing exercise to be conducted. There are cases, where death is in any event imminent, where the factors weighing in the balance will be different from those where life may continue for some time."

On the facts of the case, moreover:



110. In any event, there is no merit in the individual features upon which the need for guidance was said to be based. The judge had well in mind the sanctity of life and said in terms at [62] that "...the simple preservation of life... is of course a fundamental principle of the utmost importance". Mr Lawson sought to suggest that PC has a 'low burden of care'. Whilst it is undoubtedly the case that PC is stable as to her base line and is not the subject to regular intrusive treatment such as ventilation or regular suctioning, the judge unsurprisingly found as a fact that "the burden of her condition on PC is a heavy one". PC is reliant on nursing care for everything, and her parlous condition is as found as by the judge as set out at [79] above and included her displays of the pain behaviours which have been described. Finally, the judge gave detailed consideration as to the sparse evidence of PC's wishes and feelings and was conscious that PC had not expressed a view as to whether to receive CANH or not to receive CANH. This was a factor which he properly weighed in the balance together with the burden of care and the sanctity of life.

King LJ, with whom Baker and Bean LJJs agreed, therefore refused permission to appeal.

### Comment

As this was a decision refusing permission to appeal, the decision has no wider precedent value (without diminishing at all its magnitude for the family and the medics involved). It is, however, clear that the appellate courts are not sympathetic to attempts to revisit the established principles relating to life-sustaining treatment authoritatively laid down in *Aintree v James*.

Although the Court of Appeal did not refer to this, it is perhaps worth noting the fMRI scanning process relied upon by the appellant was also considered in the [RCP PDOC guidelines](#)<sup>3</sup> at section 2.4, which make clear that such scanning (along with electrophysiology):

*do not form part of the standard assessment battery, nor do they represent a 'practicable step' required by s.1(3) MCA to support a person's capacity to make relevant decisions. They should be only applied in the context of a registered research programme.*

### Futility and best interests before the Court of Protection

Re XY [2024 EWCOP 37 (T3)] (Hayden J)

*Best interests – medical treatment*

### Summary

When medical treatment can be considered to be a futile is an important, but sometimes difficult, question. What can make it difficult in the context of those with impaired decision-making capacity is the need to ensure that the concept is not 'coding' judgment about other matters, above all judgments about the quality of life of the patient (an issue discussed in this important [article](#) by Cressida Auckland). In *Re XY* [2024 EWCOP 37 (T3)], the issue of futility arose in the context of a decision whether continuing life-sustaining treatment was in the best interests of a man who in a prolonged disorder of consciousness. The treating Trust wished to withdraw cease mechanical ventilation

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<sup>3</sup> Full disclosure, I was on the working group drawing up these guidelines.

and the provision of clinically assisted nutrition and hydration on the basis that its continuation was no longer in XY's best interests. He was Muslim, and as Hayden J identified:

*32. XY's daughter (DE) told me that the course proposed by the doctors would be contrary to Islamic faith, as understood by her father. She told me that the Quran decreed that "he who kills a man, kills mankind; he who saves a man, saves mankind". This is also present in the Torah and has resonances in the Bible. Thus, it is a facet of each of the Abrahamic faiths. All the family share this belief. By this I mean that each of them told me that A would wish to continue in his present circumstances, even if in pain, because he would have known that he would continue to provide succour to his family. I have come to the very clear view that whatever their understanding of the medical evidence might be, the loss of A is unbearably painful to this family and dominates their response. F told me that if she were in XY's position, she too would wish to endure similar circumstances to comfort her own children by her continued presence. I accept the sincerity of her statement and consider it reflected her honest position. It is argued by Mr Mant, Counsel on behalf of the family, that F's reasoning is entirely consistent with the way XY has lived his life, putting his family first at every turn. I find this to be a sensitive and well-reasoned submission.*

XY's Islamic beliefs were also underpinned an alternative plan proposed by the family, namely:

*35. [...] withdrawal of ventilation but reintroduction of CANH after a period of intermission, required for medical reasons. I need not burden this judgment with those reasons. There is agreement that XY would not be resuscitated in the event of cardiac arrest. It was suggested that alongside this, there would be no antibiotic treatment for almost inevitable infection, consequent upon micro aspiration. I should say that this second option was contemplated by the family but I did not sense any real enthusiasm for it. Its primary objective was centred upon what XY might have wanted in the circumstances that he found himself. His inevitable death on this alternative plan would not be in consequence of a particular action by man but more easily reconcilable with his Islamic beliefs. It was not constructed as casuistry; it was a sincere endeavour to reconcile the severity of XY's medical situation with the sincerity of his beliefs.*

Hayden J identified that:

*35. [...] Many people would recoil from XY's present circumstances and profoundly wish to be released from them as quickly as possible. Where those wishes are identified, the Court of Protection is vigilant to promote the individual's autonomy. However, the Court is similarly obliged to promote the autonomy of those whose views many might disagree with. The essence of autonomy is the promotion of an individual's right to take their own decisions. The important proviso is whether those decisions are lawful or whether they require others to act in a way that represses their own autonomy, morally and ethically.*

Hayden J could not countenance the alternative plan:

*36. [...] Ms Paterson KC, Counsel on behalf of the Official Solicitor, highlighted an important dissonance in the reasoning underpinning the alternative plan. In their assertion that XY would have preferred to remain in this profound disorder of consciousness, from which their lies no recovery, the family have attributed to him a degree of awareness which, I have found, is not supported by the evidence. Accordingly, their view that he would choose his present situation to afford comfort to them is based on their false premise of what his situation actually is. The severe brain stem dysfunction that XY has sustained is consistent with the view that perhaps even basic pain*

sensations may not be experienced or perceived. The continuing lack of any detectable response on the EEG is also supportive of this. Thus, in a very real sense, A is no longer there for his family. Grief, by its very nature, sadly, sometimes alters both reasoning and perception.

37. Having heard so much about the man XY has been, and listened to the powerful tributes paid to him, it is clear to me that the code by which XY has lived his life is predicated on principled beliefs. Those principles incorporate honesty, integrity, duty and love of his family, as well as humanity more generally. The 'alternative plan', as Ms Paterson identifies, is predicated on an inaccurate assumption. The responses that the family believe they see are misinterpretations. They superimpose upon XY, that which he cannot achieve or experience. The distortion of these relationships, at the end of XY's life, especially in such a close and loving family, runs counter to everything that each of them believes in. Of course, I include XY centrally in this. It does not sit in any way comfortably with the man he has been or the integrity that he has shown throughout his life. I do not believe, from all I have been told, that he would wish those who he has loved to believe that he was still there with them, in any meaningful sense, when the awful truth is that he no longer is.

Hayden J, finally, also agreed that:

38. [...] burdensome treatment of the kind contemplated here, can only be truly ethical where it can achieve benefit for the patient. Here, the treatment is futile. Dr A believes that XY is no longer receiving treatment in any real sense of the word i.e., it is not treating any condition. In short, it generates harm, not benefit and is irreconcilable with his professional oath. I entirely understand why he has come to that conclusion and for my part, in the light of my analysis above, cannot see how he could have arrived at any other. I would emphasise that his commitment to XY and his family has been unflinching.

Hayden J therefore made the declarations sought by the Trust.

## Comment

As noted at the outset, futility can be a difficult concept. It must be correct that a medical intervention which is not treating a condition is futile. However 'treatment' is a slippery word. Lady Hale in *Aintree v James* made clear that an intervention can still be treating a condition even if it is not curing it – if, for instance, it is maintaining the person's quality of life at a level they consider acceptable, even if, for others, such a situation might appear intolerable. See paragraph 43:

[i]t is setting the goal too high to say that treatment is futile unless it has "a real prospect of curing or at least palliating the life-threatening disease or illness from which the patient is suffering". This phrase may be a partial quotation from Grubb, Laing and McHale, *Principles of Medical Law* (3<sup>rd</sup> edition 2010), para 10.214, where the authors suggest that "Treatment can properly be categorised as futile if it cannot cure or palliate the disease or illness from which the patient is suffering and thus serves no therapeutic purpose of any kind". Earlier, they had used the words "useless" or "pointless". Given its genesis in *Bland*, this seems the more likely meaning to be attributed to the word as used in the Code of Practice. A treatment may bring some benefit to the patient even though it has no effect upon the underlying disease or disability.

[....]

43. *I also respectfully disagree with the statement that "no prospect of recovery" means "no prospect of recovering such a state of good health as will avert the looming prospect of death if the life-sustaining treatment is given". [...] where the patient is close to death, the object may properly be to make his dying as comfortable and as dignified as possible, rather than to take invasive steps to prolong his life for a short while (see paras 62-63). But where a patient is suffering from an incurable illness, disease or disability, it is not very helpful to talk of recovering a state of "good health". The patient's life may still be very well worth living. Resuming a quality of life which the patient would regard as worthwhile is more readily applicable, particularly in the case of a patient with permanent disabilities. As was emphasised in Re J (1991), it is not for others to say that a life which the patient would regard as worthwhile is not worth living.*

In a case such as XY's, therefore, it might be thought that talking of futility in the way framed by Dr A and Hayden J in fact simply brings matters full circle back to the interpretation of XY's will and preferences (to use the language of the CRPD), because it required consideration of whether he would perceive the treatment to be achieving any purpose. And, arguably, on the case put forward by the family, was achieving a purpose – it was keeping XY alive, and not contravening his Islamic faith. Indeed, Dr A himself tacitly acknowledged this, identifying earlier at paragraph 18 that, whilst he himself could not reconcile continued treatment with his clinical ethics, there would be other clinicians who would be prepared to take a contrary course if the court authorised it.

If treatment was truly futile, in the sense that it could not achieve any purpose – i.e. it would simply not work to keep XY alive – then this would have been a rather different application. Put another way, Dr A's views and those of the Trust would have been determinative of the issue, because no one could compel them to provide the treatment, as opposed to being a significant part of the mix alongside P's wishes.

One final, unrelated, procedural observation: the neutral citations for Court of Protection cases have now changed so that they identify at the end what Tier of judge has heard it: Tier 1 (District Judge), Tier 2 (Circuit Judge) or Tier 3 (High Court Judge).<sup>4</sup> This is extremely useful, because it makes clear what cases are (or could be) setting precedents, and what cases are in effect worked examples. For more on how to read a Court of Protection judgment, see [here](#).

### Following through a decision to withdraw life-sustaining treatment

NHS NW London ICB [2024] EWCOP 35 (Theis J)

*Best interests – medical treatment*

#### Summary

In this case, the Vice-President of the Court of Protection, Theis J, gave a careful and considered judgment about the continuation of clinically assisted nutrition and hydration ('CANH') of Z, a 70 year old man in a prolonged disorder of consciousness. Of enormous importance to the family, the majority

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<sup>4</sup> Before people write in, we know that a judge sitting in the Court of Protection is sitting as a CoP judge, not as a High Court judge, but the tiering system is identifying what level they are at when not exercising functions as a nominated CoP judge.

of the issues in the case will be familiar to those working in the field, and we do not set them out here. A novel point raised, though, was raised by the man's sister, given the evidence before the court that death following the withdrawal of CANH would usually take 1-3 weeks. Z's sister was clear that he would not wish to be in his current state, but that:

*32. In her view Z would, like most of us, want 'a quick painless passing, knowing how [Z] was also very practical and pragmatic I believe that given all the aspects of this tragic situation and available options now he would not see a managed withdrawal of the CANH as the worst thing and that he would consent to this.'*

At paragraph 70, Theis J noted:

*As Mr Patel observed when the time comes for us all everyone would want what W says Z would want; a quick and dignified death. That is not an option in this case. What I have to do is look at the wide canvas of evidence and consider what is in Z's best interests as between the available options.*

At paragraph 71(1), she noted, in this context, that one of the benefits of continuing treatment could be said that could be said to:

*the hope that Z would die quickly through some other cause, such as a cardiac arrest. Whilst that is a consideration, the reality of the medical evidence is that this is not more than a hope if CANH is continued. Even if such an event does take place, it may and probably will involve other complications.*

She noted at paragraph 71(9):

*In seeking to understand Z's wishes and feelings, beliefs and values there is unanimity that he would not want to live in his current condition. I agree. There are then differing views about what his wishes would be if he could not die swiftly. No one suggests Z had this discussion with them. W relies on the fact that he searched dying with dignity after his diagnosis. What W says is that Z would find it difficult to accept the changes to his body brought about if CANH was discontinued. Even accepting that some changes may take place it has to be balanced with the alternative which is for him to remain living, possibly for a number of years, in a way that everyone accepts he would not want. As Dr H described he did not believe that Z would wish to be 'remaining alive at all costs in a state of permanent unconsciousness from which all semblance of a treasured identity has since departed'.*

## Comment

For those who want to understand more about the dying process following the withdrawal of CANH, we would recommend [this article](#) by Lynne Turner-Stokes and others. As the Royal College of Physician's [guidance](#) on PDOC makes clear (see section 5B), there are steps that can lawfully be taken to seek to palliate any distress that may be suffered by the patient in the period after withdrawal. The doctrine of [double effect](#) makes clear that it is lawful for such steps to be taken, even if they have the incidental effect of shortening the person's life. However, Z's sister, and Theis J, were undoubtedly right that the law as it stands does not allow for active steps to be taken to bring about the end of a person's life after life-sustaining treatment that been withdrawn. And, even if were assisted dying to be made



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legal under the [political proposals](#) that are regularly put forward, they would not change the position in cases such as Z, because they have always been predicated on a current, capacitous, request by the individual; in a case such as Z's, there would be no such possibility of a request being made. This [article](#) provides a fascinating and provoking thought experiment which teases out some of the implications of the fact that it is lawful to stop life-sustaining treatment in a case such as that of Z's, but not lawful then to take steps actively to bring about their death.

### Short note: ARFID and the Circuit Judge

It is only (relatively) recently that it has been accepted that serious medical treatment cases can be heard before Tier 2 (Circuit) Judges.<sup>5</sup> The decision in *Health Body A v JW* [2024] EWCOP 40 (T2) breaks no legal ground, but merits noting as an example of such a case (referred to the Vice-President but then released to a Tier 2 Judge). It concerned the administration of dental treatment including possible extraction under general anaesthetic in respect of a young woman diagnosed with learning disability, autism and Avoidant / Restrictive Food Disorder ('ARFID'). The judgment is notable for the careful self-directions of HHJ Howell as to the law, and the equally careful application of that law to the facts before her. That having been said, one tantalising point that in the judgment is HHJ Howell's reference to the observation of Munby J (as he then was) in *A Local Authority v MM and Another* [2007] EWHC 2003 (Fam) to the effect that if one does not believe a particular information one does not, in truth, understand, use or weigh it. After HHJ Howells had heard the case (and, it is likely, after the procedures in question had been carried out), Munby J's observations about belief were held to be wrong by the Court of Appeal in *Re Sudiksha Thirumalesh (dec'd)* [2024] EWCA Civ 896. The judgment in the JW case does not contain enough detail about JW's problems with decision-making (her lack of capacity in the material domains being agreed) to identify whether HHJ Howells had been led up the garden path in her analysis of JW's capacity.

### Sexual capacity in context

*PS v A Local Authority, WP, DT & RS* [2024] EWCOP 42 (T2) (HHJ Burrows)

*Mental capacity – sexual relations*

#### Summary<sup>6</sup>

This case concerned PS, a 79 year old lady with what was described as an extremely serious memory impairment related to alcohol use. She had been in a sexual relationship and lived with WP for almost twenty years. By the time the matter came before the court PS was residing in a care home, but it was common ground that both PS and WP wished for their sexual relationship to continue. However the care home had put in place a protocol to prevent the couple having time alone together in PS's room because of concerns that PS lacked the capacity to consent to sex.

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<sup>5</sup> There is a separate question as to what "serious medical treatment" means given the withdrawal and non-replacement of the Practice Direction governing such cases.

<sup>6</sup> Neil having been involved in the case, he has not contributed to this note.

The issues in the case centered on PS's capacity to make decisions about contact and engaging in sexual relations. The expert found that PS was unable to assess risks that a person with whom she was having contact with may pose to her. In addition, she was liable to misidentify people – she had for example mistaken other men for WP. HHJ Burrows perhaps unsurprisingly therefore found that she lacked the capacity to make decisions about contact with people in general and WP in particular.

With respect to PS's capacity to engage in sexual relations, HHJ Burrows held that given PS's age, the relevant information did not include the fact that pregnancy could result from sexual intercourse. Further, HHJ Burrows held that as WP and PS were in a monogamous stable sexual relationship, the risk of transmission of sexually transmitted infections could also be excluded as part of the relevant information. He accepted that PS could understand, retain etc the mechanics of the sexual act and the fact that the other person must consent to the sexual activity. He also accepted the expert's view that PS understood that she must also consent to the sexual activity. There was some discussion about whether or not PS had the capacity to change her mind once sexual activity had started. HHJ Burrows came to the view that if she did so, this would become apparent from her behaviour and WP would need to stop the activity. Unsurprisingly, he concluded that PS had capacity to consent to sexual relations and the presumption of capacity had not been displaced. However, importantly, he held that

*the presumption or assumption of capacity only survives in the event that a proper protective care plan can be put in place to enable PS to enjoy sexual activity with WP if she (and he) want it. As I said using other words during the hearing, that will be a challenging TZ care plan<sup>7</sup>. That will require a set of arrangements that enables the couple to have time together in privacy when they wish.*

## Comment

Some might think that in his approach to sexual capacity, HHJ Burrows came as close as it is possible to the line in terms of maximising PS's capacity to make decisions in relation to sexual relations. Some might also think that the case suggests that the bedroom is peculiarly unsuitable for the sort of legal exercises that are required by the (statutory) law as it stands.

What is also particularly interesting about this case is the separate consideration HHJ Burrows gave to PS's capacity to make decisions about contact with people in general, and then with WP in particular. HHJ Burrows took this approach because PS's deficits in the functional part of the capacity test arose from her seriously impaired short-term memory. However, because WP had been her partner of many years, she had "a strong sense of memory of him at a very deep level". In other words, HHJ Burrows felt, it was important to consider whether this might mean that she retained capacity to make decisions about contact with him. In fact, he found that she "had no ability to initiate or refuse contact within the

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<sup>7</sup> This refers to the case of *A Local Authority v TZ* [2014] EWHC 973 (COP) in which Baker J (as he then was) grappled with the appropriate way to provide support to TZ who had capacity to make decisions about sexual relations, but not about contact. Baker J found that TZ lacked the capacity to make decisions about whether an individual with whom he may wish to have sexual relations is safe and the capacity to make a decision as to the support he required when having contact with such an individual. A TZ care plan therefore is shorthand for the care plan that sets out the support to be provided to a 'P' in having a sexual relationship should (s)he wish to do so.

context of her relationship with WP, other than simply following her basic feeling that she knows him, and he is her husband/partner."

### Short note: a tantalising (non) decision about sexual relations

The decision of Theis J in *NHS Birmingham and Solihull ICB v JI* [2023] EWCOP 66 has only recently appeared on Bailii (having been decided in December 2023). It is a decision which is tantalising, as it looks at the outset as if it is going to put further flesh on the bones of the decision of the Court of Appeal in *Re C* [2021] EWCA Civ 1527, in particular as regards the extent to which the Court of Protection can endorse care packages which involve support for individuals accessing paid sexual services short of sexual relations (in the case in question private lap dancing) at an establishment called 'Adult World.' This had been going on for a number of years, generally at JI's request. However, in light of the decision in *Re C*, the ICB and the local authority, who jointly commissioned JI's care package, decided:

9. [...] that the support workers are at risk of committing an offence under section 39 of the Sexual Offences Act, in that it could be said that the care workers cause JI to engage in sexual activity, or they are creating the circumstances for the sexual activity to take place. The Integrated Care Board considers the risk of this is more than fanciful. As a consequence, they have made the decision to phase these visits out gradually to manage the impact on JI.

The Official Solicitor sought the following declarations under s.15 MCA 2005:

- 1) That it is lawful for JI's support workers to continue to support him to attend Adult World for the two further visits planned by the Integrated Care Board and the Local Authority.
- 2) Also to declare, as would inevitably follow, it will be lawful for them to continue to provide the same on a longer term basis in line with the proposal set out by Mr P in his statement, namely the management of such visits as I have just summarised, and then at the end of the declaration it would say if the Integrated Care Board are willing to commission that support.

Theis J, however, declined to make the declarations sought, because of the evolving nature of JI's circumstances. Importantly, she noted:

23. Firstly, the Integrated Care Board have made their decision in the context of other services they are going to put in place as set out in Mr G's statement. Those are at the very early stages of being put in place and will be reviewed at the 12 weekly review that is going to take place in February.

24. Secondly, that review may result in changes to the current care plan so that the visits to Adult World may be reinstated, may be less frequent, or may not occur at all. Mr Patel has rightly been clear that the door in relation to consideration of these matters is not closed.

25. Thirdly, any decision about best interests is multifaceted, and it is important that the most up to date factors and relevant evidence to best interests are taken into account in considering whether the Court should take the step that the official solicitor invited the Court to do.

26. Fourthly, the declaration being sought by the official solicitor is being made in what I consider to be an evidential vacuum. It may no longer be an issue in March, I do not know, there may be other ways JI can explore his sexual identity or urges, and as I had indicated in the documents that

*the Court has got, JI chose not to pursue that activity in November as a result of him prioritising his financial resources in a different direction.*

*27. Fifthly, this is a different situation at this moment in time than that envisaged by Baker LJ in paragraph 75 of Re C. The situation he was envisaging is that there was an actual care plan in place. In relation to the future declaration sought on behalf of the official solicitor, that care plan is not yet in place, and that will be the position when the Court reconsiders this case in March.*

*28. Finally, generally the evidence and analysis that supports the various positions needs updating, particularly in the light of the additional support that is going to be put in place. Mr G, the allocated social worker, has just taken over, and Mr A has only just taken over from Mr P who has been involved for a significant period of time, so for those very brief reasons I decline to determine the issue in relation to the declaration sought on behalf of the official solicitor at paragraph 24(2) of the position statement.*

Theis J also further emphasised the need for there to be in place a care plan complying with the guidance of Baker J (as he then was) in *A Local Authority v TZ (No. 2)* [2014] EWCOP 973, given that JI had capacity to make decisions about sexual relations, but lacked capacity to make decisions about contact.

Procedurally, Theis J also expressed displeasure at the fact that the directions made had not been complied with – noting that they were not

*34. [...] optional extras that can just be complied with or not at will. It has caused enormous inconvenience, no doubt to the parties in the case, but also to the Court to be able to have to manage the reading and getting back on top of the difficult issues in this case.*

[...]

*37. [...] If there is very good reason not to comply with a direction the Court, of course, will always consider any request, but it is causing real problems in managing cases, managing Court lists and managing hearing times caused by a culture of casual non-compliance with court orders.*

## 2023-2024 DoLS statistics

The DoLS statistics for England for the year 1 April 2023 to 31 March 2024 were published on 22 August 2024. They show that, despite heroic efforts by local authorities up and down the country, they continue to fight a losing battle actually to secure that all those requiring the safeguards are provided with them.

In headline terms:

- There were an estimated 332,455 applications for DoLS received during 2023-24. This is an increase of 11% compared to the previous year.
- The number of applications completed in 2023-24 was estimated to be 323,870. The number of completed applications has increased over the last five years by an average of 9% each year.
- The reported number of cases that were not completed as at year end was an estimated 123,790, a 2% decrease the previous year, and the proportion of standard applications completed within the

statutory timeframe of 21 days was 19% in 2022-23, the same as the year before. The average length of time for all completed applications was 144 days, compared to 156 days in the previous year.

- Data new for this year show that:
  - An estimated 162,655 cases were closed without any assessments as at year end: i.e. there had been no substantive consideration of whether the person met the criteria under Schedule A1.
  - Only 3% of cases of applications had been fully completed and fully assessed were not granted. Of the 4,315 cases which were assessed and not granted, 51% were not granted because of a change in the person's circumstances (for instance they had been discharged from the hospital in question), 25% because the person had died; only 915 were not granted because one or more of one of the DoLS criteria were not met. Of these, 305 in fact had the relevant decision-making capacity, 20 were ineligible applying the MCA/MHA interface in Sch 1A, the assessment process found that deprivation of liberty was not in the person's best interests, necessary and proportionate in 25 cases, and 5 failed the no refusals test.

The changes in the data recording make it difficult to work out how many people died whilst waiting for the assessment procedure to be completed – in 2022-2023, it was 50,000, and it is a reasonable guess that a very significant number, again, died this year in similar circumstances.

The DoLS statistics only tell part of the story, because the framework does not apply where the person is not yet 18, or is deprived of their liberty other than in a care home or hospital. There were 1,211 applications to the Court of Protection for judicial authorisation of deprivation of liberty in the first quarter of 2024, but it is very difficult to get a sense of by a factor of how many this number is short of the number of applications that should be made.

Alex has made some modest suggestions about how embattled public authorities can seek to respond to the situation in light of the indefinite delay to the LPS here. He has also given some thoughts about care providers and legal ice here.



## PROPERTY AND AFFAIRS

### CoP Property and Affairs Court User Group minutes

The minutes of the CoP Property and Affairs Court User Group meeting of 10 July 2024 are now [available](#). Two exchanges in respect of the (relatively) new COP3 form perhaps merit particular mention:

*Q: Are there any plans for a prescribed or approved list of professionals, professional qualifications or experience that would make a person suitable to complete form COP3? The previous COP3 had some examples on it of who may be a suitable person to complete the form. There have been a few instances reported recently where an assessment by a social worker who is experienced in assessing mental capacity has been rejected and a medical assessment requested. An approved list for both internal and external users of the Court of Protection may prevent any confusion in this regard.*

*A (Senior Judge Hilder): responded that the review of the COP3 by the Rules Committee which led to the current form of the COP3 specifically considered this question and determined that an exhaustive list was not possible, not least because the landscape of roles in this area is constantly changing. For example, "Physician Associates" are new. (So far, HHJH has not been persuaded that Physician Associates have sufficient expertise/experience to conduct capacity assessment.) Typically, the appropriateness of an assessor depends on both the expertise/experience of the assessor and the circumstances of the incapacitated person. The decision maker needs to be satisfied that the assessor is appropriately qualified in the circumstances required.*

And:

*Q: If the old COP3 is on the old form, will it still be acceptable if the content is appropriate.*

*A: (Senior Judge Hilder): advised that the 6-month window for using the old COP3 had now expired. If an old COP3 form is to be relied, there will need to be explicit confirmation that circumstances have not changed.*

### Court of Protection deputyship and attorneyship update

[This is a guest post from [Caroline Bielanska](#)]

At a recent meeting with the Court Manager, it was suggested that the Court's Practice Directions which are held on the Judiciary website, could be embedded into the gov.uk website to make it easier for those not familiar with the court process. The Court Manager is to consider this further.

Since January 2023, applications for the appointment of a property and affairs deputy can be made on line via the gov.uk website. Since then the process has been adapted to make it easier for users and the court administration. Most recently, the process has removed the need to complete and upload form COP1A (information about property and affairs), as the process allows applicants to include this information during the online journey. However, for professionals the process still uses form COP1A to collate the data, meaning they input the same information twice: once when they are collating it and secondly when they use the online process. When the file is costed, the time

taken will not be fully recoverable because of duplication. The Court Manager has confirmed that users have a choice as to how to submit this information- either directly online or upload form COP1A. This is good news for professionals who will certainly want to continue with standard usual practice.

There are still about 30% of professional users who are not making their deputyship applications online. There is likely to be a change to Practice Direction 9H which may result in professionals being prevented from having their costs paid from the person's funds if they make a paper application. The court is making contact with professional applicants to remind them to make the application online. This has the advantage that they will receive their order quicker. It is important that this is shared within practices, particularly if it has branch or regional offices.

### **Clarity on Ministry of Justice's position for Certificate Providers**

The OPG has the power under paragraph 11(1) of Schedule 1 of the MCA to determine that an instrument is not made in accordance with Schedule 1 and so has not been validly executed. In that context, the OPG may request relevant information from the Certificate Provider to verify the circumstances in which the LPA certificate was provided.

Following a recent conversation with the policy team responsible for the implementation of the Modernisation of Lasting Powers of Attorney project (MLPA) at the Ministry of Justice (MoJ), they have confirmed that the Certificate Providers will not be legally required to respond to inquiries made by the OPG.

The Powers of Attorney Act 2023 is yet to come into effect, but it and its underlying regulations will realise the MLPA project. It had been hoped that the planned amendment LPA regulations would expressly make provision for Certificate Providers to respond, particularly as the OPG will become responsible for investigating any concerns raised by any person prior to the registration of the LPA, without the need for the concerned party to make a court application.

The MoJ policy team confirmed they would be happy to include a line in the Certificate Provider Form to encourage people to comply with any future requests from the OPG in circumstances where a dispute about an LPA has been raised. While this would have no legal enforcement under the MCA, it may increase understanding of the role and enhance protections for the donor.

Solicitors who act as a Certificate Provider who respond to the OPG's inquiries will be in breach of rule 6.3 of the Solicitors Regulation Authority's Code of Conduct.

The rule requires they keep the client's affairs confidential unless disclosure is required or permitted by law or the client consents. Disclosure is permitted if a solicitor knows that a crime or fraud is being committed. However, it would be extremely hard to imagine a situation where a solicitor who acted as a Certificate Provider, which in part confirms their opinion this is no fraud, would subsequently consider there was a crime being committed at that point.

To avoid breaching rule 6.3 solicitors should obtain advance consent from their client when acting in relation to the making of an LPA. To help solicitors, here is an example of advance consent.

### **ADVANCE CONSENT**

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**TO DISCLOSE CONFIDENTIAL INFORMATION RELATING TO YOUR LASTING POWER(S) OF ATTORNEY**

When you make a Lasting Power of Attorney, it must be signed by an independent person who has formed an opinion that:

1. you have the mental capacity to make the power;
2. you understand the scope and purpose of the power;
3. you are not being put under undue pressure to make the power;
4. it is not being fraudulently made; and
5. there is nothing else which would prevent you from making the power.

Concerns can be raised with the Office of the Public Guardian who can investigate. The Office of the Public Guardian acts to safeguard people from making lasting powers where they do not have capacity or are being tricked or pressured into making a power. They may ask the person who acted as your Certificate Provider to answer questions as to how they formed their opinion. The outcome of the investigation might result in an application to the Court of Protection for a judge to be decide what should happen.

Where a solicitor is to act as a Certificate Provider it is necessary for you to give your consent to them answering questions. This is because solicitors are required by their Regulations to keep your information confidential.

It is very rare for concerns to be raised, but please can you sign the attached consent form, which will permit the certificate provider to answer questions should they be made.

**ADVANCE CONSENT  
TO RESPOND TO QUESTIONS  
RAISED BY THE OFFICE OF THE PUBLIC GUARDIAN**

I [insert client's full name and address] give my consent to:

[insert legal practice's name and address] (the legal practice) which includes any successive or amalgamated practice which has resulted in a change of its name or address:

To disclose any confidential information held or known in respect of me relating to the making of my lasting power(s) of attorney, to the Office of the Public Guardian and the Court of Protection.

I understand that any confidential information disclosed will be limited to what is considered by the legal practice at the time to be necessary and appropriate.

Signed.....  
Dated.....

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## PRACTICE AND PROCEDURE

### Equal Treatment Bench Book - new edition

A new (2024) edition of the Equal Treatment Bench Book (ETBB) has been published. As it notes in the preface:

*Treating people fairly requires awareness and understanding of their different circumstances, so that there can be effective communication, and so that steps can be taken, where appropriate, to redress any inequality arising from difference or disadvantage. This Bench Book covers some of the important aspects of fair treatment of which all judges should be aware, making some suggestions as to steps that judges may wish to take, in different situations, to ensure that there is fairness for all those who engage in legal proceedings in our courts and tribunals.*

And as King LJ notes in her foreword:

*Since 2018 it has been published online and, whilst its focus is primarily aimed at all judicial office holders and is written by judges for judges, it has also come to be regarded as an invaluable resource for litigants in person and to many other people connected directly or indirectly with issues relating to equal treatment.*

Each chapter has been updated, with significant revisions, in particular, to the chapter on "capacity (mental)."

### Article 5(4), community deprivation of liberty and jury-rigging a solution

*Re PQ (Court Authorised DoL : Representation During Review Period) [2024] EWCOP 41 (T3)*, Poole J

Article 5 ECHR – deprivation of liberty

#### Summary<sup>8</sup>

Poole J has examined in some detail the requirements of Article 5(4) ECHR in the context of court authorised deprivation of liberty. On the facts of the case before him, he held that Article 5(4) required that PQ, the subject of the authorisation, had to be represented throughout its length, by a litigation friend, an ALR or a rule 1.2 representative. He noted (at paragraph 57) that:

*My conclusion that there would be no compliance with Art 5(4) without the appointment of a representative, be it a Litigation Friend, an ALR, or a r1.2 representative, is consistent with the domestic authorities, in particular the judgments of Munby J and Charles J set out above and the recent observations of Senior Judge Hilder in Bolton Council v KL (above). The likely need for representation for a P who is deprived of their liberty has been recognised not only in relation to the planned review of their deprivation of liberty but also during the whole of the review period. My conclusion also sits comfortably alongside the mandatory requirement for P to have a representative when deprived of their liberty in a hospital or care home under the DoLS regime. In*

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<sup>8</sup> Arianna having been involved in the case, she has not contributed to this note.

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*the present case, without some form of independent representation, PQ's Art 5 rights would be "theoretical and illusory" not "practical and effective".*

Poole J also had to grapple with what to do where there was (as is often the case) no person who can act as unpaid 1.2 representative, and no funding available for a paid representative. He did not consider that the option of using a Court of Protection visitor was viable, not least because the OPG advised the parties that they were not known to have been used for purposes of providing ongoing representation. Having examined the public funding situation (and found it distinctly lacking), he held on the facts of the case – which arose at the end of proceedings in which the Official Solicitor had been involved – that:

*66. [...] Taking all matters into consideration, having determined that PQ's participation requires either the continued role of a Litigation Friend or the appointment of a representative, each being independent of the detaining authority, and there being no option to appoint a r1.2 representative, I shall direct that P shall continue to be a party and that the Official Solicitor shall continue to act as Litigation Friend until further order. Were an ALR appointed in place of the Official Solicitor acting as Litigation Friend, and were the duties of the ALR to include monitoring the arrangements during the review period and raising challenges and making applications as appropriate, then I would be satisfied that the appointment of an ALR would meet the requirements of Article 5 for the purposes of the review period. However, the Official Solicitor is already in place. I do not have evidence that the costs of maintaining the Official Solicitor as Litigation Friend will be disproportionate or indeed that they will be higher than the costs of appointing and then funding an ALR. I would consider authorising the appointment of a suitable ALR on application if assured that funding were secured and that it would be proportionate to make the appointment and to discharge the Official Solicitor as Litigation Friend but, for now at least, I shall direct that the Official Solicitor shall continue to act as Litigation Friend for PQ.*

Poole J identified that the question of PQ's continued participation was to be revisited at a review hearing, but that:

*67. [...] During the dormant period of the proceedings in the review period, the Official Solicitor as Litigation Friend should act as would an RPR under the DoLS scheme or as would a r1.2 representative. She must monitor the implementation of the Care Plan, provide to the Court updating information on the implementation of the Care Plan ahead of the review hearing as provided for in the order which the Court will make, and she must make an earlier application for review of the Court's order if she considers that the Care Plan no longer serves the best interests of PQ and that an application is required. She may act through a solicitor for those purposes or she might perhaps engage another kind of professional representative to carry out those functions insofar as they do not involve making or responding to court applications. For example, a professional RPR might be suitable for the purpose of monitoring the care arrangements, care plans, and the deprivation of PQ's liberty, reporting on them to the Official Solicitor.*

Poole J expressed the hope (at paragraph 68):

*that the LAA will reflect on the need for such services to be provided to secure PQ's participation and the state's compliance with Art 5. These functions are important and they are connected with ongoing proceedings. There is no alternative form of representation available. There may be a need for future oral hearings but that cannot be known in advance. The very purpose of representation*

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would be to ensure that the need for an oral hearing during the review period was swiftly identified and appropriate applications to Court were made.

He noted that the outcome was:

69. [...] *unsatisfactory because, although important, the functions that the Official Solicitor will be performing during the review period could as well be performed by a r1.2 representative. I have not been provided with comparative costs but presume that the cost of a r1.2 representative would be less than the cost of retaining the services of the Official Solicitor and the solicitor or representative instructed on her behalf. The costs will fall on the LAA rather than the Local Authority. There is therefore an incentive on Local Authorities to refuse to fund r1.2 representatives if they know that the LAA will fund an ALR or the Official Solicitor. Charles J referred to these "budgetary battles" and sadly they are continuing eight years after his plea for a resolution. In the end, the state pays and the solution to which I have been compelled to arrive means that the state will probably pay more than it should pay. The Official Solicitor has not asked the Court to consider the wider ramifications for the allocation of limited resources, but the potential ramifications are plain for all to see. The solution, which lies in the hands of the state through central government and Local Authorities, is to fund a professional r1.2 representative. The failure to do so results in a solution that probably imposes a higher burden on the taxpayer. However, I cannot countenance the alternative of leaving PQ with no independent representation of any kind during the review period.*

Anticipating that the LAA might withdraw funding, he made directions:

71. [...] *that, in the event of a decision by the LAA to refuse or to withdraw funding of the Official Solicitor and/or an ALR:*

- i) The matter shall be re-listed before the Court for further consideration of PQ's participation.*
- ii) The LAA shall provide a full explanation to the Court of its decision not to fund PQ's representation.*
  - i*
  - iii) The LAA shall be requested to secure ongoing funding for PQ's representation by a solicitor instructed by the Official Solicitor or an appointed ALR pending further determination of the Court of the participation of PQ.*
  - iv) The Local Authority shall review its decision not to fund a r1.2 representative and shall provide a written explanation to the Court in the event that it decides not to fund a representative even when, as a result, PQ in their care will have no independent representation.*
  - v) The Secretary of State for Justice shall be joined as a party and required to provide evidence as to the provision of funds for a professional r1.2 representative for PQ.*

Poole J did, however, emphasise that he did not rule out that:

72. [...] *in some cases, compliance with Art 5(4) may not require the appointment of a representative or litigation friend during a review period or at all.*

Earlier in his judgment, he had amplified this point thus:



49. [...] That is not to rule out circumstances in which the Court might be satisfied that there is no requirement for P to be a party, and so to have a Litigation Friend, or to be supported by an ALR or a r1.2 representative. In principle, having regard to the matters to be considered under COPR r1.2(1), the Court might discharge P without appointing a representative if satisfied that there is no prospect of any contentious matters arising in the review period and that there will be sufficient monitoring and sufficient opportunity for P to raise concerns or to make challenges pending the planned review. Such circumstances are likely to be rare but to the extent that Charles J held in *Re JM* that it could never be Art 5 compliant for P as a non-party to have no representative when deprived of their liberty, I respectfully disagree. However, in most cases the Court will not be satisfied that P can participate without either being a party with a Litigation Friend or ALR, or as proceeding as a non-party with an ALR or a r.1.2 representative.

## Comment

Given that a litigation friend cannot be compelled to act, it would have been open to the Official Solicitor simply to decline to act on an ongoing basis (or decline to act absent a cast-iron guarantee as to her legal costs in the 'dormant' period, which the court clearly could not provide). It is to her credit that she did not seek to do.

Whilst Poole J made clear that he was determining the issues solely as they related to the circumstances of PQ's case, the reality is that the observations that he made were of wider relevance, and his suggestion that there may be "some" cases in which there was no need for a rule 1.2 representative / ALR / litigation friend is, in reality, encompassing only rare circumstances. The continued (and it appears indefinite) non-appearance of LPS means that the issues considered by Poole J will remain live for the foreseeable future, together with the attendance complexity and additional expense required to jury-rig Article 5(4) compliance into the system.

## Which decisions are for the courts, and which for clinicians?

*Re AA ((Withdrawal of Life-Sustaining Treatment: No Best Interests Decision) [2024] EWCOP 39 (T3)* (Henke J)

*Best interests – medical treatment – practice and procedure*

## Summary<sup>9</sup>

This case concerned a young man, AA, in a prolonged disorder of consciousness, identified by the treating team as being on the border of a vegetative state/minimally conscious state-minus. His parents did not agree either with his diagnosis or prognosis. At the outset of the case, the applicant ICB<sup>10</sup> sought a determination as to which of two options were in AA's best interests.

1. Transfer to one of two identified nursing homes on a palliative care pathway, with no readmission to hospital, and continuation of clinically indicated medications and CANH.

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<sup>9</sup> Tor having been involved in the case, she has not contributed to this note.

<sup>10</sup> Who, as the subsequent costs decision made clear, only became involved at the point when it became clear that one of the options for future care would include treatment outside hospital it would have commissioned.

2. Withdrawal of CANH at the hospital where he was being cared for, with provision of palliative care.

Matters then evolved in light of the deterioration in AA's condition, such that the applicant ICB contended that there was no available option other than a move to palliative care at the hospital. The ICB initially sought a transfer to the High Court under the inherent jurisdiction on the basis that there was no basis to suggest that the proposed plan was in breach of duties owed to AA in negligence or of his rights under the ECHR, and no necessity for further medical evidence in light of the opinions already received. In light of considerable resistance from the Official Solicitor and AA's parents, the ICB sought either a declaration of lawfulness under the inherent jurisdiction or a declaration of lawfulness and best interests under the MCA 2005.

Henke J made clear that she considered that the case should have been brought earlier than it was, given that AA's parents "*fundamentally do not accept and have not accepted the clinicians' opinion throughout his admission to hospital*" (paragraph 35). However, given where matters now were:

*I have reminded myself of s.1(5) MCA and s.4. If the court is being asked to exercise its powers under the Act, then the court is required to exercise its judgment and to determine the application in accordance with the Act by reference to all the relevant circumstances. However, in this case I find myself with no choice of available treatment options. As Moylan J put it in *An NHS Trust v L & Others* [2012] EWHC 4313 (Fam) at paragraph 113.*

*"113 [...] If there are no treatment options, then the court has no effective choice to make. This is not the same as the situation where the medical evidence is all to one effect as in the case of *NHS Trust v MB and others* [2006] EWHC 507 Fam"*

Henke J agreed with these observations, and accepted the "well-established" principles that

*i. a patient cannot require a doctor to give any particular form of treatment and nor can a court - *NHS Trust v Y* [2018] UKSC 46.*

*ii. It is an abuse of process to try to use a best interests declaration under the MCA 2005 to persuade a clinician to provide treatment where none is being offered - *AVS v A NHS Foundation Trust & Anor* [2011] EWCA Civ 7.*

The ICB was recorded as inviting the court to consider proceeding to make a best interests decision as Moylan J (as he then was) had done in *An NHS Trust v L* and Judd J had done in *London North West University Healthcare NHS Trust v M* [2022] EWCOP 13. Whilst not stated on the face of the judgment it appears, reading between the lines, that the ICB was not positively advancing the proposition that a best interests decision should be made. Rather, it was doing so on the basis that this was a course of action open to the court in light of the approach taken in those two cases, in both of which there was, in fact, only one option. Henke J, however, was not prepared to do so. She considered that the two cases were different:

*Moylan J had heard extensive evidence over many days and that he reluctantly proceeded to make a best interests decision because all parties asked him to and no one took the no other available option point before him. In the *London North West* case Judd J had had the opportunity to receive*

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*and hear evidence from the treating clinician, the second opinion doctor and another who appears to be a court appointed expert who had provided a review. Having read that case with care, it seems to me that the case Judd J had before her was one where all the available evidence, including that obtained through the court process, was all to one effect.*

Here, however, Henke J noted, the Official Solicitor had not pursued the instruction of an expert, because this would have been “futile,” given:

*40. [...] the Applicant's clear position that regardless of any further expert opinion, they were only prepared to implement the PCP they had submitted to this court. The case before me is built on the evidence provided by the clinicians and that obtained by them. I do not for one moment doubt the good intentions or integrity of the clinicians in this case. Professor Turner-Stokes in evidence was an obviously committed and caring professional who understood the gravity of her task and made her clinical judgment in accordance with her considerable expertise and conscience.*

As the clinical view was that there was only one option, and the clinicians would only treat AA in accordance with that option:

*40. [...] This case is stark. There is only one available option before this court. The reality is that this court has no choice to make. Accordingly, I have concluded that there is no best interest decision to make here, and I do not do so.*

Henke J declined then to do what the ICB actually wanted it to do, namely to make a declaration in the inherent jurisdiction that it was acting lawfully. She accepted (at paragraph 41) that she could do, but the question was whether she should. As she noted:

*Clinicians are not legally obliged to seek a declaration from a court as to the lawfulness of any proposed treatment - see Re Y [2018] UKSC 46 at paragraphs 29-33. Professor Turner-Stokes gave evidence that regardless of whether or not I granted the declaration, the clinicians would continue to treat AA in accordance with their clinical judgment and implement the PCP. That begs the question: why is the declaration being sought when whether or not I grant it does not affect the outcome for AA? It appears to me that the declaration is really being sought to protect the clinicians and medical staff now and in the future from potential legal action given AA's parents fundamental disagreement with the PCP. I have considered whether I should grant the declaration sought in such circumstances. If I thought that on the ground that the declaration would make any difference to the outcome for AA then I may have been persuaded to make it. But the reality here is that the declaration will not alter anything. The clinicians will continue to treat in accordance with their clinical judgment whether or not I make the declaration. AA's parents' views, whether reasonable or not, are deeply held. In my view, granting the declaration sought will not change his parents' views nor actually how they are likely to behave to staff implementing the plan. It is purposeless.*

Henke J made clear that she shared the Official Solicitor's frustration that the court process had been rendered “nugatory.” She would have liked to permit the Official Solicitor's application to instruct an expert to overview the clinical evidence and that obtained from other sources by the clinicians. This would have given the court “*arms-length evidence which may or may not have supported the views of those treating AA*” (paragraph 42). But, as she noted, this would have been futile:

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*unless the expert was prepared to take clinical responsibility to implement any alternative plan. The stark reality of his case is that AA is too fragile to be moved to another hospital and that those at the RHRU are clear that the only treatment plan clinically viable for AA and which they are prepared to implement is the PCP. The court has no choice and I have asked myself whether in circumstances such as these, when the court has no choice at all, it should rubber stamp the decision of others. I have decided that I should not. In coming to that decision, I should emphasize that I have the greatest respect for the clinicians in this case and the difficult decisions that they have had to take and will have to take until AAs death. They do so in accordance with their [Hippocratic] oath and to the highest of professional standards. I do not criticise them or the judgment they have made. However, the reality of this case is that the treatment decision in this case is purely a clinical decision not the court's decision. The court's approval is not required to implement it. The court is not needed to sanction the plan and the court has no further role to play in what treatment AA does or does not receive.*

There was, therefore, nothing else that the court could do, and the proceedings were a “purposeless distraction from AA and the remainder of his life however long it may be” (paragraph 43).

Henke J made clear that she had in mind AA himself, and that there was no direct evidence before her as to what he would have chosen if he was not going to recover and would experience pain. His mother, she noted, thought he would, and his siblings' views had not been ascertained:

*46. When Professor Turner-Stokes was asked about a bespoke plan for AA, she told me that the PCP plan for AA would be bespoke in that it would be varied to meet his presenting clinical symptoms as and when they occurred. That is a reasonable reaction from a doctor and is a reasonable clinical view, but it is one which in my judgment does not take into account that a person is more than their clinical symptoms. The plan, however, is set. The stance of the Applicant was clear in closing. Further evidence of AA's wishes and feelings is not necessary and, in any event, would not cause them to change their mind. I remind myself that would be an abuse of process for me to try to change the clinical view in this case. I therefore do not do so. I simply note that the PCP is the only option before the court and that further evidence from family about AA's wishes and feeling will not alter it.*

Shortly after the judgment was circulated to the parties, AA died; the judgment itself was not made public until the transparency order made in his case expired.

## Comment

It is not entirely clear from the judgment why the application was not made earlier in AA's case. In the subsequent costs judgment, however, Henke J declined to make an order for any costs against the ICB in favour of AA's parents, noting that

*the criticism that the Court has made both about delay in initiating proceedings and the conduct of the Trust in this case cannot be levied against the ICB. They are a separate entity. The Trust did not appear before me. The ICB were not responsible for AA's care and treatment in the hospital. They only became involved when there was an option for care outside the hospital which it would have commissioned.*

It is also, though, not entirely clear what difference that an earlier application would have made to the substantive outcome, if AA was, in fact, on a downwards trajectory, such that the clinical options (which

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only the clinicians themselves can determine) were in fact narrowing. That does not mean that there might not been a different flavour to the proceedings – but the reality also is that it may well have the case that AA had died before any external evidence could be obtained.

However, taking a step back, there are two critical observations of Henke J which are of wider importance:

- (1) Clinicians are not legally obliged to seek a declaration from a court as to the lawfulness of any proposed treatment in respect of adults with impaired decision-making capacity.<sup>11</sup> They may well be well advised to,<sup>12</sup> but there is no legal obligation upon them to do so.
- (2) Not only can the Court of Protection not seek to ‘magic’ up options which are not there through the lens of best interests, it is in fact an abuse of process to do.

It may be thought that these observations are not entirely easy to square with the observations of Hayden J in *Re GUP* discussed [here](#), but, to the extent that they are inconsistent, the observations in the former case were obiter, whereas the observations here form part of the ratio of the decision, and were reached after full (if compressed) argument.

More broadly, however, they show that the courts and the clinicians remain engaged in a delicate dance. Alex first commented on this dance [nearly a decade ago](#), and these cases show, to him at least, that:

- (1) The rules of the game could perhaps usefully do with consideration through a restatement of the wider principles in play (not least for instance, one might think, in an updated Code of Practice for which Hayden J’s guidance on serious medical treatment was only ever meant to be a stop gap).
- (2) Questions of medical decision-making, and the authority for such decision-making, are ones about which there remains a considerable degree of ambivalence. Much of my work now seems to involve digging into this sources of this ambivalence and thinking about ways in which to help think more transparently about it – and this [briefing document](#) may help at least give a framework for starting to identify some of the factors in play, to allow a better discussion.

### Short note: a (not) closed hearing judgment

*P v Manchester City Council & Ors* [2024] EWCOP 43 (T1) is a rare published example of an important type of judgment, namely that following an application for a closed material order (in this case, to prevent disclosure of material to P’s mother, with whom he lived). Wherever such decisions are taken, and the outcome is that either material is withheld or a hearing takes place in the absence of a party, the [guidance](#) from the former Vice-President, Hayden J, makes clear that a judgment is required. In the

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<sup>11</sup> The position may be different in respect of children, at least in respect of non-therapeutic sterilisation: see *AB v CD & Ors* [2021] EWHC 741 (Fam) at paragraph 116.

<sup>12</sup> When we say “well-advised” above, that advice would be very strong if the question was one of which option was in the person’s best interests: as the Supreme Court made clear in *NHS Trust v Y* at paragraph 125, “[i]f, at the end of the medical process, it is apparent that the way forward is finely balanced, or there is a difference of medical opinion, or a lack of agreement to a proposed course of action from those with an interest in the patient’s welfare, a court application can and should be made, and there should be no reticence about involving the court in such cases.”



instant case, it might be thought that a judgment was, strictly, not required, because District Judge Matharu refused the application, in essence because the evidence did not come close to satisfying the threshold required, and there was “not a shred” of evidence that disclosure of the relevant materials would put P at risk from his mother. She further ordered that all the public body applicants (who had all sought non-disclosure) should pay the costs of P’s mother and of the Official Solicitor as P’s litigation friend.

### Short note: the BBC, transparency and the naming of P

In *British Broadcasting Corporation v Cardiff Council & Ors* [2024] EWCOP 50 (T3), Hayden J had sought to vary a transparency order made in relation to a man called MC, whose case had been before the court for a number of years. The BBC sought the variation of the order to allow MC, his adoptive mother (and her parents) and adoptive father, to identify his current accommodation as a specialist secure mental health unit in Cardiff and to name a psychologist formerly involved in his case, with her consent).

As Hayden J identified:

*13. There are two competing rights involved. One is freedom of expression, freedom of the press, a fundamental right protected by Article 10 which requires jealousy to be guarded. And the other is the broad umbrella of MC's rights to family life i.e., to privacy, and to appropriate and proportionate protection of his vulnerability as an adult with disabilities.*

*14. Whilst these are, manifestly, rights which have a wholly different complexion, they require to be balanced in a parallel analysis. Lord Steyn expressed that balance in the terms referred to above. The emphasis is that neither right has precedence over the other. Where they are in conflict, the focus is on the comparative importance of the specific rights on the individual facts of the case. In this exercise, the justification for interfering with each right requires to be considered, in which process proportionality is the lodestar.*

*15. In her methodical submissions, Ms Overman emphasised the danger of conflating the approach to the making of a Transparency Order or Reporting Restriction Order during proceedings, with the analysis of the factors properly in play at this application. She emphasised, correctly to my mind, that the scope of the existing order is rooted in Rule 4 of the Court of Protection Rules 2017 and section 12 of the Administration of Justice Act 1960. This is not a steamroller which tramples all before it, in terms of freedom of expression. The provisions are focused on protecting the identification of the individual involved in the Court of Protection proceedings. They go that far and no further.*

*16. What then of the competing rights themselves? An important piece of evidence filed in this application is the statement of Dr R. She is employed by the Health Board as a Consultant learning disability psychiatrist. She has been involved with MC's care since the commencement of the Mental Health Act proceedings in February 2024. It is obvious that she has got to know MC well and feels strongly that he should be protected from what she sees as the inevitable intrusion into his life, in consequence of his involvement and profile in the proposed documentary. The Health Boards' position, articulated succinctly by Mr Jones, is that they oppose the application made by the BBC because of real concern about the potential for adverse impact on MC's personal and private life should the application be granted. In the course of exchanges Mr Jones agreed that the essence of his clients' case is that there can be no advantage of any kind at all for MC of participating in this programme. Conversely however, he submits, there is real potential for harm.*



*From this perspective, the Health Board consider that an evaluation of the parallel analysis comes down very heavily against MC's participation in the programme. Whilst this is an important analysis, the exercise is wider than that. Even were there to be likely harm to MC in consequence of the BBC's programme, I am still required to evaluate any such harm alongside the competing rights and interests under Article 10. This is not solely a welfare issue.*

*17. There is, as I have said, no doubt that MC has latterly made real progress. Perhaps the most powerful evidence of that comes not from the evidence of the Trust, nor indeed from the litigation friend, but from MC's mother (CD). Her obvious delight and relief in her son's recent improvement, having gone through what have plainly for both been the darkest of hours in some very difficult years, was almost palpable. In my judgement, the risk of jeopardising that progress, recognising the enormous importance of it in unlocking (almost literally) MC's potential to live a more unrestricted life which promotes his autonomy, weighs very heavily when considering his Article 8 rights. Evaluation of MC's "private and family life" requires me to consider not just his present circumstances but the whole of his life and the importance of his treatment regime in providing potential for his future happiness and wellbeing*

On the evidence before the court, Hayden J found that:

*24. MC can be eloquent and voluble, a little bit like his mother in some respects, if I may say so. But he is entirely unable to engage in the exercise which I am charged with, that is to say he is unable to weigh and assess the advantages to him, personally, of participation in the contemplated programme and weigh them against any identified disadvantages. Were he asked, there is no doubt he would agree with alacrity to participate in the programme. It would doubtless appeal to the gregarious and outgoing side of his personality. But it would entirely omit any contemplation of the negatives. I am clear that MC's treatment is poised at a very delicate stage. His participation, however limited, in a programme which will inevitably and no doubt properly contain criticisms of the mental health system, is fraught with danger for MC. That danger is not confined to his immediate situation but risks having an adverse impact on his whole life. I reiterate the professional aspiration for MC is to afford him the opportunity to develop his potential to the full and achieve some degree of independent living. Jeopardising that opportunity would require me to identify a competing interest that should be afforded greater weight. That has not been established in this case and I am entirely satisfied that MC's Article 8 rights are supported by qualitatively greater evidence than that which can be afforded to the Article 10 rights of the BBC. For these reasons, I dismiss the application.*

### **Short note: how does the HRA apply when the wrong-doer is said to be the court itself?**

*R (MTA) v The Lord Chancellor* [2024] EWCA Civ 965 concerned claim under the Human Rights Act 1998 (HRA) arising out of an injunction made against the Claimant, which was later set aside by the County Court. The injunction was accompanied by a power of arrest under s.1 of the Anti-Social Behaviour, Crime and Policing Act 2014, and the underlying claim also sought damages arising out of the subsequent arrests of the Claimant following alleged breaches of the injunction.

The Claimant, MTA, was described as a young man who suffered from severe mental ill-health, including episodes of acute psychosis. The underlying injunction had been granted on 17 February 2020. The injunction (which had been applied for by a housing association) barred MTA from entering certain areas for two years. MTA had not been present at the time the injunction was granted, but his family members had attended and informed the court that he had learning disabilities. The court

granted the injunction, but advised that MTA should seek legal advice, and gave leave for a capacity assessment to be filed, giving a return date in a few months' time.

MTA had been arrested for a suspected breach of the injunction on 18 May 2020; the injunction proceedings had remained live as of this time due to the ongoing issue around MTA's capacity. MTA was brought to court the following day, and was remanded in custody for three weeks pending a decision on whether in view of his mental ill-health he had capacity in relation to the breach proceedings and, subject to that, whether he should be committed. On the return date he was found not to have the requisite capacity and was released. On two subsequent occasions, on 10 and 29 June 2020, he was again arrested and detained overnight, but he was discharged when brought to Court the following day. In due course the injunction was set aside, again on the basis that the Claimant lacked capacity. Underhill LJ considered that "it is necessarily implicit in [the] findings that the Claimant did not have capacity at the time of his remand in custody and accordingly that that order was wrongly made at the time and had, in the language of CPR rule 21.3 (4), 'no effect'" (paragraph 27). None of these orders were subject to any appeal.

The HRA claim was brought by MTA, acting through the Official Solicitor as litigation friend, on the basis that the episodes of loss of liberty referred to above constituted detention in breach of article 5.1 of the European Convention on Human Rights and were accordingly unlawful by virtue of s.6 HRA 1998. It was argued that:

1. the injunction had no legal effect because MTA had lacked capacity in the underlying proceedings (and thus the Metropolitan Police lacked any lawful basis to arrest MTA) and the Lord Chancellor was liable for the 'judicial act which results in unlawful detention' under s.9 HRA;
2. the order remanding MTA into custody following his arrest had no legal basis because he lacked capacity; and
3. making the order breached MTA's Article 6 rights.

The Lord Chancellor had applied to strike out the claim on the basis that it was an abuse of the process of the court for the claimant to bring proceedings in respect of the impugned orders unless and until they had been overturned on appeal. Freedman J had dismissed the strike-out application, and that dismissal was the subject of the appeal; the claims against the Metropolitan Police were not considered in this appeal. For the purposes of this report, we focus on the capacity-related issues.

In considering the effect of an order made where a party lacks capacity and has no litigation friend, Underhill LJ noted that CPR 21.3(4) states in relevant part "[a]ny step taken before a ... protected party has a litigation friend has no effect unless the court orders otherwise." He noted that "[t]here was some discussion before us about whether the words 'has no effect' mean that a court order made before the protected party has a litigation friend is invalidated retrospectively; and following the hearing counsel prepared a helpful joint note. I have no doubt that that is indeed what those words mean" (paragraph 11).

The Court of Appeal upheld the first instance judgment, and found that, as a matter of law, it was possible to bring proceedings under s.9(3) HRA in respect of a judicial act which had not first been appealed, and this would not be an abuse of process. *"The reason why collateral challenges are*

*objectionable is that they involve one court holding that the decision of another court of co-ordinate jurisdiction is unlawful. But if that other court has itself already held, in circumstances where it was entitled to review its own decisions, that the decision in question was of no effect that objection cannot arise*" (paragraph 61). In considering the effect of an order which should not have been made (in this case, due to a want of capacity to conduct proceedings by the person it was made against), Underhill LJ found at paragraph 64 that:

*The impugned orders were of course effective in the sense that they were acted on by the police officers and (initially) the Court and resulted in the Claimant's detention, and that is what matters for the purposes of his pleaded claim; but it is not inconsistent with them having been wrongly made from the start.*

In other words, the key issue is substance rather than form. Here, it did not matter that a spent order remanding the claimant into custody had not been set aside, as doing so would have been "pointless" (paragraph 65). What mattered was that "the impugned order was found by a competent court to have been of no effect. That being so, it cannot constitute an illegitimate collateral challenge for the court hearing the Claimant's damages claim to be invited to make a finding to the same effect, albeit on a different ground" (paragraph 65). This meant that:

*71. In those circumstances I can see no basis on which it could be an abuse of process for the Claimant to pursue his claim for damages under the 1998 Act, in the forum prescribed by the Act, without having first had them set aside in an appeal court. It also necessarily follows that I do not accept that there is any blanket rule such as that contended for by the Lord Chancellor.*

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## MENTAL HEALTH MATTERS

### A Mental Health Bill on the way?

In the mental health context, the big news is that the King's Speech contained a commitment to bring forward a Mental Health Bill. For more on this, see [here](#).

### The hard edges of the MHA 1983

*North Tees and Hartlepool NHS Foundation Trust & Anor v KAG & Ors* [2024] EWCOP 38 (T3) (Victoria Butler-Cole KC (sitting as a Deputy Tier 3 Judge)

*Mental Health Act 1983 – interface with MCA*

#### Summary<sup>13</sup>

*North Tees and Hartlepool NHS Foundation Trust & Anor v KAG & Ors* [2024] EWCOP 38 (T3) is a case confirming the hard-edged nature of s.63 Mental Health Act 1983. It concerned a woman, KAG, who developed severe depression and in consequence was not eating or drinking. For extremely complicated reasons, including potentially crossed wires as to what the Official Solicitor's position, the case ultimately came before Victoria Butler-Cole KC (sitting as a Deputy Tier 3 judge), who was asked to declare that it was lawful for a PEG to be inserted to provide KAG with clinically assisted nutrition and hydration. She did so, but made clear that:

19. *[t]his application was not required. The AMHP rightly determined that the MHA was the correct legal framework to provide treatment to KAG for her mental disorder, including the provision of CANH, and that is the framework that should have been applied. While there will be cases where the scope of s.63 MHA is in question, this was not one of them. The Official Solicitor did not object to the court making a declaration of lawfulness in the exceptional circumstances of this case, but did not expect similar applications to be made in future. This judgment should not be taken as any sort of encouragement to statutory bodies to seek the court's intervention where there is no uncertainty on the part of a treating Trust as to whether treatment can be provided under s.63 and s.145 MHA, even in the face of objection by a patient.*

20. *As Lieven J explained in in Re JK* [2019] EWHC 67 (Fam) at §66:

*"The MHA gives the power to decide whether to compulsorily treat a patient to the responsible clinician and not to the Court. This is a fundamentally different scheme to that in the MCA where many decisions are given by statute to the court. The difference makes sense because the MHA is a statutory scheme for, inter alia, detention and compulsory treatment in the public interest, where the responsible clinician has a specific role in the statutory scheme. There is no statutory process in the MHA to question the decision of the clinician. However, if the clinician decides to impose treatment, then the individual can judicially review that decision."*

21. *The observation by Mrs Justice Lieven in the subsequent case of A Healthcare and B NHS Trust v CC* [2020] EWHC 574 (Fam) at paragraph 48 needs to be read carefully. The judge accepted a submission that "considerable care needs to be taken in the use of section 63 [MHA] if it is not to

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<sup>13</sup> Tor having been the judge in the case, she has not contributed to this note.

*become a way of treating detained mental patients, with or without capacity, without their consent. However, the safeguard that is in place is the requirement set out by Baker J in NHS Trust v A[2013] EWHC 2442 (Fam) at [80] that in cases of uncertainty, the appropriate course is to apply to the Court." Lieven J is there referring to a risk that s.63 MHA is given such a broad interpretation that it can be relied on to treat conditions that are not manifestations or symptoms of a mental disorder – it is self-evident that s.63 MHA permits the treatment of mental disorders without consent. The uncertainty referred to by Baker J (as he then was) is "doubt as to whether the treatment falls within section 145 and section 63 MHA". It is not a reference to cases where the detained patient objects to treatment.*

*22. The question whether, where a detained patient objects to treatment being imposed on them under the MHA, and lacks capacity to conduct proceedings or to instruct a representative to bring proceedings for judicial review, the treating Trust has any duty to find a litigation friend for the patient or take any other steps to bring the dispute before a court, does not fall to be determined in this case, as the Trusts have in fact brought an application in respect of the lawfulness of the proposed treatment.*

Victoria Butler-Cole KC found on the facts of the case before her that it was:

*24. [...] unquestionably in KAG's interests to receive CANH. Equally, it is clear to me that it is now in her interests for CANH to be administered by way of PEG rather than nasogastric tube. As I have previously set out, a PEG will be less risky, more comfortable and more effective. It is reversible, and KAG will be able to eat and drink normally while it is in place should she wish. While the operation to insert the PEG has the potential to be an unpleasant experience, sedating medication will be given, and it will only last for around 10 minutes. Once in place, KAG will be able to move to a suitable therapeutic environment where she can receive the treatment she needs for her mental disorder. Dr A was clear that this was simply not possible in her current hospital which is not a psychiatric hospital. Although KAG is fearful of the procedure, it is the only realistic option to maintain her physical health and to help her to get through this period of depression, as she has in the past.*

## Comment

This judgment is delivered at an interesting point, coming as it does as the Government has announced plans to bring forward plans to amend the Mental Health Act 1983. A considerable amount of attention was paid by the independent Review of the Mental Health Act 1983 (to which Alex was the legal adviser) to the question of whether the current procedural safeguards around treatment for mental disorder complied with Article 8 ECHR. The review concluded (at pages 75-6) that:

*At the moment, a patient has only very limited ability to question the treatment they are receiving in the first three months of their detention, and most decisions are taken on the basis of the opinion of the patient's Responsible Clinician alone. After three months a second opinion from a SOAD is required if the patient lacks capacity or has capacity and has not consented. Until that point, most treatments can be administered despite a patient's refusal, without any statutory requirement to explain or justify that decision. Criticism of this situation was raised as an issue by service users. Service users' unhappiness with the way they were treated, more even than the detention itself, persisted long after the period of detention or treatment was over. We are clear that the current approach does not go far enough to meet either the ECHR or the CRPD [...]*

*At the moment the only way for a patient to challenge the decision of the RC and SOAD is a right to appeal treatment by way of Judicial Review, but we have reached a firm conclusion that it is simply inaccessible. It is both too difficult and too expensive. We believe there should be a route of challenge to a single judge of the Tribunal, supported by non-means tested legal aid. That judge would have the power either to require the Responsible Clinician to reconsider their treatment decision or to order that a specific treatment is not given where they find that it is a disproportionate interference with the patient's rights. The judge would not have the power to order that a specific treatment is provided, but only to prevent treatment (as set out above). We do not think that the judge would, in most cases, need to obtain further clinical evidence, but we think they should have the power to request evidence (for example a medical report) if necessary. Where the patient themselves does not have capacity to bring the application, we think that either their NP or their IMHA should have the power to do so on their behalf, where the patient is unable to do this themselves, and the NP or IMHA believe that the patient would not agree to that treatment (or the NP or IMHA themselves has reason to believe the decision is not in the patient's best interests)*

The draft Mental Health Bill did not include this proposal. The Joint Committee convened to consider the draft Bill noted that:

*263. We agree with the Independent Review that a slimmed down Mental Health Tribunal should be able to consider whether a patient is entitled to challenge their treatment plans, if requested, following a Second Opinion Authorised Doctor review of their care and treatment plan or a major change in treatment. We recommend that the Government amend the draft Bill to allow for pilots in the first instance, to ensure that the additional workload is manageable and the Tribunal and clinicians' roles are not compromised*

It will be interesting to see what the Bill brought forward says in due course.

One other observation: whilst the application did not need to be brought, this is not the same as saying that Trusts cannot bring applications where they consider that the arguments for and against treatment are finely balanced. There is a steady stream of cases involving patients with disordered eating (usually, but not exclusively patients with anorexia) where Trusts could use s.63 MHA 1983 to treat, but vote with their feet to seek a determination instead from the Court of Protection as to whether (1) the person has the capacity to make the relevant decisions; and (2) if not, what is in their best interests.

### Codes, case-law, restraint and children

*An NHS Trust v Mother & Ors* [2024] EWHC 2207 (Fam) (Family Division) (Francis J)

*Other proceedings – family (public)*

### Summary

This is a case which throws two issues into stark relief. The first is the problem of government by guidance. The second is what might be thought to be the increasingly urgent need for an appellate level decision on the rights of children in the context of restrictive interventions. The judgment was delivered in slightly curious circumstances, almost a year after a consent order had been endorsed providing for the feeding by naso-gastric tube of a 12 year old girl. The parties (including the girl's parents, and by



her Guardian) were able to reach agreement, but Francis J agreed to produce a reserved judgment to address:

*an apparent tension between, on the one hand, the common law authorities around consent to treatment and restrictions for children and, on the other, the Code [of Practice to the Mental Health Act 1983].*

G was not, in fact, detained under the MHA 1983, but at paragraph 13, Francis J held that:

*it would be incorrect to regard this case as being subject to different principles simply because it technically falls outside of the Code. In my judgement, the Trust is correct in contending that it is, in effect, bound by the Code, even though strictly speaking G is not detained pursuant to the Mental Health Act 1983. In my judgement, the Code is properly to be seen as guidance for registered medical practitioners and members of other professions in relation to the medical treatment of patients suffering from mental disorder.*

Francis J set out the relevant passages of the (English) Code of Practice, namely paragraphs 19.40 and 19.41. He identified that:

*19. Eva Holland's very helpful skeleton argument on behalf of the Guardian correctly identifies that the Code refers to a number of cases in a footnote to section 19.40 and these are also referred to in the Position Statement on behalf of the Trust. The Code came into force in 2015. Ms Holland submits to the court that practitioners must be guided by the developing case law in this area. I agree; it is, it seems to me, clear that the Code must follow case law. Case law will be developed with the basis of legal analysis following expert evidence. Parliament produces statutes. Judges interpret statutes where that is necessary. The Common Law is derived from judicial precedents, to which the long established and understood doctrine of precedent applies. These are basic truisms. It is a fundamental principle of our doctrine of precedent that the Common Law in England and Wales is developed by Judgments of the High Court and above. Of course when delivering a Judgment, judges will always take into account the expert evidence that is placed before them. I am not in any doubt that it is judges, and not those writing the Code, that state the law. Indeed, I cannot see how any student of jurisprudence could suggest that a Code of Practice could be superior to judicial precedent. From time to time the Code will be developed and updated, based upon judicial precedent. I agree with the submission that there should be no tension between the Code and the common law authorities. However, if there is, the matter must be referred to the court for the judge to decide.*

He agreed with the submissions made on behalf of the Trust that:

*21. [...] the authorities establish the following proposition: where a child lacks Gillick competence to make their own decision, and there is agreement between the clinical team and parents as to the best interests of the child, a parent can consent to both medical treatment and any consequent deprivation of liberty. This enables clinicians lawfully to carry out the treatment plan. In those circumstances, no court authorisation is required. NG Tube feeding, even if contrary to the non-Gillick competent child's wishes, does not fall within a special category that requires court authorisation. The primary purpose of the tube feeding is to preserve life. Rather than being a case where it will have long-term physiological consequences, I agree with the submission made on behalf of the Trust that the opposite is in fact true, to the extent that without tube feeding the child might (probably would) die. I agree with the submission made by the Trust that the guidance in the*

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*Code that there are limits on the decisions which can be taken by parents in relation to treatment of their children under the age of 16 is erroneous. Where there is consensus of the clinical team and parents, the parents are able to provide their consent.*

He noted that the Code – which had not been updated since 2015 – required updating.

*22. The Trust, supported by the Guardian, invites the court to conclude that for those in G's situation, a parent can consent to treatment on their behalf, even that which is repeatedly invasive and amounts to a deprivation of liberty, and a court application is not required. It seems to me that the Code has not been updated since 2015 and that updating is now required. It is not, of course, the judicial function to become immersed in the drafting of such guidance; however, of course, the Code will from time to time be amended to reflect judicial decisions.*

He also address the question of restraint and deprivation of liberty, and agreed with Lieven J in *Lincolnshire County Council v TGA* [2022] EWHC 2323 (Fam) that G's parents could consent to what would otherwise be a deprivation of her liberty. Indeed, he went even further than had Lieven J in *TGA*, Lieven J had held that parent could only exercise their parental rights – including (as she put it) consenting to deprivation of liberty – if they were acting in their child's best interests. If they were not, she said, then such a decision would no longer fall within the zone of parental responsibility. Francis J noted that:

*25. [...] It seems to me that even a decision which was made contrary to the child's best interests could still be a decision made in the exercise of parental responsibility. Every day parents will exercise parental responsibility and will sometimes make decisions that are contrary to their child's best interests. This is still exercising parental responsibility. It is the duty of the State to intervene where a decision is contrary to the best interests of the child, and might cause the child to suffer significant harm. However, where, as in the instant case, the treating medical team and the parents agree, the state's intervention is unnecessary; indeed, in my judgement, it would be inappropriate unless, for example (in what I believe would be a very rare case) a local authority or the Children's Guardian took the view that both the hospital and the parents had "got it seriously wrong". Such cases, as I have said, will be extremely rare.*

Accordingly, Francis J concluded at paragraph 26:

*that in G's sad and difficult situation, where the parents and the treating medical team are "at one", it is lawful to rely on parental consent, that an application is not only unnecessary, but would make an already almost unbearable situation in respect of G (from her family's perspective) even more difficult, and would also cause huge expense and delay. Accordingly, a declaration that it is in G's best interests to receive the treatment and, if needed, to be restrained in order to receive the NG treatment, is unnecessary.*

## Comment

Francis J is undoubtedly right to say that a Code of Practice cannot make the law, as oppose to reflect it (a point also made by reference to the Code of Practice to the MCA 2005 by the Supreme Court in *NHS Trust v Y* [2018] UKSC 46). The Code of Practice to the MHA 1983 undoubtedly needs updating in several respects, including, most relevantly, to address the fact that – as a matter of law – parents cannot consent to the confinement of their children when they turn 16, following the decision of the

Supreme Court in *Re D*. However, an appellate level decision is, we would suggest, urgently required to address the position of children below the age of 16. None of the cases determined by Lieven J in recent years (including that of *TGA*), nor that of Francis J, have featured any actual arguments about the scope of parental rights in respect of restrictive interventions in the case of children below the age of 16. And the case of *AB v CD* upon which Francis J placed considerable reliance in suggesting that cases were not required to go to court where there was agreement between parents and clinicians involved a situation where the course of action was in line with the child's identified wishes and feelings. That may be thought to be feel very different to a situation where the course of action is against their known wishes and feelings – on Francis J's analysis at paragraph 21, that could be said to be irrelevant if the child lacked Gillick competence. It might be thought to be challenging, not only by reference to the UNCRC and UNCRPD, but also by reference to Articles 8 and 14 ECHR, that a body of case-law is developing which could be characterised as replacing the voice of the child with that of the parent without a clear requirement to identify whether the two are identical. We have a very extensive body of case-law now making clear that incapacity is not an off-switch for a person's rights and freedoms when they are being looked at under the MCA 2005. It is not immediately obvious, one might think, that a lack of Gillick competence means that a child's wishes, feelings, beliefs and values should not be put into the mix.

### Valdo Calocane – the CQC, the MHA 1983 and the MCA 2005

Following the conviction of Valdo Calocane ('VC') in January 2024 for the killings of Ian Coates, Grace O'Malley-Kumar and Barnaby Webber, the CQC was commissioned carry out a rapid review of Nottinghamshire Healthcare NHS Foundation Trust ('NHFT'). The review has been delivered in three parts. The first two, an assessment of patient safety and quality of care provided by the trust and assessment of progress made at Rampton Hospital since the most recent CQC inspection, were published in March 2024. The final part, published in August 2024, was a rapid review of the available evidence related to the care of VC during the period he was under the care of NHFT, alongside a small number of other cases for benchmarking purposes, to determine whether this evidence indicates wider patient safety concerns or systemic issues with the provision of mental health services in Nottinghamshire. The conclusions include a recommendation that NHS England, together with the Royal College of Psychiatrists:

- *reviews and strengthens the guidance to clinicians relating to medicines management in a community setting, for example depot vs oral medication.*
- *reviews how legislation is used in the community to deliver medication for those patients who have a serious mental illness and where it is known they are non-compliant with medication regimes.*

The Mental Capacity Act 2005 features significantly throughout the rapid review, although it is not always entirely obvious how the authors of the review consider it to be relevant vis-à-vis the MHA 1983. The latter is not a capacity-based regime. But in circumstances where (as appears to have been the case) there were serious question-marks about VC's capacity to make decisions about his care and treatment, there was potentially an entirely separate decision-making structure which could have been in play overseen by the Court of Protection, providing a framework for treatment even in the face of non-engagement. It may be that the review provided for above will address this.

### DHSC guidance on ordinary residence on s.117 MHA 1983

DHSC has again updated its guidance following the *Worcestershire* s.117 ordinary residence decision. As previously reported, DHSC has lifted the stay on ordinary residence decisions involving similar issues to those in *Worcestershire*, but appears not yet to have published any determinations on them. New referrals continue to be accepted.

In the updating guidance, DHSC has confirmed that it does not intend to amend paragraphs 19.62-19.68 of the Care and Support Statutory Guidance in light of the decision. DHSC states that *[t]hese paragraphs reflect the current legal position and so do not need to be amended.* These paragraphs relate to which local authority holds responsibility for a person's mental health aftercare. These set out both the pre-*Worcestershire* position and the current position (which is effectively unchanged). Notably, the substance of these paragraphs were also not amended during the pendency of the *Worcestershire* litigation, though DHSC's official position had changed during this period.

The updating guidance further states that *"DHSC does not intend to amend the Care and support statutory guidance to address paragraph 58 of the Worcestershire judgement at this time."* Paragraph 58 of the *Worcestershire* judgment states:

*The test articulated in Shah requires adaptation where the person concerned is someone such as JG who lacks the mental capacity to decide where to live for herself. It seems to us that in principle in such a case the mental aspects of the test must be supplied by considering the state of mind of whoever has the power to make relevant decisions on behalf of the person concerned. Under the Mental Capacity Act 2005 that power will lie with any person who has a lasting power of attorney or with a deputy appointed by the Court of Protection or with the court itself. Applying this approach, JG's residence in the area of Swindon was adopted voluntarily in the relevant sense, as it was the result of a choice made on her behalf to live in the accommodation that Worcestershire provided for her following the first discharge. Manifestly, her residence in that place was also adopted for settled purposes as part of the regular order of her life for the time being. Thus, if the term "ordinarily resident" is given its usual meaning, it is clear that immediately before the second detention JG was ordinarily resident in the area of Swindon. Indeed in these proceedings the Secretary of State has not sought to argue otherwise.*

The current Statutory Guidance on determining the ordinary residence of people lacking capacity is based on the test as articulated in the *Cornwall* Supreme Court decision, rather than the paragraph above (a paragraph which, it should perhaps be noted, did not represent an issue about which the Supreme Court heard any argument).

Finally, DHSC sets out its view that the *Worcestershire* judgment does not impact on s.117 funding responsibility for ICBs, and is to be determined by reference to the National Health Service (Integrated Care Boards: Responsibilities) Regulations 2022 and the NHS Who Pays? Guidance.

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## THE WIDER CONTEXT

### Education and training standards for AMHP and BIA courses

Having (in essence) given up on the LPS coming into force any time soon, if ever, Social Work England have launched new education and training standards for both BIA courses and AMHP courses, to be used to approve new courses and reapprove existing courses from summer 2025.

### The inherent jurisdiction, Article 3 ill-treatment, and the limits of the State's obligations

*Re P (Vulnerable Adult: Withdrawal of Application)* [2024] EWHC 1882 (Fam) (High Court (Family Division) (Gywnneth Knowles J))

*Inherent jurisdiction*

#### Summary<sup>14</sup>

How far can the State be expected to go in seeking to secure the rights of those in challenging situations? A few months after this issue was looked at (albeit slightly curiously) from the perspective of Article 2 ECHR in *R (Parkin) v His Majesty's Assistant Coroner for Inner London (East)* [2024] EWHC 744 (Admin), Gywnneth Knowles J has looked at it from the perspective of Article 3 ECHR. In *Re P (Vulnerable Adult: Withdrawal of Application)* [2024] EWHC 1882 (Fam), she was asked to consider the question of whether she should continue to use the powers of the High Court to compel a 29 year old woman to live apart from her father.

P's circumstances were summarised by Gwynneth Knowles J thus:

*9. The local authority first became aware of P following a referral from the police in early March 2022. X [P's mother] had reported her concerns to the police, namely that Y exercised control over P; that P lacked access to basic necessities such as heating and food; and that P was financially dependent on her father who lived on a very limited income indeed. P and Y were living together in the family home at this time. The initial police report detailed how P - then aged 27 years - appeared to look like a young teenager, being underweight, and pale with sores on her mouth. Following the referral, the local authority attempted in vain to engage P, making over 17 visits to the family home between March 2022 and May 2023. The social work evidence showed a concerted effort by P and Y to evade health and social care professionals and the police. It is important to note that, at that time, P had never been known to Children's Services and, save for obtaining the Covid vaccine, had last attended her GP a decade earlier for a minor ailment. She left school at 16 without any qualifications and appeared never to have been in paid, formal employment or to have claimed state benefits. She was socially isolated with no friends or contact with other family. P has a brother, Q, who has been diagnosed with a serious psychotic illness and was hospitalised in March 2022. He has never returned to the family home since then and presently resides in a mental health unit as a voluntary patient. Q has said almost nothing about his sister's circumstances in the family home.*

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<sup>14</sup> Tor and Neil having been involved in the case, they have not contributed to this note.



10. In April 2023, P and Y were evicted from the family home because Y had failed to pay the mortgage and the property was repossessed. Thereafter, both P and Y slept in a car parked on the property's driveway, using an external mailbox at the property to collect post. There was no evidence that P or Y were trying to find somewhere else to live or making a claim for state benefits to enable them to do so. In May 2023, two separate referrals were received from members of the public expressing concern about P's living circumstances.

11. Concern about P's circumstances was heightened by the information gleaned about X's experiences in the family home before she left in 2015. Both X and P's brother, Q, reported Y to be controlling, paranoid about government, and suspicious of professionals. X described family life as "cult-like" with Y assigning family members roles in the family home so that he could concentrate on his health. X gave an account of her life to the local authority detailing prolonged domestic abuse by Y in which P and Q had been required to participate. Neither X, P or Q were allowed to leave the family home unaccompanied by Y, work, or claim state benefits. Shopping was done as a group and Y controlled the family finances, only allowing £1.50 a day for food for the entire family. Food was rationed and measured out in small amounts and the family diet often consisted of bread and jam/mustard. X reported that P and Q had to wear covert recording equipment to school so that Y could monitor their interactions with others. Y had refused to sign a learning agreement which resulted in a B-Tec course for P being terminated. His control over the family appears to have extended to limiting showers; cutting the family's hair himself; and restricting P's access to funds so she could purchase sanitary towels.

Proceedings under the inherent jurisdiction of the High Court were started by the local authority in July 2023. Orders were made by HHJ Burrows to the effect:

11. [...] that it was in P's best interests to be accommodated at a care home and to be transported to that place, if necessary, with the use of force. The recital to the court's order explained that the court had concluded, on the available evidence, that P was under the influence and control of Y and that P was at significant risk of serious harm because she was living in a car with Y in cold weather, appearing to be malnourished. In those circumstances, the court determined that the need for protective action was urgent and that the conveying and accommodating of P at the care home amounted to a deprivation of her liberty, authorised in accordance with Article 5(1) of the European Convention on Human Rights (ECHR). HHJ Burrows did not impose restrictions upon P that prevented her from leaving the placement during daylight hours. When the matter returned before the court on 16 November 2023, HHJ Burrows authorised continuation of the placement in circumstances where the car in which P had been living with her father had been repossessed by the finance company, thus depriving P anywhere at all to go should she leave the placement. HHJ Burrows recognised the draconian nature of the orders he made but considered them necessary so that P's circumstances could be assessed away from the influence of her father. He emphasised the critical importance of P being represented and encouraged both her and her father to obtain legal advice. He stressed the court's and the local authority's genuine concern for her welfare but made clear that there may come a point where the court was unable to alter P's mindset and circumstances, rendering the proceedings otiose.

12. In December 2023, the court directed a report from a consultant psychiatrist, Dr Ince, and listed the matter for further review. Y was prohibited from having contact with P at any place other than the residential placement, such contact to be prearranged and supervised; and prohibited from behaving in any way so as to prevent P from attending court or having access to health or social care professionals or to Dr Ince. In order to prepare his report, Dr Ince spoke



with P in January 2024 but P refused to leave her room and speak with him on his next visit in early February 2024. Having considered all the material and interviewed P on one occasion, Dr Ince concluded that P did not have a mental disorder or mental impairment. Her behaviour and views were a manifestation of the undue influence of her father arising from coercion and control. As a result, P lacked the capacity to conduct the proceedings and to make decisions about residence, care, contact with her father and state benefits. In his opinion, P did not recognise the impact of Y's beliefs and behaviour upon her own well-being or broader decision-making and Dr Ince drew attention to the positive impact of her relationships with staff at placement as a protective factor, these allowing objective but supportive challenge to P. Though hesitant to make significant comments about P's best interests, Dr Ince suggested that P was developing some confiding and supportive relationships with the current care team together with social connections in the placement. Should the court be satisfied that P continued to require the protection of the inherent jurisdiction, Dr Ince was of the opinion that her continued placement within a supportive environment would be a positive step towards a greater level of independence. Without such a framework or if there were to be a hasty removal of the placement, there would be a significant risk that P would not have developed the relevant and necessary skills to prevent a return to her father's control and a re-establishment of her prior dependence, enmeshment, and coercion.

13. In March 2024, HHJ Burrows declared that P lacked the capacity because of undue influence to conduct the proceedings and to make decisions as to residence, care, contact with her father, and applying for state benefits.<sup>15</sup> The placement arrangements did not any longer deprive her of her liberty but were a necessary and proportionate interference with her rights under Article 8 of the ECHR. He invited the Official Solicitor to act as P's litigation friend, appointing her to act as such if she accepted the invitation to do so. Directions were given for the filing of further evidence and the matter was set down for trial before me on 2 July 2024 with a pre-hearing review on 7 June 2024.

Unfortunately, the move to the residential placement did not achieve any positive benefit for P:

16. P was conveyed to the residential placement without the need to use restraint or force. Following her move, P was unwilling to provide information about herself but eventually she seemed happy to engage in some activities. She had a set list of food that she would eat which was rather limited. P appeared to spend considerable time researching the law relevant to these proceedings which she explained to staff, appearing to be reading from a script. She was focused on some matters but did not appear to have an understanding of the court order as a whole. By the time of this hearing, P continued to engage superficially with the psychological help provided at the placement but would not take part in formal sessions. She did however engage with staff and participated in planned activities and appeared to have formed some friendly relationships with other residents. She now ate the food provided at the placement and no longer appeared to be underweight. P had declined state benefits despite an application for Universal Credit being made on her behalf by the local authority. She had some engagement with an Independent Domestic

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<sup>15</sup> Note, this may seem confusing, but is correct. The inherent jurisdiction applies to a person who is unable to make their own decision (i.e. in a broad sense does not have the 'capacity' to do so), but who does not fall within the scope of the MCA 2005. The MCA 2005 only applies to those who cannot make their own decision (defined as being unable to understand, retain, use and weigh the relevant information and communicate any decision they have made) because of an impairment of or disturbance in the functioning of their mind or brain.

*Violence Advocate via email and information about controlling behaviour and undue influence was going to be sent to her but P had ended the contact before this could take place. P had declined to meet with the social worker to discuss alternative residential options.*

*17. The local authority social worker was of the opinion that, during P's residential placement, there had been little progress made in either P's understanding of the risks arising from her enmeshed relationship with her father or her recognition that she had been subject to controlling, coercive and abusive behaviour. P was unlikely to make significant progress unless contact with her father could be prevented, but the only means by which this could be achieved would be placing P in a locked setting and restricting her access to the internet and social media. In those circumstances, the social worker considered it would be disproportionate to require P to continue living in the placement.*

*18. It is important that I record that, throughout the proceedings, P has challenged the local authority's actions in a series of letters and emails, many of which are in the court bundle. I have read them all. These polite but insistent communications make crystal clear P's consistent refusal to accept help and support to alter her living arrangements. She wants nothing to do with the local authority or any services it might offer her and wants to leave the placement to return to her old way of life. Those wishes are also expressed in all P's dealings with local authority or other care staff involved with her. For example, on 23 November 2023, during a visit from the team manager, P said that she wished "to get my own accommodation and have my own life and to know you won't be there". She added that "I want to be left alone to be with my dad. I want to be in a house or a flat... You might not be happy with my life choices but it's my life".*

As the local authority recognised when seeking the permission of the court to withdraw the proceedings:

*19. [...] the hearing marked an important crossroad in P's life. Having spent it all so far under the influence and control of her father, this had been her first opportunity to live a life independently of him. However, P was either unable or unwilling to take that opportunity and had declined all efforts of support. The local authority recognised that safeguarding measures such as the residential placement - though necessary - had with the passage of time become disproportionate and that more draconian measures would be required to cut off all ties between P and her father. Given the strength and consistency of P's will and the limited reason to believe that such measures would be effective, the local authority had come to the conclusion that further protective orders were disproportionate.*

However, and importantly:

*Given the risk of P returning immediately to her father, Miss Butler-Cole KC submitted that the court needed to be satisfied that neither the local authority's obligations under the ECHR nor those of the court would be violated if the proceedings ended with no ongoing orders. She therefore invited me to determine whether ending the current protective measures would breach the State's positive obligations. On a careful analysis of the future risks in the event of the discontinuation of protective orders, the local authority submitted that there was no real and immediate risk that P would experience degrading treatment by her father such as to engage Article 3 of the ECHR.*

P's mother made clear that she would "very much prefer C submitted that she would very much prefer the current orders to remain in force and feared that, once lifted, P would return to a life of chaos and

coercion" (paragraph 20), but reluctantly agreed that the residential placement did not seem to have made any difference. The Official Solicitor, acting as P's litigation friend, shared the analysis of the local authority.

Gwynneth Knowles J then set out a detailed analysis of the nature of the State's obligations under Article 3, drawing on the local authority's position statement. I do not set it all out here, but one passage is particularly interesting. At paragraph 35, she cited the following:

*"the toolbox of legal and operational measures available in the domestic legal framework must give the authorities involved a range of sufficient measures to choose from, which are adequate and proportionate to the level of risk that has been assessed in the circumstances of that particular case": Tunikova and Others v Russia (55974/16, 14 March 2022 at [95]). A failure to take reasonably available measures which could have had a real prospect of altering the outcome or mitigating the harm is sufficient to engage the responsibility of the State: O'Keeffe v Ireland (35810/09, 28 January 2014 at [149]).*

In other words, and in the context of a risk posed by an identified third party, the ECHR requires that the State must have the power not only to punish the third party after harm has been caused, but also have a set of tools which allow it to take steps to prevent such harm from occurring in the first place.

Gwynneth Knowles J, endorsing the local authority's application to withdraw the proceedings, identified that:

*36. This is a difficult and sensitive case and I agree with Miss Richards KC that there are, in reality, no good outcomes for P. P's mindset has not been altered during her time in the residential placement – she is as firm as ever about her desire to decline help from the local authority and to do what she wants. Sadly, she has no insight into the dysfunctional relationship that she has with her father and it is likely that, once she leaves the placement and whatever she might say about wanting her own place to live, P will be drawn back into his orbit and surrender herself once more to his control. I am wholly satisfied on the evidence before me that P is a vulnerable adult who lacks capacity because of the ongoing undue influence of her father. However, P's refusal to engage and accept offers of help does not necessarily discharge the local authority of its statutory responsibilities.*

*37. The stark choice is thus between the cessation of the protective framework with the overwhelming likelihood that P will return to live with her father (in circumstances where it is unclear where they will live and how they will support themselves) or a further prolonged period of residential care which is likely to be as ineffective as the previous period in helping P gain insight into her circumstances and free herself from the undue influence of her father.*

*38. Applying the case-law cited above and on fine balance, the real and immediate risks to P – though very concerning – fall short of establishing a real and immediate risk of degrading treatment for Article 3 purposes. Whilst there appears to have been financial and psychological abuse of P by Y, he does not appear to have physically assaulted her and his treatment of her is not such as to cause anguish and inferiority capable of breaking P's moral and physical resistance. Destitution - which P faces given her reluctance and that of her father to claim state benefits - is not sufficient to amount to degrading treatment. Even if I am wrong about all that and a real and immediate risk of engaging Article 3 exists, I find that the local authority has, in*

*the recent past, taken all reasonable steps to negate that risk including bringing these proceedings and accommodating P in a residential setting. P has consistently refused all offers of help and accommodation and has failed meaningfully to engage with domestic abuse and mental health services. Further, though the police declined to intervene in April 2023, I consider that P would not presently support any criminal prosecution of Y for his behaviour towards her. In those circumstances, I endorse the view shared by the represented parties that it would be disproportionate to make further protective orders in respect of P. The inherent jurisdiction is not unboundaried and, given that all investigations into P's circumstances have now concluded, there is no lawful justification for the continuance of protective orders. Further protective orders in circumstances where they are unlikely to manifestly alter P's situation would represent an unjustifiable interference with P's Article 5(1) rights to liberty and security of person. I am thus satisfied that, despite the risks to P's welfare should she reject the offers of support from the local authority and return to live with her father, further orders regulating her residence or otherwise constraining her choices are unjustified and disproportionate.*

*39. The local authority made some proposals which it asserted were an appropriate discharge of their statutory obligations to P. First, it is proposed that the local authority will set up a prepaid card with a balance of £500 which it will make available to P via her advocate or the library where P spends much of her time. This will be a safety net for P should she wish to make use of it. Second, the local authority has agreed to withdraw the claim for state benefits it made on P's behalf and to inform the Department of Work and Pensions that P should not be assumed to lack capacity to make any future application for state benefits. Third, a pack of information which might help P access help and support should she wish to do so has been prepared and will be given to P's advocate to give to her in case P maintains contact with her advocate following her departure from the residential placement. All of the above represent a reasonable response to the reality of P's situation and I am satisfied that they are an appropriate discharge of the local authority's statutory obligations to P.*

Gwynneth Knowles J concluded by thanking not only the advocates in the case, but the social workers “involved with P who have tried hard to engage her and promote true independence for her” (paragraph 40), but that:

*41. Regrettably, I think it is almost inevitable that P will come to the attention of the authorities in future. I hope this will be in a context where she is seeking help to forge her own course in life, free from the undue influence of her father but I suspect that, unless something significant changes, future contact is likely to be at a time of crisis for P.*

*42. P should have access to a copy of my judgment if she wishes to read it. I wish her well for the future and, notwithstanding my endorsement of the consent order, I remain concerned about her wellbeing.*

## Comment

Given the calibre of those involved in the case, it appears clear that this must have been a case in which every identifiable potential cause of incapacity within the scope of the MCA 2005 must have been

explored and eliminated, leaving this a ‘true’ inherent jurisdiction case.<sup>16</sup> Perhaps strikingly, though, the actual relief that was granted at the outset was essentially the same as it would have been had it been a case determined within the Court of Protection – i.e. an order requiring P to live apart from her father in a specified placement, and authorising her deprivation of liberty there. Similarly, on the facts of the case, it might well have made no actual difference to the outcome had she been found to lack capacity to make the relevant decisions for MCA purposes, because the court could well have reached the conclusion (in P’s name) that it was simply not in her best interests to seek to keep her at the placement where it was not achieving any good.

The more blurred the lines become between the inherent jurisdiction and the MCA 2005, the more some might think that it might be time to dust off Part IX of the Law Commission’s report on Mental Incapacity – when framing what became the MCA 2005, it always recognised that this could not stand in isolation, and it was necessary to have a set of “*legal and operational measures [to] give the authorities involved a range of sufficient measures to choose from, which are adequate and proportionate to the level of risk that has been assessed in the circumstances of that particular case*” (to use the language of *Tunikova*). Those measures were never taken forward, leaving the courts in the difficult position of having to craft them on an ad hoc basis.

### Covert medication and the CQC

*R (Seabrooke Manor Ltd) v The Care Quality Commission* [2024] EWHC 2203 (Admin) (High Court (Administrative Division)) (HHJ Karen Walden-Smith, sitting as a judge of the High Court)

*Best interests – medical treatment – other proceedings – judicial review*

#### Summary<sup>17</sup>

A care home company judicially reviewed a ‘Requires Improvement’ CQC rating, which was reached after an unannounced inspection. The main focus of the challenge related to the CQC’s policy on covert medication. In particular, it was argued that the policy - which recommends that a medicine care plan should include how the medicines are to be administered covertly - went beyond the NICE guidance so the CQC was acting irrationally to impose this as effectively a mandatory requirement. In response, the CQC argued that this is non-statutory, best practice guidance whose purpose is to provide basic advice to care providers about the administration of covert medication.

In dismissing the application, HHJ Walden-Smith noted the definition of covert medication is “*when medicines are administered in a disguised format, such as when they are hidden in food and drink without the knowledge or consent of the person who is receiving them*” (paragraph 50). Key aspects of the guidance were set out, including the importance of the MCA 2005 and how:

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<sup>16</sup> For comparative purposes, we note that P might well be found to lack capacity for purposes of the equivalent legislation in Ireland, where there is no requirement for the inability to make the relevant decision to be caused by an impairment of or disturbance in the functioning of the person’s mind or brain.

<sup>17</sup> Tor having been involved in the case, she has not contributed to this note.



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*Covert administration is only likely to be necessary or appropriate where:*

- *A person actively refuses their medicine and*
- *That person is assessed not to have the capacity to understand the consequences of the refusal. Such capacity is determined by the Mental Capacity Act 2005 and*
- *The medicine is deemed essential to the person's health and well-being.*

HHJ Walden-Smith noted:

*52. The CAM Guidance goes on to set out that covert administration must be the least restrictive option after trying all other options; that a functional assessment should be carried out to try to understand why the person is refusing to take their medicines; and alternative methods of administration should be considered. This is a sensible, logical and rational piece of advice pointing out the potential dangers of giving medicines covertly.*

The recommendation for the way in which medicines are to be administered covertly to be included in the medicines care plan was *"a sensible and rational piece of advice to prevent errors in the covert administration of medication by ensuring that care homes maintain proper detailed recording of the provision of covert medicines for any particular patient. It is not necessary for that information about the administration of medicines covertly to be within one document, and the care plan may refer to other documentation containing information about the resident's covert medication"* (paragraph 53). Nothing in the guidance ran counter to the NICE guidance. Moreover:

*69. It appears that the Claimant does not accept that a covert medication plan should include the amount of food or drink to be used, the priority in which medicines should be given, nor whether multiple medications can be covertly given in the same food or liquid. In my judgment, there is nothing irrational or unreasonable about the CQC expecting the covert administration of medicines to deal with these specifics. It is an obvious concern that if a resident is being given covert medicines and starts to refuse to take food or liquid that it is known how much of the covert medicine has been consumed. It is also an obvious concern that if some medicines are more essential to administer that they should be ranked higher than other medicines, should a resident start refusing to take food or liquid and for the care home employees who administer covert medicines to know if they can be concealed in the same cup of liquid or plate of food.*

## Comment

This judgment is a helpful reminder of the importance given to the proper administration of covert medication to those lacking such capacity. It emphasises that the CQC guidance is not statutory in nature but contains best practice and that to expect details of how covert medication is to be administered to a specific person is an entirely rational approach for the CQC to take. Not only could the administration method determine whether or not the medication is being given on or off licence, but it could also undermine its effectiveness. For example, in one resident's case it stated that liquid risperidone should be given with tea or juice, when, clinically, the advice is that risperidone must not be given in tea as it denatures the active ingredient.



### Rethinking the UK's approach to dying: lessons from an end-of-life helpline

The charity Compassion in Dying has published a comprehensive and powerful [report](#) based on analysis of calls and emails received on its information line, together with a YouGov poll, outlining how talking about end of life decision-making in the United Kingdom is not currently working. Entitled *Rethinking the UK's approach to dying: lessons from an end-of-life helpline*, the report finds that:

- Talking about dying is not enough to ensure people's wishes are followed.
- Opportunities to help people consider, discuss and record their preferences are missed.
- The healthcare system can be dismissive of people's attempts to make decisions:
  - Advance decisions to refuse treatment are not always respected
  - Health attorneys are not always listened to
- People cannot make informed decisions without realistic and straightforward information

The report recommends that government, health and voluntary and community organisations collaborate to:

- Introduce an advance care planning conversation guarantee, initially through the NHS health check
- Deliver a public health campaign on advance care planning
- Create more opportunities for people to record what matters to them at the end of their lives
- Introduce a duty of openness and transparency in end-of-life conversations to enable properly informed consent around treatment decisions
- Develop mandatory training for healthcare professionals on end-of-life decision making under mental capacity legislation
- Develop mandatory training for healthcare professionals to recognise when a person is approaching the end of their life and to support a transition to comfort care

Although not a substitute for the steps recommended, some may find this [video on advance care planning](#) of assistance (based on the law in England & Wales).

One point that it is important to understand is that the report is based upon the law as it currently stands. Many will be aware of political initiatives to change the law to make the provision of assistance with dying legal: for those who want to think this through, this video may be of assistance. Without taking a stance for or against legalisation, one point that we would highlight as requiring consideration in any moves towards legalising assisted dying is as to the impact that it would have on conversations of the nature that the report highlights as of being so necessary.

### Assisted dying – Lord Falconer's Private Member's Bill

Lord Falconer's Private Member's Bill is now [available](#). At the time of writing, there is no date yet set for Second Reading in the House of Lords. As the Parliament [website](#) explains, Second Reading "is the first opportunity for members of the Lords to debate the key principles and main purpose of a bill and to flag up any concerns or specific areas where they think amendments (changes) are needed." The progress of Lord Falconer's Bill can be followed [here](#).

Alex has a page of resources which may be of assistance for people wishing to educate themselves about the issues. It includes a [table of cases](#) decided in Canada in a period in 2016 when the equivalent of High Court judges were deciding applications brought by individuals seeking (in effect) confirmation that they met the criteria for assisted dying. Lord Falconer's Bill would require the consent of High Court judge in each case; the extracts from the cases in the table may be of interest for those wanting to think about what the role of the judge would be.

We would also recommend the [resources](#) of the British Medical Association on physician assisted dying for those who want to understand the issues in context (including the international context).

### Co-Producing Accessible Legal Information

The Co-Producing Accessible Legal Information (COALITION) Project has recently [published](#) its concluding report (and accompanying Easy Read version) The project used facilitated coproduction research workshops to explore barriers to access to legal services for people with learning disabilities, and to investigate how legal services could be made more accessible to disabled people with cognitive impairments. There were two interlinked aims in this project: first, to model ethical co-production practice in academic research, and second, to understand the potential that accessible information holds for access to justice and access to legal services for disabled people with cognitive impairments. The core outcomes from the project were:

1. An Accessible Research Toolkit to support academic research involving disabled people with cognitive impairments.
2. A set of materials to support access to legal services for disabled people with cognitive impairments.
3. Priorities for accessible legal information and for future research in this area.

Key findings from the research were that:

1. Using easy read participant information sheets and consent forms to support research practice can help to ensure that people with learning disabilities give informed consent to participate in research.
2. Skilled specialist facilitation helps to equalise power relationships in co-production research, modelling how to work together across difference. Specialist facilitation also helps to ensure that researchers are fully involved in the co-production process.
3. People with learning disabilities experience barriers to access to justice at every stage of seeking advice about a legal problem. This includes difficulties in accessing general information about law

that can help them to identify when to seek legal advice, difficulties in accessing legal service and choosing the right service provider, understanding complex terms of business and 'client care' letters, and in understanding legal jargon when they do receive legal advice and services.

4. People with learning disabilities have high levels of unmet legal need, which can be assisted by the development of high quality accessible legal information on a range of different legal topics.
5. The project generated 6 recommendations:
6. Researchers working with people with learning disabilities should use easy read research materials to support informed decision-making about participation.
7. Co-production research should be carried out using specialist co-facilitation partners to ensure inclusive research practice.
8. Legal regulators, legal service providers and disabled people's organisations should work together to develop an accessible web database of easy read information about law.
9. Legal regulators should develop a 'disability-friendly' quality service mark for law firms and increase the emphasis placed on accessibility of legal services in existing quality marks.
10. Legal service providers should develop tailored easy read client information to improve accessibility of their services.
11. Legal service providers should develop easy read information about common legal issues to support disabled clients.

### What's in a name? Competence and capacity (and is it enough for a child?)

*Re BC (Child in Care: Change of Forename and Surname)* [2024] EWHC 1639 (Fam) (High Court (Family Division) (Poole J)

*Other proceedings – family (public)*

#### Summary

In *Re BC (Child in Care: Change of Forename and Surname)* [2024] EWHC 1639 (Fam), Poole J approved a request by a 15 year old subject to a care order to change both her first and last name "because they are attractive to her and the actual initials of her new name would be of significance to her in relation to her recovery from the trauma inflicted by her father" (paragraph 2). The local authority opposed the application because it was concerned that "BC's actions concerning her names do not match her expressed wishes, that the change of names will be detrimental to her relationship with her family, that she is vulnerable to the impact of others asking her why she has changed her names, and that she will regret the decision" (paragraph 5).

As Poole J noted:

*20. An adult can change their name by usage. Now, however, changing one's name by usage alone will not carry much weight with agencies such as the Passport Office or the DVLA. For an adult to*

*change their name they should execute a deed poll. A deed poll is a declaration signed by two adult witnesses. Deeds poll can be enrolled which is a process governed by regulations involving notification in The Gazette and enrolment at the Royal Courts of Justice with the payment of a fee.*

[...]

*22. I note that the GOV.UK website states that you can change a child's name (a child being someone under 18) by an enrolled or unenrolled deed poll, but that a 16 or 17 year old child can change their own name by making their own unenrolled deed poll. The Mental Capacity Act 2005 applies to 16 and 17 year olds as well as to adults. It provides that a person is assumed to have capacity unless otherwise proven. I have not been referred to and am unaware of any statutory provision that a 16 or 17 year old who is not subject to one of the orders set out below may or may not change their name without the consent of those with parental responsibility, but it is clearly the convention, operating to allow people to change their names by unenrolled deed poll, that a 16 or 17 year old can do so without the consent of any person with parental responsibility or the leave of the court.*

However, by operation of a number of parts of the Children Act 1989:

*24. [...] a 16 or 17 year old may not cause their own surname to be changed without the consent of every person with parental responsibility or the leave of the court if they are the subject of a care order, child arrangements order with a "lives with" order, or a special guardianship order. Other 16 to 17 year olds may cause their own surname to be changed without consent or leave. They could do so by executing an unenrolled deed poll. The Enrolment of Deeds (Change of Name) Regulations 1994, as amended, prevent any deed poll executed by a child under the age of 18 being enrolled except by someone with parental responsibility for the child (unless the child is a female aged at least 16 who is married). A child who is 16 or 17 has themselves to consent to the enrolment. But enrolment is not a pre-requisite for a formal change of name.*

Poole J asked himself why the position of a 16 or 17 year should vary depending on whether or not they are subject to (amongst other things) a care order, and it is fair to say that he did not seem entirely convinced that there was a good reason. He directed himself by reference to the (now relatively old) authority of *Re S (Change of Surname)* [1998] EWCA Civ 1950, [1999] 1 FLR 672, the Court of Appeal was concerned with an application by a child in care aged 15 to change her surname (not their forename). He noted that:

*42. In my judgment, care has to be taken in applying some of the authorities to the case of an application by a Gillick competent 15 year old, or indeed a capacitous 16 or 17 year old, in care. I reject the submission that the court may only permit the change of a name if the continued use of the current name would be likely to cause the child "significant harm". In *Re C* [2023] Cobb J said that, "The issue of whether there is a power within the inherent jurisdiction to prevent a parent with parental responsibility from naming their child with a particular name is dependent on whether the court is satisfied that to allow such a name to be used would likely cause that child significant harm." He was dealing with an infant whose name was said to be unsuitable, similarly to the name 'Cyanide' considered in *Re C* [2016]. As Thorpe LJ found in *Re S*, some of the principles in the authorities do not stand transplanting into an application of the kind now being considered.*

*43. I acknowledge that there are differences on the facts between *Re S* and the present case including that BC is asking to change both her forename and surname. I accept that the double*

*name change requires particular consideration. BC is not asking to adopt her mother's surname in place of her father's surname. A request to change to a name that has no association with the family is a matter to be weighed in the court's determination. On the other hand, it might be said that even more weight should be given to BC's wishes and feelings than in the case of the young applicant in Re S because (i) BC was the actual victim of the sexual abuse by her father and so her motivation to make the change might be given even more weight, and (ii) the father has been found by the Family Court to have sexually abused her whereas no findings had been made in the Re S case. Findings have also been made against her mother as set out above.*

*44. I consider that I should follow the authority of Re S and consider very carefully the wishes, feelings, needs, and objectives of the applicant when giving paramount consideration to her best interests. It is not disputed that BC is competent to make a decision for herself about her change of name. The evidence from her school is very persuasive that she is mature for her age. She will be 16 in a few weeks from now. She will have capacity to make the decision to change her names. Change of name deeds poll are effective for 16 year olds who are not in care, and not subject to child arrangements orders or special guardianship orders.*

*47. A change of either a forename or a surname is a serious matter. Whatever the reason why the law requires the consent of those with parental responsibility or the leave of the court for a change in surname for a 16 or 17 year old in care or subject to relevant orders, but not for others of the same age who are not subject to relevant CA 1989 orders, the law is clear. The court should not give leave simply because a Gillick competent child applies for leave. The court must consider the benefits and harm to the applicant from either granting or refusing the application but taking into account also that rights under Article 8 of the European Convention on Human Rights are engaged and that when the child is 18 they will be able to change their name without consent or leave. The views of those with parental responsibility including the Local Authority, and other relevant individuals and agencies should be taken into account.*

Having reviewed the material before the court, Poole J concluded as follows:

*61. A change of forename and/or surname for a child is a serious decision whatever the age of the child. The court's paramount consideration is the best interests of the child. The views of others, in particular of those with parental responsibility, are to be taken into account. The family's views are relevant insofar as they may affect their conduct and attitude and therefore affect the welfare of the child. The views of the Local Authority, having parental responsibility in respect of a child in care, are of importance. The court must take into account the child's competence to make the decision, their age and maturity, the steadfastness of their wish to change their names, and the reasons behind the wish to make the changes. The court should consider the choice of name(s) – are they frivolous or would they be liable to be detrimental to the welfare of the child because of their nature or associations? The court should have close regard to the impact on the child of allowing them to change their name(s) as well as the impact of refusing them leave to do so. In the case of an older child, the court can have regard to the fact that a 16 or 17 year old not in care and not subject to a relevant child arrangements order or special guardianship order, could change their name without consent or leave, as could any 18 year old.*

*62. Having regard to the legal framework and all the evidence and circumstances in this case, I have little hesitation in allowing the application and in giving leave to BC to change her forename and surname so that she shall be known as JKL. I suggest that if she wishes to do so, once she is 16 years old, she should be assisted to change her name by unenrolled deed poll. My order gives her leave to do so. I give considerable weight to the settled wishes of a mature, competent 15 year*

*old who has good reason to wish to change both her forename and surname, who has chosen sensible new names that are not frivolous or provocative or liable to be detrimental to her welfare in any way. I am content that she has thought through the decision and is aware of the significance of the changes proposed. I am confident that she will be well supported at school and in her foster placement in the change process, that she will enjoy psychological and emotional benefit from the changes, and that she would be liable to suffer psychological and emotional harm were her application to be refused. The Local Authority might consider funding further therapy to support her through the process of the name changes (and the pending trial of her father). I do not believe that her family relationships will be harmed by the proposed name changes. In my judgement it is clearly in BC's best interests to allow this application.*

*63. I have referred throughout this judgment to BC but from the making of my order she may be known as JKL. I wish JKL well for the future.*

## Comment

It is easy to see why Poole J was somewhat sceptical about why it should necessary make a difference that a child is subject to one of the relevant provisions of the Children Act 1989. The more important issue is arguably whether they have the ability to make the decision themselves. Whilst it was common ground before the court that BC (now JKL) was competent to make the decision, there does not appear to have been any discussion of what the relevant information was that she needed to be able to process in order to make that decision, nor what (when she turned 16) she would need to be able to process in order capacitously to make that decision. In an unreported case Alex was involved in, the Court of Protection approved the following list of relevant information that a 16 or 17 year old needed to be able to understand, retain, use and weigh:

- *You want to change your name and have people call you by your new name;*
- *You are making a document which has a legal effect;*
- *You are making a document which you can use as proof of your new name;*
- *You may not be able to do everything that you would like with this proof;*
- *When you turn 18 you can do something more formal which would allow you to prove to everyone that you have a new name; and*
- *If you want to have a formal proof now which everyone can accept, someone else will have to do this for you.*

One important point to note is that enrolling a deed poll (which an adult can do, but must be done on behalf of a 16 or 17 year old) is a step which has some stark consequences which the 16 or 17 year would need to understand if they were to have the capacity to request someone to apply on their behalf. In the context of a change of gender, these were set out by Master McCloud in *W, F, C and D (minors)(Name changes disclosing gender reassignment and other matters)* [2020] EWHC 279 (QB) at paragraphs 27-28:

*28. [...] the current position in respect of formal Deeds is that the enrolment of a Deed is very public and leads to publication of the child's new and old names on the internet by the Court office, by way of publication of a notice in the London Gazette.*



29. *The internet enables easy search for people and makes it very easy to identify that a child such as Child W was formerly known as X and was from a particular date known as Y. Enrolling a name change Deed to all intents and purposes makes permanently public the name change and will in many instances therefore amount to what will later be taken as disclosure of a change of social or legal gender, whether by child or adult. In other words it 'outs' them.*

## Ireland

Our Ireland correspondent, Emma Slattery, is enjoying a well-earned break this month, but will be back next month. In the meantime, many may find the [Mental Health Bill 2024](#) published at the end of July will keep them busy reading-wise.

## SCOTLAND

### Scottish Government consultation on AWI amendments

After carrying out considerable work in informal discussions over recent months, on 25<sup>th</sup> July 2024 Scottish Government published its “Adults with Incapacity Amendment Act: Consultation”. The consultation document contains 99 questions. Here, I give a selective overview. 99 consultation questions raise many issues, and points picked out here may not necessarily be all of the most important ones. However, it is hoped that they give a flavour of the task ahead for consultees from now until the consultation closes on 17<sup>th</sup> October 2024.

There is clearly nothing yet that is prescriptive about the document. It seeks “thoughts on proposals for reform” to the 2000 Act. The consultation makes it clear that partial responses, replying to selected questions, will be just as welcome as more comprehensive responses. The document envisages a two-stage process, of which it addresses the first only: updating the 2000 Act in advance of the second stage, which will address wider reforms “that may take place over the next five to ten years” as set out in Scottish Government’s response to the Scottish Mental Health Law Review (“the Scott Review”, which was followed by “the Scott Report”). The stated aims at the outset of the consultation document probably do not give a full impression of the breadth and depth of coverage. The aims are stated as:

- Improve access to justice for adults affected by the AWI Act.
- Shift the focus of the AWI Act to one that truly centres on the adult.
- Enable adults to access rights more easily.
- Ensure adults are supported to make and act upon their own decisions for as long as possible.
- When an adult cannot make their own decisions despite support, ensure that their will and preferences are followed unless doing so would be to the overall detriment of the adult.

The consultation is set out in six Parts that correspond to Parts 1 – 6 of the 2000 Act, followed by Part 7 dealing with deprivation of liberty, and Part 8 (“which can be considered in isolation”) addressing the topic of authority for research under section 51 of the 2000 Act, and associated regulations. The document acknowledges the need for changes in practice, and for training to help achieve that. It would be useful if there could be acknowledged from the start the need for an equivalent of the implementation steering group which oversaw implementation of the 2000 Act itself, extending far beyond training of professionals and others to general publicity, and including the details of leaflets in social work offices and GP surgeries, dissemination arrangements, and generally turning the words of statute into something that worked in practice. The steering group inevitably picked up needs for further adjustments, which after review were included in the Adult Support and Protection (Scotland) Act 2007 (“the 2007 Act”). A similar process could usefully be added to the agenda for the planned second tranche of reforming legislation.

What is however lacking from this document is any commitment to a timescale for legislation, albeit in two stages. The first stage is urgently required. The introductory material narrates the proposals on deprivation of liberty made by Scottish Law Commission in 2014, and the two much broader

consultations in 2016 and 2018. It suggests that the long gap in progress since then was to allow the Scott Review to complete its work. One has to say that this suggestion is misleading. In March 2019 Scottish Government expressly undertook to continue work on deprivation of liberty, and on essential AWI reform generally, in parallel with the work of the Scott Review:

*“At the same time as the Review takes place, we will complete the work we have started on reforms to guardianship, including work on restrictions to a person’s liberty, creation of a short-term placement and amendment to powers of attorney legislation so that these are ready when the Review is complete.”*

No such work was done. Nothing was ready by the time that the Scott Report was issued. But “we are where we are”, and one has to acknowledge the considerable amount of work done since publication of the Scott Report, leading to this consultation.

### Part 1: Principles and other provisions

The good news here is that just as the Scott Report, in Chapter 13, largely adopted the recommendations of the Three Jurisdictions Report, Scottish Government has followed suit. Specifically, the consultation document quotes and accepts the recommendation of the Three Jurisdictions Report that there should be a *“rebuttable presumption that effect should be given to the person’s reasonably ascertainable will and preferences ... Action which contravenes the person’s known will and preferences should only be permissible if it is shown to be a necessary and proportional means of effectively protecting the full range of the person’s rights, freedoms and interests”*. The consultation proposes a shift from references to “wishes and feelings”, to “will and preferences”, following CRPD (the UN Disability Convention). The inter-relationship between will and preferences, and the difference between them, are not explored, but the intention is clear. There does not yet appear to be a proposal for an attributable duty to ascertain these. In parallel with this recommendation, however, it is envisaged that there should be clear obligations to ensure that all necessary support has been given to the adult in accordance with Article 12.3 of CRPD. Again, however, while there is an obligation for interveners (as defined in section 1(1) of the 2000 Act) to ensure these matters, there is not yet in the proposals any clear attributable duty to ensure provision of support.

An apparent flaw in the consultation document is that it refers to support for making decisions, failing to recognise the quite fundamental difference in this regard between the law of England & Wales, and the law of Scotland, and more generally this aspect of the significant difference between common law systems generally, and civil law systems generally. Law reform processes in the 1990s in England & Wales were encapsulated by the title of the consultation documents: “Who decides”. The focus was on decision-making, and there was much debate between so-called substitute decision-making and so-called supported decision-making. That debate did not feature significantly in the Scottish process, focused on the wider concept of “acting and deciding” rather than deciding only. Likewise, CRPD does not once mention either supported decision-making or substitute decision-making, and the travaux préparatoires demonstrate that the drafting committee stepped back from being drawn into making any rulings in favour of, or against, supposed “substitute decision-making”. The requirement of Article 12.3 is to provide adults with the support they require in exercising their legal capacity, and one would hope that this wider concept will permeate any legislative proposals, once this exercise proceeds from the present rather generalised discussion to actual proposals for legislation itself.

Also, there needs to be greater clarity around how the principles are to be applied. The consultation document asserts that “the principles have parity”, and then proposes as an intended change that an amended section 1(4)(a) would give clear priority to the adult’s will and preferences. The consultation document, in asserting “parity”, does not address the views of Sheriff Principal Stephen (as she then was) in *G v West Lothian Council*<sup>18</sup> that the benefit principle is “the essential principle” which should be addressed before consideration is given to the other principles. In a sense, both views are correct. On the one hand, to assess whether a proposed intervention will benefit the adult, or whether its purpose could be achieved without the intervention, is likely to require compliance with all of the principles. It is unlikely to be possible to judge whether a contemplated intervention will benefit the adult without knowing the adult’s relevant wishes and feelings, or will and preferences. On the other hand, the principles do form a step-by-step process as one goes through them. If a proposed intervention will not benefit the adult, stop there. No further consideration is necessary. The same applies if the desired benefit can be achieved without the intervention; and to the requirement for the least restrictive intervention in relation to the freedom of the adult; and so on, all of these being questions to be answered in sequence.

In the context of Part 1, the consultation fails to address the points that jurisdiction in adult incapacity matters was given to the sheriff court, firstly, to facilitate a “one-door approach” for both incapacity and mental health applications, and, secondly, was predicated upon a recommendation that there should be specialist sheriffs. “One door” disappeared with the creation of the Mental Health Tribunal under the 2003 Act. Specialisation has happened *de facto* in some courts, but not in others, producing the disparity in standards that has attracted so much criticism. Scottish Government needs to grasp that nettle. Proposals have been “on the table” since responses to the 2016 consultation, to merge mental health and incapacity jurisdictions in a single tribunal. That does not need to await unified legislation. Indeed experience of such a tribunal, operating the two regimes, will be invaluable in shaping unified legislation.

Also needed without further delay is to apply the principles of the 2000 Act, and provisions such as the jurisdiction of the court under section 3(3) to give directions, to encompass woefully non-compliant, in human rights terms, procedures such as appointment of appointees to administer social security benefits. That can be done in relation to benefits now administered in Scotland. To make that extension would either persuade UK Government to allow the same for UK benefits, or at least – surely – shame them into addressing that situation.

Entirely commendable proposals in relation to section 3(3) involve allowing directions to be given to past holders of functions under the Act (such as attorneys and guardians who have ceased acting) and to others with roles that would affect administration under the Act – the example is given of pension funds making payments to persons whose finances are administered under the Act.

The consultation document does suggest, surprisingly, that the distinction between financial and welfare powers “is made differently” as between powers of attorney and guardianship. That assertion is not justified. A difference in terminology is however addressed, helpfully. Scotland’s reference to

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<sup>18</sup> 2014 GWD 40-730 (see also case commentary by Eccles and Watson at 2015 SLT (News) 35).

“continuing powers of attorney” to mean powers of attorney in property and financial matters is idiosyncratic and confusing. The suggested reform to call them “financial powers of attorney” should remove that confusion. A further consideration not mentioned is that, Europe-wide, “continuing power of attorney” describes any power of attorney that may enter into force, or continue in force, notwithstanding the granter’s loss of relevant capacity.

A surprising feature of the discussion of Part 1 is to suggest that the investigatory role of the Office of the Public Guardian in relation to financial powers of attorney be transferred to local authorities. OPG would still investigate financial guardianships, issues under Parts 3 and 4, and so forth. Why not continue to use the considerable experience and expertise of OPG? Would one really have a situation in which OPG would supervise an attorney where that attorney has been put under the supervision of OPG under section 20 of the 2000 Act, but would not investigate malfeasance? One is prompted to remember the international presentations at the World Congress in Edinburgh in 2022 of the whole process of investigating and where necessary prosecuting financial fraud by attorneys and guardians. Without doubt, it is a highly skilled and highly specialised task. The most skilled fraudsters will certainly be likely to “pull the wool over the eyes” of any inadequately trained and experienced financial investigators. This writer is not aware of any significant previous consultation on this topic, nor of the views of OPG: it surely requires further thought as to basic operational practicalities.

## Part 2: Powers of attorney

Recommendations regarding the certification process deserve consideration and probably development. Clinical psychologists may well be the best certifiers of capacity. The importance of safeguards against undue influence and other vitiating factors is mentioned, but not fully addressed. That is an obvious area for potential abuse: as successive Mental Welfare Commission investigations have identified.

Proposals for mandatory training of attorneys are commendable, but like other aspects require further thought. Clearly, the training should take place upon appointment, because the need to commence acting could arise suddenly. However, a young couple might appoint each other to be attorneys as a precaution, and it could be 40 years or more before either began to act. Likewise, the power of attorney document could appoint substitute and alternative substitute attorneys who might never act. Should they be trained, in advance of accepting appointment, or only after accepting appointment, with the problem that they may require to commence acting immediately?

The document does address the peculiarity that as matters stand granters require to confirm that they have considered what should be the trigger for commencing acting, but are not required to specify it. There perhaps requires to be greater clarity around the point that many granters, particularly elderly and frail granters, may wish an attorney to take over administration of their financial affairs upon appointment, regardless of any question of impairment of capacity, and then to continue acting as their own capabilities gradually wane. A similar consideration in relation to welfare powers is that although they can only be exercised upon incapacity, or reasonable belief of the attorney, that is too simplistic. Frequently, capacity fluctuates, and capacity for different acts varies and fluctuates. That flexibility requires to be accommodated. It is notable that in many jurisdictions registration of a power of attorney only takes place once it is brought into force. Should Scotland introduce such registration, or at least

a secondary noting on the register, when any provisions of a power of attorney come into force and the attorney begins to act?

So far, the proposals do not extend to revocations the attempts to simplify procedures and make them more workable. An attorney may simply wish to change a substitute appointment under an existing power of attorney. At present, the only way in which that can be done is to revoke the entire document and go through the process of replacing it. That surely needs to be changed.

### Parts 3 and 4

It is proposed that Part 4 administration cease, and be taken over by Part 3 administration, with Part 3 improved. That would appear to be sensible, as are proposals to address the need – identified long ago – to facilitate transitions of financial administration among Part 3, intervention orders and guardianships, in each case in both directions. In a manner which seems strangely inconsistent with the proposals regarding powers of attorney, it is proposed that OPG “should actively supervise withdrawers” under Part 3. The unstated logic behind this is that withdrawers, unlike financial attorneys, are not appointed by the adult.

It is proposed to introduce greater flexibility in allowing adjustments to the arrangements without always requiring a formal fresh application. That should make the system more workable. It is also proposed that the scope of what a withdrawal certificate authorises should be widened.

### Part 5

It is proposed that authority to treat under section 47 should be extended, where appropriate, to conveying a person to hospital to receive treatment, which could include treatment for a physical issue: there would be a new adapted section 47 certificate that would expressly allow a person to be conveyed to hospital and ensure that the process is authorised. A raft of related proposals would appear to be designed to subject this to the minimum necessary intervention principle; they are probably also designed to ensure compliance with Article 5, on deprivation of liberty, of ECHR (the European Convention on Human Rights), but that aspect is likely to require careful consideration.

There are further proposals for an enhanced section 47 certificate to prevent a person who is being treated for a physical condition from leaving hospital, whether temporarily or permanently. These again raise significant issues, including in relation to Article 5, and human rights compliance generally.

Scottish Government describes its concerns about authority to give medication for the purpose of alleviating serious suffering on the part of the adult, or to prevent serious deterioration in the adult’s medical condition, while a dispute between a proxy and a medical practitioner is being addressed under the procedure provided for in section 50. The consultation document suggests that this be altered. This is an area to be entered with great care, as the issues that led to the “section 50 compromise” were the one area of significant political concern in relation to the 2000 Act itself which could have derailed the whole legislation. The document appears to give no statistical evidence of the prevalence of such a situation. It is known that references under section 50 are relatively rare, though it is understood that the number approximately doubled during the pandemic, the point of contention in many of the extra cases being whether to vaccinate.



## Part 6: Guardianships

The tentative proposals that have now emerged will without doubt lead to much discussion. It is asserted bluntly that “incapacity reports are not included in the GP contract and GPs are not obliged to carry them out”. It is also suggested that “GPs are not experts in incapacity assessments, so may not feel confident, or may refuse because of the volume of their existing work”. It also points out that “there are fewer psychiatrists, but they are experts at assessing incapacity where it results from mental disorder”, and that “it is generally part of their contract to complete incapacity reports”. It acknowledges that a psychiatrist may refuse to report if not already familiar with the adult. Scottish Government is accordingly considering reducing the number of medical reports from two to one. A welcome proposal is to add clinical psychologists to those who might provide them.

On mental health officers’ reports, the proposals rather seem to duck the issue. Simplification of the form of reports is proposed. What is needed, plainly, is adequate allocation of resources to ensure at least doubling of the MHO workforce: in relation to remuneration sufficient to justify suitable social workers taking on the extra training and responsibility, and all areas of recruitment, training and retention.

The possibility of improving the form of report by a “person with sufficient knowledge” is also addressed.

There is discussion of allowing Part 6 applications to be considered even although the MHO report is outwith the current 30-day limit. One wonders, however, how a sheriff could be assured that the situation has not changed if the MHO does not confirm that. Here again, perhaps what is essentially a resources issue is being masked: in contrast to most other jurisdictions, Scottish Courts Administration gives remarkably low priority to the need to address and determine such applications promptly.

There are further proposals suggesting abbreviated reports for urgent applications seeking interim orders; and for simplification of requirements where financial powers are requested to be added to a hitherto welfare-only guardianship, or the opposite. However, there does not appear to be an attempt to reconcile the wider tension between the requirement of the principles that they be applied rigorously to all powers sought, and the understandable tendency in practice to seek a wide range of powers on a precautionary basis. What is surely needed, as has been proposed, is a two-tier arrangement under which “precautionary powers” may be granted, but there should be at least a minimum notification requirement if they are brought into operation. There is still a general tendency to seek, and renew, excessive powers: often coming to light at time of renewal when a guardian is asked, power by power, whether they have all been operated at all.

There are commendable proposals to eliminate the human rights violations of excessive duration of guardianship orders. There might be scope for strengthening the proposals, to ensure adequate independent judicial supervision. It is at this point that the notorious “Aberdeenshire case” is discussed, though it is not clear that all of the lessons to be learned from it have in fact been learned.

There is a surprising section on adding substantially to the potential exclusions from powers that could be conferred upon a guardian. One would suggest that these proposals are clearly non-human rights compliant unless the intention is that the matters in question could be authorised by an intervention

order. Proposed exclusions such as “making a Will”, even when to do so would comply with the principles, would seem to be regressive unless (again) that may be done under an intervention order. Indeed, all of the proposed exclusions would appear to amount to preventing something amounting to exercise of legal capacity by or on behalf of the adult which would nevertheless satisfy the section 1 principles: that would appear to be regressive.

### **Part 7: Deprivation of liberty**

Discussion of these proposals at this time and in this item is probably beyond the reasonable scope of this item. The proposals certainly require massive examination and consideration. One does not see any clear replication of the 2014 proposals from Scottish Law Commission. It is difficult to see that they adequately address the two-step requirements of ensuring compliance with Article 5 when someone is empowered to authorise a deprivation of liberty; and ensuring compliance whenever, in particular circumstances and in a particular way, such power is exercised. One would simply say at this stage that much more work on this seems to be necessary, but at least this consultation document will trigger that process.

### **Part 8: Participation in research**

This specialist topic is not addressed in this article.

*Adrian D Ward*

### **World Congress on Adult Care and Support, Argentina, August 2024**

The 2024 World Congress on Adult Care and Support took place in Buenos Aires, Argentina on 27<sup>th</sup> - 30<sup>th</sup> August 2024. This report has been prepared by Adrian D. Ward and Sarah G. Prentice immediately after the event.

Adrian attended as president of the last preceding World Congress in Edinburgh, 2022, and as one of the two members present in Buenos Aires of the steering group of the International Advisory Board that recommends the allocation of hosts for future Congresses, and provides necessary support to each. Sarah accepted an invitation to join him as an expert in the field, fluent in Spanish. The latter role expanded into facilitating endless cross-language conversations and introductions throughout the period of the Congress, at all times of day and night.

This was the largest Congress so far, with approximately 600 attendees, of whom 200 were speakers and presenters, over plenary and four parallel sessions throughout long days from 9am until 8pm. The vast majority of attendees and speakers were from Latin America, and new to these World Congresses. All of them participated with great enthusiasm, and if they can be encouraged to attend future congresses, they will represent a massive addition to the strength of these events, particularly in view of all the exciting recent developments across Latin America, focused on achieving compliance with the principles with the United Declaration on the Rights of Persons with Disabilities (“UN CRPD”). Several, however, reported a deficit between the standards required by their new legislation, and implementation, even by judges. It was necessary for Adrian to point out in the closing Plenary Session that passing laws is at most 50% of the task: there needs to be sustained and planned effort to have them fully implemented in practice.

Beyond South America, there was representation from 32 countries across every inhabited continent. If there was a deficit, it was that despite major representation from Spanish speaking Latin American countries, and a significant attendance from Dutch speaking Surinam, there was only one delegate from the whole of Portuguese speaking Brazil.

Pleasing for Adrian and Sarah, as delegates from Scotland, was the repeated commendation from many who had attended the Edinburgh event in 2022 of the standards achieved there. Equally significant, though simply taken for granted by so many rather than explicitly commented on, was the extent of the continuity of development of the whole subject over the two years since Edinburgh. At the concluding session in Edinburgh, Wayne Martin, Professor of Philosophy at Essex University, gave a masterly summing up. He marvelled at the dynamic progress in our subject, worldwide, exemplified at that Congress. He suggested that the many and varied contributions to that Congress reflected “a shared understanding of a common challenge”, to which he attempted to give this explicit formulation:

*“How shall we devise new regimes of legal capacity which are respectful of the rights of older persons and persons with disabilities, and which are maximally inclusive of populations that were previously excluded from full recognition in society?”*

At the 2024 Congress one could likewise marvel at how the dynamic progress identified in 2022 has been sustained, worldwide, with a broad consolidation of consensus as to how to meet that challenge, and real progress towards developing and enacting laws to give effect to it.

Unlike previous Congresses, there was much greater emphasis upon issues faced by older people as well as by people with disabilities. One could not escape the relevance of contemporary events in South America, and comments from speakers that there is worldwide focus on starvation among children, but little attention paid to starvation among older people. It was quoted that in Argentina the basic costs of living, including adequate diet, amount to about \$700 per month. The current pension for old people is \$200 a month. For those without significant family or other support, the consequences can be fatal, particularly since - as one delegate put it - “the first symptom of significant ill health” is “the last symptom in their lives”. Yet, when during the course of the Congress a group of older people protested in Buenos Aires about their level of pension, they were brutalised by police with batons and tasers. With the unanimous support of all present, the dynamic President of the 2024 Congress, Prof Maria Isolina Dabove of the University of Buenos Aires, personally signed a declaration unequivocally condemning that action.

It was in this context that proposals for a United Nations Convention on the Rights of Older Persons featured significantly. Did this have a place in a World Congress focused on issues of Adult Capacity? Answers were emphatically provided, even by the very title of the book “Aging of the Oppressed: A Pandemic of Intersectional Injustice” by Silvia Perel-Levin, advocate for the human rights of older persons, billed as attending from “Geneva and Tel Aviv”. She was one of several who made passionate contributions on this topic. Adrian publicly confessed his reservations about an accumulation of Conventions on the rights of particular categories of persons. There will always be those who fall between the cracks, and whose needs may be greatest of all. One contributor quoted the magnificent first paragraph of the Universal Declaration on Human Rights: but when almost every subsequent paragraph commences “everyone” and “no-one”, and if these words mean what they say, why should

implementation be limited to particular groups? The answers provided at the Congress introduced the concept of “the whole universe around a Human Rights influence, regardless of content or ratification of particular Conventions”. Thus, although the United States has not ratified the UN CRPD, it was narrated that to date 29 U.S. states have based reforms in law and practice upon its principles. Adrian publicly acknowledged that one of the successes of an event such as the Congress was when people - such as him in this matter - were persuaded to change their minds.

The venue for the Congress must surely have been the largest and most impressive Law School building anywhere, a massive rectangular block with an imposing presence on top of a small hill, a free university currently serving 14,000 law students, exceeding the most ever before encountered by Adrain anywhere in the world - the previous highest being 10,000 in mainland China.

That the Congress happened at all was a triumph for Isolina Dabove and her organising team. They built up to host the event in 2020, were defeated by the pandemic, postponed to 2021, then cancelled that also, eventually to step in two years behind the Scottish Congress of 2022. To have sustained the will and capability to deliver through all of that, on top of all the “normal” considerable demands of running such an event, is an achievement that may well never be equalled. Less visible but equally notable was the supporting role played by Jochen Exler-Konig, present of International Guardianship Network (IGN), now at least partially rewarded by a substantial increase in membership of IGN.

It was confirmed that the next Congress will take place in July 2026, jointly hosted in Amsterdam by Kees Blankman, Professor of Elder Law at the Free University (“VU”) Amsterdam, and his colleague Dr Rieneke Stelma-Roorda, best known to a wider readership for her monumental recent book (in English) *“In anticipation of a future period of incapacity”*.

It is likely that the 2028 World Congress will be held in Girona. It is notable that the large delegation from Catalonia in 2022 was repeated at the 2024 Congress. It is hoped that the involvement of Latin America generated by Isolina Dabove and her colleagues in 2024 may be sustained by the accessibility for Latin Americans of transport links to Amsterdam, and linguistic links to Spain.

*Adrian D. Ward and Sarah G. Prentice*

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## Conferences

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

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

Adrian will be speaking at the 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.

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Our next edition will be out in October. 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](mailto:marketing@39essex.com).

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