Essex CHAMBERS

MENTAL CAPACITY REPORT: COMPENDIUM

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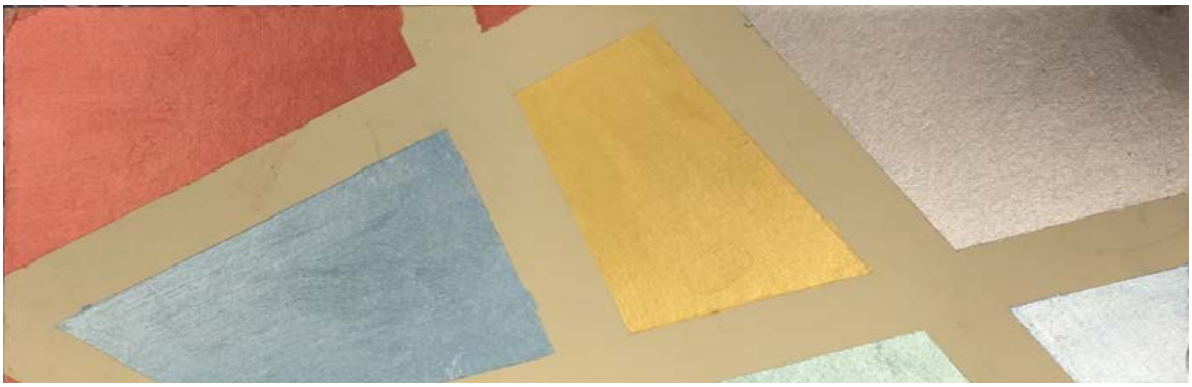

Welcome to the November 2024 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: anticipatory declarations; systemic failure in considering PDOC patients, and the CQC and DoLS.

(2) In the Property and Affairs Report: Senior Judge Hilder reversing reverse indemnities and considering the scope of deputies' authority in the context of Personal Health Budgets;

(3) In the Practice and Procedure Report: costs and delay and capacity in cross-border cases;

(4) In the Mental Health Matters Report: the Mental Health Bill is introduced;

(5) In the Wider Context Report: Strasbourg suggests that the Supreme Court was wrong in the *Maguire* case.

(6) In the Scotland Report: Scottish Government's law reform proceeds at breakneck speed, and a symposium for Adrian.

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.

His fellow editors congratulate Alex on his receipt of a Honorary Fellowship of the Royal College of Speech and Language Therapists (and he uses this opportunity to give his usual plug for their vital role as capacity supporters).

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.

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

Anticipatory declarations and supporting P in her wish to protect herself

Leicestershire County Council v P & Anor [2024] EWCOP 53 (T3) (Theis J)

Mental capacity – assessing capacity

This is both an interesting and an important decision.[1]

It is interesting because it is the first reported English[2] case considering Dissociative Identity Disorder and capacity (although, in fact, it appears that the appropriate diagnosis was Complex PTSD with dissociative characteristics).

It is important because Theis J, the Vice-President of the Court of Protection:

1. Confirmed, (contrary to a slightly surprising submission on behalf of the local authority) that ss.5 and 6 MCA 2005 are not limited to emergency situations;

2. Confirmed, (again, contrary to the submission on behalf of the local authority, and obiter observations of Mostyn J) that the Court of Protection does have jurisdiction to make 'anticipatory' declarations;

3. Gave (at paragraph 137) useful guidance as to when the court should consider making anticipatory declarations, as follows:

> *(5) Whether the jurisdiction to make an anticipatory declaration should be exercised will depend on the facts of each case. The court will need to carefully consider the underlying principles of the MCA which is to protect and, where appropriate, make decisions for those who lack capacity in relation to a matter, but take all necessary steps to preserve the autonomy of those who have capacity. In The Shrewsbury and Telford Hospital NHS Trust Lieven J refused to make such a declaration as there was nothing more than a 'small risk' that the woman might lose capacity which was 'insufficient' to justify an anticipatory declaration, it risked the woman's autonomy being overridden and there were other ways of managing the situation, such as inviting the woman to enter into an advanced declaration or relying on necessity.*
>
> *(6) In deciding whether to exercise the jurisdiction under s15(c) the court will need to carefully consider a number of factors, including:*
>
> > *(a) Whether there are other ways in managing the situation, for example whether s5 MCA can be utilised. As Lady Hale made clear in N v A CCG [2017] UKSC 22 [38] '…Section 5 of the 2005 Act gives a general authority, to act in relation to the care or treatment of P, to those caring for him who reasonably believe both that P lacks capacity in relation to the matter and that it will be in P's best interests for the act to be done. This will usually suffice, unless the decision is so serious that the court itself has said it must be taken to court. But if there is a dispute (or if what is to be done amounts to a deprivation of liberty for which there is no authorisation under the "deprivation of liberty safeguards" in Schedule A1 to the 2005 Act) then it may be necessary to bring the case to court…'. This provision is not limited to only address emergency situations but there are clearly limits.*

[1] Tor having been involved in this case, she has not been involved in the writing of this note.

[2] There had been a previous reported case from Northern Ireland: *A Health and Social Care Trust v P and R* [2015] NIFam 19.

> *(b) The need to guard against any suggestion that P's autonomy and ability to make unwise, but capacitous decisions is at risk or any suggestion that the court is making overtly protective decisions.*
>
> *(c) To carefully consider the declaration being sought, and whether the evidence establishes with sufficient clarity the circumstances in which P may lack capacity and in the event that P does the circumstances in which contingent best interest decisions would need to be made. This is to guard against the risk that if the facts on the ground were analysed contemporaneously the court may reach a different conclusion.*

4. Declined, on the facts of the case, to make anticipatory declarations, and in so doing made observations which are of wider relevance:

> *138.* [….] *(6) P remains protected by the existing statutory framework in s5 and 6 MCA that give general authority to those caring for P who reasonably believe both that P lacks capacity in relation to the matter and that it will be in P's best interests for the act to be done. Using this framework will have the advantage that decisions are taken contemporaneously both as to capacity and best interests, having up to date information on matters such as P's wishes and are more appropriate to guard against such infrequent occasions as in this case. I recognise that s5 and 6 may not have been intended to provide a complete catch all means by which carers can implement a care plan and are arguably more designed to provide protection from liability for carers to carry out certain but not all tasks, but on the particular and unusual facts of this case that legal framework better provides for P as it has the advantage of decisions being made contemporaneously, particularly where, as here, the risks being guarded against happen relatively infrequently so need to be considered in the context of an extended time frame. I fully take into account the submission that by making an anticipatory declaration it could provide more certainty for carers but there is nothing preventing the crisis plan including the same information, whether or not an anticipatory declaration is made, as, in effect, the carers or others are going to need to be making the same capacity assessment whether a declaration is made or not.*

These latter observations are particularly helpful, because they reflect, in fact, what happens in the majority of situations involving fluctuating capacity which do not come to court. If they are truly situations of fluctuating capacity (as to which see our guidance note at paragraphs 55 – 60), then those seeking to provide care and treatment to the person will inevitably be proceeding on the basis of whether they reasonably believe at the relevant point in time that the person has or lacks capacity to consent to the relevant intervention.

A further point of interest in the case is that the woman herself (who was found to have litigation capacity and was therefore instructing her representatives directly) made very clear that she wished to be protected from the risks that she was at the point when she was dissociating and therefore lacking capacity to make the relevant decisions (see paragraph 138(3). Whilst not framed in precisely these terms, the judgment was therefore endorsing the creation of an advance choice document (included within a crisis plan) in which the woman was, herself, making clear that she wished robust steps to be taken in the name of her best interests to protect her. Such advance care planning is something which can be equally important in the context of other conditions, such as bipolar disorder, where the person themselves can identify both when they are well and unwell, and also wishes to endorse robust steps to protect them (including from themselves) when unwell. This can give rise to ethical dilemmas (see

this Radio 4 documentary), but can be enormously important in arming social care and health professionals with the knowledge that they are doing the 'right thing' at the time that the person is unwell.

A systemic failure as regards PDOC patients?

NHS NW London ICB v AB & Ors [2024] EWCOP 62 (T3) (Theis J)

Best interests – medical treatment

Summary[3]

Following a *"wholescale systemic review of their practices and procedures"* (paragraph 9) prompted by Hayden J's scathing criticisms in *North West London Clinical Commissioning Group v GU* [2021] EWCOP 59, a further application for the determination of the best interests of a patient in a state of prolonged disorder of consciousness ("PDOC") receiving clinically assisted nutrition and hydration ("CANH") at the Brain Injury Service at the Royal Hospital for Neuro-Disability ("RHN") has been heard before the Vice President, Theis J.

This case concerned AB, a then 50-year-old mother of three who, in 2015 suffered a catastrophic brain haemorrhage during an exercise class. After a period in intensive care, AB was transferred to the RHN where she remained, in PDOC, receiving CANH via a percutaneous endoscopic gastronomy ("PEG") for the next nine years.

In May of this year, and following the *GU* inspired review of existing practices at RHN, the relevant Integrated Care Board ("ICB") NHS North West London ICB brought an application for a determination of whether or not AB'S CANH should be continued.

Describing a "*systemic failure in the RHN to have the relevant framework in place for making these best interest decisions in a timely way*"; noting that, "*prior to the recent changes there was simply a vacuum within the RHN, with no system for best interest decisions to be made*" (paragraph 10) Theis J heard that, despite almost annual assessments of AB's PDOC, all of which showed no change in her consciousness from minimally conscious minus, no best interests review had been initiated until 2023 – seven and a half years after her admission.

Noting changes that had been brought about in the hospital in 2022 onwards, following its widespread review, Theis J observed that *"decisions need to undertake the balance whether treatment which may have enhanced the patient's quality of life or provided some relief from pain may 'gradually or indeed suddenly reach a pivoting point where it becomes futile, burdensome and inconsistent with human dignity. The obligation is to be vigilant to such an alteration in the balance' (per Hayden J in GU [105]). Whilst not detracting from the excellent care afforded to AB it is unacceptable that decision making structure did not happen in AB's case for many years due to the essential framework for that to be done simply not being present in the RHN*" (paragraph 12).

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

The court heard that AB had suffered some 20 plus infections during her admission; she had a long-term sacral sore and required suctioning via tracheostomy 3 times daily. While she was noted to move away from noise, to smile, to look up when her name was called, all of these responses were considered generalised and reflexive rather than as actual emotional responses to the outside world; she was noted to exhibit signs of discomfort during care, to grimace on movement and to have suffered a number of protractions as her PDOC persisted. While AB's continued survival was attributed to the resilience of her brainstem function, it was noted that her *"'loving, planning… brain, has not been there since 2015'"* (paragraph 29).

While the majority of her family supported the withdrawal of CANH, her son PB was recorded as "*expressing the view that AB "would want it to be natural", when she is 'ready"' although agreeing AB's current quality of life was not acceptable 'at all for anybody' but felt AB would want CANH to continue*" (paragraph 35). Otherwise, the court had no evidence as to AB's past wishes and feeling regarding life sustaining treatment.

Noting the burdens of treatment to AB, the minimal awareness that allowed for the experience of distress but provided no indication of experience of pleasure Theis J concluded

> *85. These amount to significant burdens to AB that arise both from her condition and from her treatment. Those burdens are, in my judgment, likely to get worse. I agree with the submissions of the Official Solicitor that AB now has little or no quality of life. Her life expectancy is inherently unpredictable, even with the high quality of care she is receiving and she is exposed to an increasing number of unpleasant, uncomfortable and undignified experiences through the level of nursing care that is required to keep her alive. AB's Article 2, 3 and 8 EHCR rights have been upheld by the RHN's adherence to the RCP PDOC Guidelines and the external review by Dr Nair and Mr Mitchell. The Article 8 rights of AB's family have been protected through their full participation in these proceedings.*
>
> *86. Considering the wide canvas of evidence, balancing the competing considerations outlined above I have, with deep sadness, reached the conclusion that AB's best interests in the widest sense require CANH to be withdrawn, as to continue to provide it is not in AB's best interests due to the very significant and increasing burdens her condition and treatment involves that outweigh the presumption of maintaining life.*

Comment

Theis J's conclusions were, arguably, inevitable in the face of unanimous medical evidence as to AB's condition and prognosis and an almost unanimous response from family members to the prospect of discontinuing life-sustaining treatment.

It is perhaps regrettable that the Vice President did not go further and provide guidance in such a case as to whether, in fact, a fully litigated application was warranted in the circumstances. The judgment refers to a potential further twenty-odd such cases in the pipeline (at paragraph 70). Given the medical consensus, it is at least arguable that the treatment available to AB was fast becoming treatment that no reasonable doctor should be agreeing to provide, such that, ultimately, there might be no "best interests" decision for the Court of Protection to make.

CQC and DOLS

In its most recent State of Care Report, the CQC has a lengthy and detailed 'area of concern' section on DoLS, the key findings being as follows:

- *Too many people are waiting too long for a Deprivation of Liberty Safeguards (DoLS) authorisation, despite multiple examples of local authorities trying their best to reduce backlogs and ensure sustainable improvement.*

- *We remain worried about the rights of people at the heart of the DoLS system. We continue to see people in vulnerable circumstances without legal protection, which not only affects them but also their families, carers, staff and local authorities.*

- *The system has needed reform for over 10 years. Unless there is substantial intervention, we are concerned that these challenges will continue.*

In relation to backlogs, the CQC notes that:

> *Variation in backlogs between different local authorities means people in similar situations may have different experiences of the DoLS system because of where they live. Many factors contribute to this variation, including budget allocation, the make-up of local populations, and the number of hospitals and care homes in an area.*
>
> *Local authority backlogs also have a knock-on impact on hospital and care home staff: while waiting for DoLS applications to be reviewed, they have to balance keeping people safe with protecting their rights. Our inspectors told us about staff feeling stressed and confused trying to navigate the DoLS system when waiting for an authorisation. Worryingly, our inspections and assessments have also highlighted instances where backlogs in processing existing applications mean some care providers have stopped submitting new applications. This means people have restrictions placed on them without an application or any legal safeguards.*

To understand the reasons for the backlog, CQC surveyed representatives from the National DoLS Leads Network and heard the views of over 50 respondents from supervisory bodies across England. This section is worth setting out in full:

> *We heard widespread concern from the local authorities that they are often significantly under-resourced to process increasing volumes of DoLS applications, as their funding has not increased in line with the number of people requiring assessments. One local authority told us:*
>
> > *DoLS is a broken system. It was designed for a pre-Cheshire West time with relatively few applications. It is impossible to make it work with the resources we have, leading to a big backlog…The situation is so bad that, if we just stopped getting any applications and just assessed people from the backlog, we would be doing this for around 18 months just to clear it.*
>
> *Insufficient staffing levels were also identified as a primary barrier to performance. Many supervisory bodies are struggling to recruit enough assessors, with some local authorities relying significantly on independent assessors to manage the volume of applications. Some respondents*

noted high staff turnover within DoLS teams, describing working in this area as a "marmite experience" where members of staff either thrive, or more often, leave the service.

Amid these challenging circumstances, a member of our external stakeholder group described local authorities going "above and beyond to create systems that are as safe as possible." NHS England data shows that the number of applications completed by local authorities has increased over the last 5 years by an average of 9% each year. But while DoLS backlogs decreased by 2% in 2023/24, the number of people waiting for an authorisation remains significant. In our assessments of local authorities, we have seen multiple examples of supervisory bodies trying their best to reduce backlogs and ensure sustainable improvement. For example, many local authorities adopt risk-based approaches and tools to prioritise applications. We also saw local authorities recruiting and training more best interests assessors.

Respondents to our National DoLS Leads Network survey frequently cited the ADASS screening tool as a way of helping local authorities to prioritise applications, by categorising them as either high, medium or low priority. However, this method relies on detailed, accurate DoLS applications. We heard that many local authorities are not always confident that the information services provide on DoLS applications is correct. This increases the risk that people who urgently require an assessment are not being appropriately prioritised. Although tools can help local authorities to identify those in need of urgent attention, the statutory 21-day timeframe applies to all standard DoLS applications and the need to prioritise may be another symptom of a broken DoLS system.

We are also concerned that the use of prioritisation tools may result in some groups of people, such as people with a learning disability or living with dementia, being disproportionately affected by delays in processing DoLS applications. A respondent from the National DoLS Leads Network noted that while these people usually meet the requirements for DoLS, they often do not meet the prioritisation criteria and may be "overlooked". We also heard from a member of our external stakeholder group about some assessments being carried out virtually. While this may offer greater flexibility, virtual assessments are not always suitable for the people who are being assessed. A member of our external stakeholder group reflected that differences in the way local authorities approach DoLS makes it difficult to support managers of care homes spread across different counties.

Local authorities told us that ongoing issues with the level of understanding of the safeguards among health and social care staff can exacerbate the backlogs. We heard that applications from care homes and acute hospitals are not always appropriate, and we have also seen evidence of this, with some staff unclear on the circumstances that require a DoLS authorisation. This risks people who need the safeguards getting lost in the high volume of referrals, or not having an application made when they need one. Local authorities found that the quality of mental capacity assessments made by providers before they submit an application was sometimes poor, which can also result in unnecessary applications. It also means that they may need to contact providers to get information that should have been included in the application, thereby delaying the process and requiring additional resources from all parties.

Another factor that has a negative impact on the backlogs is a lack of communication between providers and local authorities. When providers apply promptly for DoLS renewals, it can help reduce workloads for supervisory bodies. Yet, we heard this does not always happen in practice. In addition, local authorities are not always informed of important changes following submissions, such as a person dying, being discharged, admitted to hospital or their condition changing. These people therefore remain on the waiting list for DoLS when they may no longer need to be. In other

circumstances, providers may also not communicate important changes such as objections or increased restrictions, preventing local authorities from giving priority to some assessments that need it.

It is not entirely clear from this section whether or not the CQC endorses the use of the ADASS (or any other) prioritisation tool.

The variation in the application of DoLS was also a theme CQC picked up in relation to the services themselves.

Our assessments highlighted some differences between hospitals and care homes in the way DoLS are applied. Because the length of stay in an acute hospital tends to be shorter than in a care home, DoLS backlogs mean often patients are not assessed before they are discharged or moved elsewhere. This means that people at the heart of the process may not practically benefit from the protection afforded by the safeguards for most of their hospital stay, despite the work and resources used by providers and local authorities to follow the process in line with the law.
Where a person has a DoLS authorisation in place during a hospital stay, we have seen the positive effects of this on their care. For example, in one case the authorisation meant staff were more aware of the patient's needs, which was evident in care records. By better understanding the patient and tailoring their care, staff were able to prevent escalations.

However, we also identified a lack of communication about DoLS at some acute hospitals, which affected numerous patients on the ward. For example, we found that people sharing a ward with someone subject to a DoLS authorisation did not always know that certain restrictions, like not being able to open locked doors, only applied to one person. In mental health inpatient settings, we continue to see different interpretations of the interface between the Mental Health Act and the Mental Capacity Act, with the safeguards being used more frequently in wards for older adults.

Although staff should be familiar with the conditions for a DoLS authorisation, this is not always the case. We identified limited oversight of DoLS at some services and we are concerned that the safeguards are viewed as a 'management issue' rather than something every team member needs to engage with to protect people's human rights. A local authority also told us that frequent staff and management changes in care homes represents a challenge, as local authorities do not have the resources to regularly undertake in-depth work with providers to improve their understanding and application of DoLS
.
While there is a clear need for further training, we found examples of a lack of training on DoLS in anticipation of the introduction of the Liberty Protection Safeguards. A member of our external stakeholder group explained that providers had invested energy preparing for LPS and some were finding it difficult to adjust to uncertainty around its implementation at such a late stage. However, it is vitally important that services ensure staff have adequate knowledge of DoLS to protect people's human rights – both now and in the future.

It is clear that there are wider problems than merely DoLs as regards the understanding of the MCA:

Concerns around providers' knowledge of DoLS and the MCA are mirrored in an analysis of our regulatory enforcement data on Notices of Proposal. At the point of registration, we expect all providers to demonstrate a clear understanding of the MCA and, when applicable, DoLS. As the regulator, we will serve a Notice of Proposal to impose conditions on a new provider or refuse

registration if they cannot demonstrate this. We analysed a sample of 139 Notices of Proposal issued in 2023/24 to new adult social care providers and managers applying to register with CQC. This found that almost half the Notices (66) were based on a lack of compliance with standards outlined in the Mental Capacity Act (MCA). In many cases, applicants also failed to demonstrate compliance with other regulations.

The Court of Protection gets a look in later in the discussion:

Several local authorities felt that more challenges to DoLS authorisations have been brought to the Court of Protection in recent years. When a DoLS authorisation is in place, people have a right to have these arrangements reviewed by a court. It is positive that people are aware of their rights to challenge a deprivation of liberty and are supported to do so. However, a local authority also told us that this can be a time-consuming process, which has a further impact on their resources.

Earlier in this report, we raised concerns about older teenagers who may fall through the gaps when accessing mental health services. Similar concerns about the quality of transitions from children to adult services have emerged through our DoLS survey, with one local authority noting that a 'start again syndrome' may happen when a young person enters adult services. They said the information provided by children's services is often insufficient for planning a DoLS application, which can lead to delays in the DoLS process when the person turns 18. At present, the Court of Protection is also responsible for authorising a deprivation of liberty for young people aged 16 and 17 who lack mental capacity, as DoLS only applies to adults. We heard some frustration from local authorities about delays in LPS implementation, as the new scheme would have helped to speed up authorisations for these young people. Like the DoLS process for adults, we have heard that there continue to be delays associated with the Court of Protection authorisation process.

The concluding remarks are stark:

The DoLS system has needed reform for over 10 years. Unless there is substantial intervention, we are concerned that these challenges will continue, leaving people at the heart of this process without the key human rights safeguards that the DoLS system was intended to offer.

In 2023/24, approximately half of the total number of DoLS applications completed were closed without any assessments happening. This means that, in many cases, the DoLS application process may not bring increased safeguards for people's human rights, despite the efforts and resources used by care homes and hospitals to submit applications, and local authorities' work to process and triage these.

With the volume of applications continuing to increase, the current system means that local authorities remain the only organisations able to process them, and many have told us they do not have sufficient resources to cope with the demand. Supervisory bodies told us that increased funding, an updated Code of Practice, better training and regulatory oversight are all factors which could help to improve outcomes for people while we wait for the LPS to be implemented.

While we heard that DoLS remains an "overly bureaucratic system", local authorities across England have also implemented some improvements to help existing processes run more smoothly. These include:

- *making assessments proportionate and using equivalent assessments when appropriate*

- *streamlining administrative processes, using IT systems and updating forms*
- *developing strong working relationships between local authorities and providers to improve communication, especially when circumstances change or when a renewal is due*
- *workshops and training for providers to reduce the number of inappropriate applications they receive and improve the accuracy of applications.*

Despite these efforts, we remain concerned that the number of people requiring the legal protection afforded by DoLS continues to increase and the system is unable to cope with this demand. Ongoing issues with the DoLS system will disproportionally affect certain groups, such as disabled people and older people, who are more likely to need the safeguards. A recent report by Age UK highlighted that in 2022/23, 84% of DoLS applications were made for people aged 65 or over, and almost 50,000 people died while waiting for their application to be processed. Reflecting on the operation of DoLS, the charity said, "The reality therefore is that the rights of some of the most vulnerable older people in our society have been and continue to be routinely denied."

Too many people are waiting too long for a DoLS authorisation, while variation in the level of knowledge of staff means that others may not have a DoLS authorisation in place when they need one. For many, the current DoLS system is not providing the vital safeguards they need. After a decade of chronic and widely documented issues, urgent action is required to ensure the system does not continue to fail people in the future.

PROPERTY AND AFFAIRS

Reversing reverse indemnities?

Re BJB [2024] EWCOP 59 (T2) (SJ Hilder)

CoP jurisdiction and powers – interface with civil proceedings

Summary

This is the first reported judgment from Senior Judge Hilder relating to so-called *Peters* undertakings; in this case, a reverse indemnity undertaking, whereby BJB was obliged to remit 98% of public funding received to the tortfeasor.

BJB suffered a hypoxic brain injury at birth, which caused her to have dystonic cerebral palsy; she requires 24-hour care. She lived with her family until 2020, when she moved into her own home with a package of care, which since 2022 has been primarily funded with direct payments from the local authority.

She received damages from the NHS in 2009, with her father acting as her litigation friend, on a 98% liability basis. She received a lump sum payment of £1.4m and periodical payments which are adjusted annually for inflation, and are now approximately £132,000. Her father, as litigation friend on behalf of BJB, gave undertakings in the Queen's Bench Division that he would inform the NHS annually "*of the amount of 'state provision' received by BJB, 98% of which is then offset against the periodical payment due to be paid*" (paragraph 10). Specifically, the litigation friend committed to returning any local authority community care funds received to the NHS. Nothing in the orders appointing BJB's receiver (under the pre-MCA regime) and then deputy made any reference to the terms of BJB's damages award.

There was included in the QBD order a mechanism for release from these undertakings, recorded as follows at paragraph 11 of the judgment:

> *The Claimant and Defendant are agreed that the Claimant may be released from any of the undertakings given within this schedule at the discretion of the Master of the Court of Protection or his successor in the event that he is satisfied that the Claimant does not have sufficient resources to meet his (sic) reasonable needs…'*

There was no limitation on BJB applying for state funding, and the deputy would not need to be released from any such undertaking; however, BJB (and it would appear, the deputy, as the person being charged with handling her property and affairs) was to return 98% of any such funds to NHS Resolution.

In 2023, BJB's property and affairs deputy made an application to the Court of Protection for release from the reverse indemnity undertakings. That application was opposed by the Hospital Trust which was the Defendant to the damages claim, and by NHS Resolution.

It appears that the direct payments rose considerably in 2022 to a level near that of the periodical payments, with previous payments having been lower due to BJB receiving care from her family (though it was not clear how much had historically been reverted). BJB's overall income had remained essentially static as the amount of the direct payments had been subtracted from periodical payments.

The deputy estimated that BJB's outgoing expenses now exceeded her income by £5000/month, with BJB receiving approximately £3,000/week in a direct payment for her care from the local authority. Fifteen years after the lump sum payment was made, she continued to have capital in the amount of approximately £1.09m. The deputy argued that using capital to 'top up' the difference in cost between the local authority's direct payments and the actual cost of care "*does not provide a solution because it will be exhausted in around ten to twelve years, leaving BJB, then at a relatively young age, reliant exclusively on benefits. Her modest quality of life would dramatically fall*" (paragraph 29). The deputy argued that her resources were not sufficient to meet her reasonable needs, and the condition for discharging the undertaking was met.

At the time of the application, it was anticipated that "*the amount received from direct payments would exceed BJB's periodical payment, which would therefore be extinguished under the terms of the settlement order*" (paragraph 15).

The deputy's application for release from the undertakings was prospective, and there was no application for reimbursement of sums deducted from periodical payments in previous years.

NHS Resolution's opposition to the application for release varied, with the initial objection being on the basis that "*if the claimant were to be released from the reverse indemnity undertaking as she seeks then it appears that there would almost certainly be double recovery*" (paragraph 17). NHS Resolution argued that BJB would have a surplus income of £32,000 to £67,000 annually if she were no longer obliged to return local authority direct payments to the NHS. However, NHS Resolution's case on whether she had sufficient resources to meet her reasonable needs was less obvious from the judgment.

The deputy argued (filing evidence from her case manager) that BJB required 24-hour 1:1 care, and this assessment was apparently agreed by the local authority. It is not apparent how the local authority had reached the determination that BJB's needs could be met for approximately £3000/week, when her actual care package was considerably more expensive; it is not known whether the local authority had taken any view on whether BJB required a solo provision, or whether it considered that her needs could be met by continuous care in a shared setting.

NHS Resolution's case appears to have changed in the course of the application, and it appears that evidence was filed quite late, leading to it not being taken into consideration. Senior Judge Hilder was critical of the manner in which NHS Resolution had participated, stating that it had "*not challenged the reasonableness of BJB's current arrangements. They have not filed any financial evidence. Their objection to the application is in essence objection to BJB having recourse to <u>both</u> state provision <u>and</u> periodical payments to meet the costs identified by the Deputy*" (paragraph 30, emphasis in original).

NHS Resolution argued that the periodical payments were to cover care and case management, and the lump sum was to cover the other heads of loss. However, "*the presumption which underpins lump sum awards of damages is that a claimant will invest the award in such a fashion that she will be able to use the income and draw down the capital over her lifetime to fund her needs, such that by the end of her life the award will have dissipated*" and "*all the outgoings identified by the Deputy except contributions to direct payments 'will have been provided for in the calculation of the lump sum' approved in the settlement order*" (paragraph 31). NHS Resolution argued that the periodical payments were no longer required as the local authority was now paying an amount to meet BJB's needs in excess of the periodical

payments. It was argued that the periodical payments which were only required where state provision (the direct payments) was less than the amount of the indexed periodical payments.

NHS Resolution argued that BJB was thus not disadvantaged, as she was receiving a higher amount from the state than she would receive from the periodical payments. It was suggested (apparently without evidence) that BJB's funds had not been effectively managed so as to provide her with a higher income from capital; this argument found no traction with the court. It was argued that BJB's projections apparently allowed her to rely on both local authority funding and index-linked periodical payments without ever having to draw on her considerable capital, and it was not reasonable that she would be released from the undertakings without any obligation to draw on capital.

After reviewing relevant case law, Senior Judge Hilder began by considering her jurisdiction in this matter. It was asserted by the deputy that her jurisdiction arose either under s.19 Senior Courts Act 1981 read together with s.47(1) Mental Capacity Act 2005 (essentially granting the Court of Protection the right to make a High Court order) or to take this as a decision under s.16(2)(a) Mental Capacity Act 2005. NHS Resolution did not set out any basis for jurisdiction, but accepted that the Court of Protection did have the necessary jurisdiction.

Senior Judge Hilder rejected both of the routes to jurisdiction offered by the deputy, but considered that "*there is in the matter now before me some sort of obligation on the Court of Protection to 'adjudicate as between the claimant and the defendant.' That obligation comes from the High Court having made an order which incorporated the clause 5 mechanism agreed between the parties, and the Deputy's COP1 application properly made in the light of it*" (paragraph 51). She concluded that she did have jurisdiction on the following basis:

> *57. So, where does my jurisdiction lie?*
>
> *58. Capacitous disputants may agree to accept the determination of any third party if they so wish – a qualified arbitrator, an elder of their community, even the milkman. The authority of that third party comes from the agreement of the disputants to accept what they decide. In this matter, where BJB herself lacked capacity to take such an approach, the High Court has approved an agreement between her proper representatives and the defendant to her claim to accept the determination of the Senior Judge of the Court of Protection. I conclude that my jurisdiction is this matter is a jurisdiction by approved consent.*

Senior Judge Hilder goes on to describe how the matter came before the court, and how the court would exercise its jurisdiction:

> *61. The matter has come to me via usual Court of Protection procedures and therefore within the framework of the Mental Capacity Act 2005. It is a principle of that Act that an act done or a decision made under it for or on behalf of a person who lacks capacity must be done or made in their best interests.*
>
> *62. There is an obvious tension between a jurisdiction based in best interest decision making, and an adjudication between claimant and defendant. Clause 5 of BJB's settlement was approved before that tension was spelled out either by Senior Judge Lush in Reeves or by Lord Justice Longmore in Tinsley, but I proceed on the basis that the High Court must have intended, and the*

parties in the High Court proceedings must have agreed to, the incorporation of the best interest principle into the determination of the clause 5 release mechanism.

63. So, I approach this matter:

a. first, by asking myself if I am satisfied that BJB does not have sufficient resources to meet her reasonable needs (the factual issue as spelled out in clause 5 of the settlement approval order);

b. and then, in the light of that conclusion, by asking myself whether it is in the best interests of BJB that her Deputy should be released from the reverse indemnity undertaking.

64. It should be clear from that approach that I am not determining any issue of 'double recovery.' If that is a deficiency, then in my judgment it is a deficiency to which the defendant in the damages claim consented and which the High Court approved. The place for addressing such deficiency is the court considering the damages claim, not the Court of Protection.

In considering whether BJB had sufficient resources to meet her reasonable needs, the only evidence before the court was from the deputy, and NHS Resolution did not challenge the contention that BJB had an additional reasonable expenditure to meet her needs of approximately £7,600 per month / £91000 per year in addition to what was currently met by the direct payments, resulting in an overall deficit (after taking into account BJB's other income) of £60,000 annually while the reverse indemnity was in effect. Senior Judge Hilder did not consider that there was any bar on the deputy's using the periodical payments to meet needs other than care and case management needs, nor that the theoretical purposes of the lump sum and periodical payments assisted: the question was whether the overall level of BJB's resources met her overall needs. It was also recognised in a recital in the QBD order that 'there may be an upward shift in BJB's needs after the age of 30 (ie around now), and that the approved sums made no allowance for that.' (paragraph 70) Senior Judge Hilder considered that this recital 'very clearly point[ed] to the mechanism for release from the reverse undertaking.' (paragraph 70)

Senior Judge Hilder summarised her consideration of this issue thus:

72. So, even accepting that all of BJB's expenditure except contribution to direct payments was in contemplation when the lump sum was agreed, when asking myself if I am satisfied that BJB has sufficient resources to meet her reasonable needs, what I consider is:

a. all of her resources, including both capital awarded and other mechanisms in the settlement order; and

b. her reasonable needs as I have found them to be, not as capitalised in the approved award.

The only evidence before the court on how long BJB's funds would be able to sustain the needs which Senior Judge Hilder found to be reasonable was evidence from the deputy, which stated that BJB's funds would be extinguished in 10-12 years, with BJB having a life expectancy of over 40 more years. Senior Judge Hilder considered whether the application was premature, but accepted the deputy's argument that "*having already reached the point where resort to capital was needed, it would not be*

acceptable for the Deputy to wait any longer to make the application because, if it were to be refused, she would need to make adjustments to BJB's expenditure (and therefore lifestyle) now to ensure that BJB's resources went as far as they possibly could" (paragraph 74). In contrast, NHS Resolution had not filed any evidence that BJB would have a significant surplus, and the Senior Judge Hilder considered that "*any outcome of double recovery is not a matter for me to adjudicate*" (paragraph 75).

Senior Judge Hilder did not consider NHS Resolution's suggestion of a revised reverse indemnity was appropriate, as "[t]*he approved mechanism for release from the reverse indemnity undertaking is binary only (release or not), on the single threshold of sufficiency of resources to meet reasonable needs. For the same reasons that I have declined to take into account submissions as to effect of exercising that mechanism, I also decline to read into it any more sophistication than a binary option"* (paragraph 76). Senior Judge Hilder accepted the effectively unchallenged evidence of the deputy on "*income and expenditure and the only evidence before me in respect of how far BJB's capital will stretch, it follows that I am satisfied that BJB does not have sufficient resources to meet her reasonable needs. It is therefore open to me pursuant to clause 5 of Schedule 2 of the settlement approval order to release the Deputy from the reverse undertakings of that Schedule. To consider that, I look to the best interests of BJB*" (paragraph 77).

At paragraph 78, Senior Judge Hilder readily found it was in BJB's best interests to have:

> *access to the widest possible resources to meet her needs. If the Deputy is released from the reverse indemnity undertaking, there is no obligation to account for whatever state provision she receives and therefore no deduction from the periodical payments she will receive. I am satisfied that this outcome is in BJB's best interests, and I should release the Deputy from the undertaking.*

Senior Judge Hilder made a closing observation that

> *80. Along with Senior Judge Lush in Reeves and with Lord Justice Longmore in Tinsley, I too doubt that it is right for issues which arise in civil litigation to be transferred to the Court of Protection in the way that they were, some time ago, in this matter. When I asked counsel before me they confirmed that, to the best of their knowledge, orders with a Peters undertaking are no longer being made. I welcome that development.*

Comment

The closing observation of the judgment echoes concerns raised by other courts about the appropriateness of leaving decisions about the discharge of components of settlements in the KBD to the Court of Protection, and it is clear that in taking this decision, Senior Judge Hilder had to adjudicate on issues which would not normally be the subject of Court of Protection proceedings. From the tone of the judgment and comments made, it is clear that Senior Judge Hilder had concerns as to whether NHS Resolution had submitted appropriate evidence to the court; it also appears that it did not meaningfully challenge any of the evidence filed by the deputy, or the jurisdiction of the court to vary KBD orders.

In the absence of NHS Resolution contesting key aspect of the deputy's case, we would question the value of this judgment as precedent, and note a number of points which may require consideration in future judgments.

Jurisdiction: We cannot see that under the Mental Capacity Act 2005, the Court of Protection has any power to discharge undertakings made in the KBD, a conclusion Senior Judge Hilder appears to have agreed with at paragraphs 54-57. It is also emphasised in this case that no party was actually raising a challenge to Senior Judge Hilder's jurisdiction, and thus it is unsurprising that this issue was addressed relatively briefly in the judgment. However, we continue to find this issue vexing. While the explanation of the court's route to jurisdiction at paragraph 59 is noted (that the parties would have been free to agree to 'accept the determination of any third party if they so wish…even the milkman' and this would grant that third party the 'authority' where the High Court had approved the agreement), it does not make clear whether this decision was considered to be delegated to the Senior Judge in his or her personal capacity, or as a judicial office within the Court of Protection. Did Senior Judge Lush's agreement to adjudicate this decision (and hold the power to discharge a QBD undertaking) apply to him specifically, or was he able to bind his successors in post and obligate them to act as an adjudicator? Could the hypothetical 'milkman's' agreement to adjudicate the dispute bind his successor as milkman on his retirement? Could the decision have been delegated to a named criminal judge who was considered appropriate at the time (for example, the Recorder of Liverpool) and bound subsequent holders of that judicial office decades into the future?

It is unfortunate that NHS Resolution did not probe this issue more fully, as we are not clear how a judge (in this case Senior Judge Lush) had the power to obligate his judicial successors to adjudicate disputes in courts in which they did not sit. We are also not clear that an agreement between parties in the QBD formalised by an undertaking (even where accepted by a QBD judge) could obligate a future judicial office holder in another superior court of record to use their time and resources on that dispute. We note that Senior Judge Hilder considered at paragraphs 50-53 that she was obligated to act in this matter, but we were less clear that the parties had any right to place this obligation upon her simply because Senior Judge Lush had agreed to act 15 years ago.

Role of the Court of Protection: The point above then leads to the question of whether in determining this dispute, Judge Hilder's authority arose as a result of her sitting as a judge of the Court of Protection at all, or whether she was essentially an arbitrator at the agreement of the parties, and the agreement of Senior Judge Lush that his successor would act as arbitrator – which would not appear to be an MCA decision. The concept of jurisdiction arising as effectively an arbitration agreement between the parties does not obviously square with the observations at paragraph 61 that "the matter has come to me via usual Court of Protection procedures and therefore within the framework of the Mental Capacity Act 2005. It is a principle of that Act that an act done or a decision made under it for or on behalf of a person who lacks capacity must be done or made in their best interests." It does not appear that the MCA 2005 had any part to play in this decision, as it did not appear within the settlement, and there was no express requirement in the order approved by the QBD for BJB's best interests to be released from the undertaking. Arguably, the sole issue that the QBD order provided for determination at any future point was whether BJB had sufficient resources to meet her reasonable needs. The application for any determination under the MCA 2005 appears to have been unnecessary here and it is not clear why this

came before the court via a 'usual' Court of Protection application, as it is not obvious that any decision was required under the MCA.

We would also express some concern as to how the MCA concept of "best interests" would come to bear on this issue: the question of release from a QBD undertaking is not a decision a person could take for him or herself, and the MCA 2005 would appear irrelevant. There would plainly be commercial implications for NHS Resolution in the discharge of the undertaking, as the undertaking would have created an ongoing revenue stream for the Respondent to offset the periodical payments. While NHS Resolution focused on 'double recovery', this would appear to have little relevance, as the key issue for the KBD Respondent was that it was losing its revenue stream by the discharge of the undertaking, which doubtless would have been a significant factor in agreeing the original settlement. The balance of rights between the parties in civil litigation in this matter appears, in reality, to have little to do with the MCA; this suggests that the issue of whether the conditions for discharge of the undertaking had been met would appear to be much better-suited to adjudication in the KBD.

Sufficiency of resources: There does not appear (on the face of the judgment) to be any criticism of the local authority's assessment of BJB's needs or its provision of direct payments to meet those needs. This would appear to imply that (a) the local authority had prepared a care and support plan which was capable of meeting BJB's Care Act-eligible needs and (b) provided direct payments in the amount required to provide this care and support plan. The deputy and case manager had chosen to arrange a care package which appeared to be considerably more expensive than the care package that the local authority considered capable of meeting her needs for care and support, and indeed, one beyond what was capable of being purchased with the additional funds from the periodical payments (which had been until recently less than the direct payments).

It is not obvious to us why NHS Resolution did not attempt to argue that, in the absence of any public law challenge or indeed any apparent criticism by the deputy, the local authority's care plan and corresponding level of direct payments were sufficient to meet her reasonable needs for care and support, and BJB had ample resources for non-care related expenses where BJB had higher-rate benefit income and capital of £1.09m to meet non-care related expenses. It appears to have been accepted by NHS Resolution that BJB's current level of expenditure (which resulted in her having an annual deficit of £60,000) was 'reasonable' and there was no obligation on the deputy to look to more sustainable arrangements even if those resulted in some changes in BJB's care arrangements or lifestyle. If NHS Resolution accepted that this expenditure was reasonable and it again appeared to accept the evidence (or at least, failed to file any credible evidence to the contrary) that she could not sustainably meet these needs in the long term, it is not entirely obvious why NHS Resolution chose to oppose this application at all. Again, it is not clear what the outcome of this decision would have been had NHS Resolution put in some focused evidence on this point and the court had had to determine a contest of what constituted a sufficient care package to meet BJB's 'reasonable' needs.

Periodical Payments: It does not appear to have been recognised by any of the parties in the case, the local authority or raised with Senior Judge Hilder, that BJB's periodical payments are not generally exempt from charging for the purposes of adult social care, and she will likely be obliged to pay most or all of these payments to the cost of the local authority direct payments. This misapprehension appears to have been at least part of what led to NHS Resolution's understanding of the double recovery

which was likely to exist if the undertaking was discharged. This issue is covered in detail in Arianna's book, 'Social Care Charging,' but briefly, unlike capital derived from personal injury awards, periodical payments are subject to a much more limited disregard under paragraphs 15 and 46 of Schedule 1 of the Care and Support (Charging and Assessment of Resources) Regulations 2014. The local authority is likely to be the primary beneficiary of BJB's being released from the undertaking, as she will likely be subject to very considerable charges from the local authority (where she now only contributes £282.36/month).

Personal health budgets and deputies

Lumb v NHS Humber and North Yorkshire ICB & Anor [2024] EWCOP 57 (T2) (SJ Hilder)

Deputies – property and affairs

Summary

This judgment considered an application by SBB's professional deputy (Daniel Lumb) to be discharged from his role. The central issue was what involvement a property and affairs deputy can/should have in the management of a Personal Health Budget under the National Health Service (Direct Payments) Regulations 2013 and specifically (as set out at paragraph 2):

a. *is management of a Personal Health Budget within the standard authorisations of a property and affairs deputyship?*

b. *can a property and affairs deputy be a 'representative'* [under the Regulations]*?*

c. *can a property and affairs deputy act as 'nominee'* [under the Regulations]*?*

d. *is the appointment of a 'representative' or a 'nominee' a best interests decision that the Court of Protection can make on behalf of SBB?*

e. *in the light of the conclusions to these questions, what steps should be taken in respect of deputyship for SBB?*

Senior Judge Hilder noted that "*Mr. Lumb has previously been involved in proceedings concerning local authority social care direct payments, a consent order from which is published at [2021] EWCOP 56. It is important to be clear from the outset that this judgment is concerned with a different direct payments scheme, in respect of health bodies rather than local authorities, to which different regulations apply*" (paragraph 3). However, the conclusions of the court as to the scope of the property and affairs deputy are broadly aligned between this judgment and the 2021 consent order.

SBB had a property and affairs deputy appointed in 2017, who was appointed, unusually, despite SBB not having any significant private assets, and having his income only from state benefits. SBB qualified for NHS Continuing Healthcare, and had a personal health budget (PHB) to purchase a package of care while he lived with his parents (a situation which has now persisted for many years). His care was provided by the ICB paying SBB's parents. The deputy was appointed to manage SBB's PHB, with the

then-CCG funding his care. The original deputy was discharged as a result of safeguarding issues, and Mr Lumb was appointed in 2020 on standard deputyship terms.

The direct payments, though provided by the ICB, were paid through a system administered by the local authority, but the local authority did not have any decision-making authority. There was agreement that SBB's parents should not administer the direct payments, where they were the primary people being paid out of the direct payments.

Mr Lumb came to the view that deputyship was not required, though an application was made to call in the original deputy's security bond; the Court of Protection considered that consideration of discharge of Mr Lumb should follow resolution of the application to call in the security bond.

After the resolution of the call-in, Mr Lumb applied for discharge of the property and affairs deputyship on the basis that SBB did not require a deputy, and that acting as a 'representative' for the purposes of a PHB was not within the scope of a property and affairs deputy's general authority. This was opposed by the ICB, which submitted that "*SBB requires a property and affairs deputy to act as SBB's representative or nominee, and that acting as such falls within the general authority of a property and affairs deputy appointed under the standard order. It is prepared to commit to meeting the costs incurred by a property and affairs deputy in managing the Personal Health Budget*" (paragraph 4(b)). The ICB was prepared, in the alternative, to appoint case management companies as the 'representative' for PHB purposes.

Noting the provisions of ss.16 and 18 MCA, Senior Judge Hilder observed that at least three of the 11 sub-sections of the powers contained in s.18 MCA[4] "*do not concern management of 'assets' which 'belong' to P. From this it may be inferred that "ownership' is not the key defining feature of a person's 'property and affairs ' ...and 'affairs' has a wider meaning. On the other hand (and noting that SBB does not have a profession, trade or business), it seems to me that only (g) could be understood as possibly contemplating dealings with money belonging to a third party, such as an obligation to pay it back*" (paragraph 35). Senior Judge Hilder also noted that under s.16(5), the court may confer on a deputy such powers or impose on him such duties, as it thinks necessary or expedient for giving effect to, or otherwise in connection with, an order or appointment made by it under subsection (2), but that this provision "is to be understood as qualified by other provisions of the Act" (paragraph 38). In particular, the deputy had authority to deal with both P's property and affairs under s.16, though other parts of the MCA referenced property only. Looking to "*Re ACC & Ors [2020] EWCOP 9 at paragraph 53.7(c), that* […] *general authority of a property and affairs deputy does not encompass determination of the care needs of P but does encompass the application of P's funds to meet the costs of P's care arrangements including, if those arrangements involve direct employment of carers, preparation of employment contracts*."

Senior Judge Hilder declined "*to make a definitive conclusion on the legal basis on which direct payment monies move from the bank balance of the health body to the bank balance of the person whose care plan they are intended to facilitate. Rather, I limit myself to considering whether direct payment monies form*

[4] (c) the acquisition of property in P's name or on P's behalf; (g) the discharge of P's debts and of any of P's obligations, whether legally enforceable or not; (k) the conduct of legal proceedings in P's name or on P's behalf.

part of SBB's "property and affairs" for the purposes of sections 16 and 18 of the Mental Capacity Act 2005" (paragraph 47). Her conclusion, based on the relevant regulatory scheme, was that "*the patient receiving direct payments does not have a right of free disposal of those monies. They must be applied for a specific purpose. The paying body exercises significant control over how funds are held, and some rights to recover payments made. None of these characteristics sits comfortably with the common understanding of 'property and affairs' as managed by a deputy*" (paragraph 49).

Rejecting the submissions of the ICB that direct payments became P's property, Senior Judge Hilder found that:

> *54.* […] the *ICB's attempt to equate direct payments of a Personal Health Budget with payments of state benefits is misconceived. State benefits can be used as the payee pleases, and when the payee dies whatever remains (as long as it was not erroneously paid post-death) forms part of his estate. In contrast, it is not permissible for anyone to expend direct payments of Personal Health Budget in any way other than to give effect to an agreed care plan and, even where properly paid during the patient's lifetime, repayment obligations can arise. From this I conclude that the patient does not 'own' the direct payments in the sense considered at paragraph 36 above and the majority of the eleven particularisations at paragraph 18 of the Mental Capacity Act 2005. In that sense, we may say that direct payments are not P's "property."'*

However, Senior Judge Hilder did find that an incapacitous person who receives direct payments "*incurs obligations in respect of them; and discharge of a person's obligations, whether legally enforceable or not, is explicitly within the powers of the Court at section 18(1)(g) of the Act. So, I conclude that direct payments do fall within the meaning of '… and affairs' as envisaged in section 16(1)(b) of the Act*" (paragraph 55).

Senior Judge Hilder then turned to the question of whether the management of direct payments comes within the standard authorisations of a deputyship appointment; or, if it does not, whether such authorisation could be specifically granted. Judge Hilder concluded that 'representative' for the purposes of PHB direct payments:

> *must be able to 'plan' care arrangements - as in 'devise' them, not simply make administrative arrangements to pay for them. Such 'planning' of care arrangements is* ***not*** *within the standard authorisations of a property and affairs deputy* (paragraph 69)

Senior Judge Hilder also noted that the role was similar to the appointment of an 'authorised person' in social care, a role which had already been found to be outside of the scope of the standard deputyship order in the 2021 decision. The ICB also eventually accepted that the Regulations required some authority of a welfare type.

Senior Judge Hilder noted that the realities of deputyships did not appear to align with the role of the 'Representative' under the Regulations, as this appeared to require a person who had both authority to act for P in relation to welfare matters and P's property and affairs. Judge Hilder observed that welfare deputies were relatively uncommon. She also considered that this conclusion had implications for the potential appointment of a Trust Corporation replacement property and affairs deputy, which, like Mr Lumb, would not have welfare authority in respect of SBB.

In considering whether a property and affairs deputy could be appointed' by the health body as 'representative' pursuant to' the PHB Regulations, Senior Judge Hilder noted that the regulations permitted the health body to appoint another person it considers appropriate to receive and manage the direct payments for the person lacking capacity. Senior Judge Hilder went on to observe that:

the Personal Health Budget representative is required to make decisions about healthcare and help develop care plans. This is an important aspect of extending the objective of 'choice' to those who, because of incapacity, need someone (other than the public body) to have determinative input into their care arrangements.' (paragraph 79)

She concluded that:

> *subject to consent, within the regulations the health body could appoint a standard terms property and affairs deputy ('D') to act as representative but that appointment would not alter the terms of the deputyship. If D agreed to act as representative, it would be outside the deputyship (leaving the oversight provisions within the Regulations themselves, without the extra supervision by the OPG.) Notably, the fees authorisation in the deputyship appointment would not extend to fees from P's funds for acting as appointed representative. Neither could the direct payments themselves be used to pay such fees. Since it is a reality of life that those who act as professional deputies would be likely to expect to be paid for their work, it seems unlikely that any such deputy would consent to such appointment unless the health body agrees to pay fees in respect of it. The health body would then presumably need to consider whether D - as opposed to, say, a case manager - represented the most appropriate appointment, in terms of best value for money and otherwise.* (paragraph 80).

The proposal of the court standing in the shoes of P to appoint a 'nominee' to manage the payments was rejected, as there is:

> *specific provision in regulation 5 as to when direct payments may be made in respect of persons who lack capacity. In circumstances where an administrative scheme itself makes provision for putting in place arrangements for management of direct payments where the recipient cannot make those arrangements themselves, it is unlikely to be appropriate for the Court to step in and make the nomination. The scheme stands self-contained….through a representative; and regulation 5(3) and (4) makes provision for where there is no representative - a health body may appoint another person it considers appropriate to receive and manage the direct payment* (paragraph 85)

However, that power rested with the health body to appoint a person, not with the Court of Protection, and "[t]*he regulatory requirements on a nominee do not fit within the standard authorisations of a property and affairs deputy*" (paragraph 91).

In considering whether the Court of Protection could specifically authorise a deputy to manage direct payments of a Personal Health Budget, Senior Judge Hilder concluded that this was possible, but cast some doubt on whether it would be desirable in this case. She noted that the ICB accepted in principle that a case manager could be appointed as the 'representative' for SBB, and stated her agreement that "*a case manager would be a suitably experienced and qualified professional to take on the role of SBB's representative for the purposes of a Personal Healthcare Budget, particularly well placed to challenge, where necessary, any decisions about the care plan so as to give meaning to the notion of 'choice' on which such Budgets are based*" (paragraph 101). She agreed to the discharge of Mr Lumb, and

concluded that "no appointment by the Court is required at all to facilitate a Personal Health Budget for SBB" (paragraph 103).

The judgment also included two significant footnotes:

Footnote 1: Judge Hilder did not reach a conclusion as to whether the deputy's administration of direct payments avoided any need for paid care staff to be CQC-registered. She noted that "*the evidence of Patrick Wright of the CQC was that he was unable to say definitely whether a property and affairs deputy acting as representative for direct payments of a Personal Health Budget would be exempt from registration requirements*."

Footnote 2: In relation to the ICB's agreement to pay for the deputyship fees, Senior Judge Hilder noted that "[a] *capacitous person receiving direct payments would not ordinarily incur fees for management of those monies. As a starting point, it is therefore difficult to see why an incapacitous person should be expected to bear such costs*."

Comment

Where precisely the line is between property and affairs and health and welfare is a matter which is not always entirely clear. As Hayden J noted in *PSG Trust Corporation Ltd v CK & Anor* [2024] EWCOP 14 (at paragraph 31):

> *Many financial issues have welfare implications, taking out mortgages, finance agreements, sustaining an extensive overdraft. This view seems to me to be entirely consistent with Judge Hilder's observations* [in *ACC*]*, indeed, she uses the term "in the realm of property and affairs" which implicitly recognises that decisions in that sphere will sometimes have welfare implications.* […] *Precisely because the Court of Protection is such a highly fact-specific jurisdiction, it is perfectly conceivable that what might appear on the surface to be a Property and Affairs issue, is on a proper construction, nothing of the kind and truly a welfare issue.*

It enacting the 2013 regulations, it might be thought that Parliament had a view that the work involved in being a representative in the personal health budget sphere was a property and affairs matter with welfare implications. Senior Judge Hilder has disabused Parliament (and the authors of the Statutory Guidance) of that notion. As she noted at paragraph 73.

> *Unfortunately, although the intention of the Regulations seems to have been to open the door to Court of Protection appointed deputies, it seems to me that the vision of deputyship held in the Regulations and Guidance is at odds with the reality of deputyship appointments as they are actually made by the Court:*
>
> *a. in accordance with the specific categories of section 16(1) the Act, the Court of Protection invariably confers property and affairs deputyship authorities separately to welfare deputyship authorities, and comparatively rarely confers the latter;*
>
> *b. decisions "about a person's healthcare" and "help[ing to] develop personalised care and support plans" fall within the remit of a welfare deputy, but "securing services" falls within the remit of a property and affairs deputy;*

c. acting as a 'representative' requires both types of authorisation.

Taking matters back full circle, the line of analysis adopted in the judgment suggests that it would be possible for a deputy to be an 'authorised' person for purposes of the receipt of direct payments under the Care Act 2014 – albeit that the deputy would have to be appointed as both a property and affairs and a health and welfare deputy (and could not be a trust corporation, because a trust corporation can only be appointed to manage P's property and affairs).

The position of direct payments, in both social care and health care, can be a difficult and sometimes frustrating intersection between public law decision-making and personal choice. The direct payment is a means of a health body or local authority delegating its public law duties to provide care to the person. While in both health and social care (see the 2021 consent order linked to above), regulations or statutes prioritise welfare decision-makers to receive direct payments on behalf of a person lacking capacity, in reality, any choices they make are highly constrained by the terms of the care plan prepared by the health body or local authority, and the putative welfare decision-maker cannot make arrangements for care which conflict with those care plans.

We would query the extent to which there is the level of personal choice in the use of a PHB which appeared to be contemplated by the court at paragraphs 40-44, and the extent of control which is exercised by an ICB over a PHB. There is no legal right to a direct payments created by statute; the Regulations set out only that an ICB 'may' make such payments, and sets out the factors to be taken into consideration. The only legal right is to ask for a PHB, and to have reasons if it is not accepted. Akin to local authority direct payments, regulations 11 and 8 of the 2013 Regulations have the effect that the patient or their representative are bound to spend the direct payments only on services which have been set out in the care plan, which is a document 'owned' and prepared by the health body: there does not appear to be discretion for the patient or representative to deviate from this unless that has been agreed by the health body. It is thus ultimately the health body that will make the decisions about how the direct payments can lawfully be spent (in line with direct payment regulations around social care as set out in the 2021 consent order), and the person holding the direct payments appears to have a more administrative role in administering P's 'affairs' than one in which significant decisions are being taken regarding P's welfare.

Footnotes in this case indicate (similarly to the 2021 consent order) that one of the two key issue motivating this application (and indeed, the initial appointment of a deputy in 2017) was a concern as to the lawfulness of personal assistants (who were not registered with the CQC, or being employed by a CQC-registered care agency) providing personal care to P. As a general matter, providing personal care as part of one's employment requires registration with the Care Quality Commission (CQC), as providing personal care is a 'regulated activity.' However, the Health and Social Care Act 2008 (Regulated Activities) Regulations also set out that certain 'prescribed activities' are not regulated activities. The Health and Social Care Act 2008 (Regulated Activities) Regulations, Sched.1, para.1(3)(c) offers the significant caveat that the definition of personal care 'does not apply to…the services of a carer employed by an individual or related third party, without the involvement of an undertaking acting as an employment agency or employment business, and working wholly under the direction and control of that individual or related third party in order to meet the individual's own care requirements…' Paragraph 1(4) defines a 'related third party' as (inter alia) 'an individual with power of attorney or other

lawful authority to make arrangements on behalf of the person to whom personal care services are to be provided.' (emphasis added)

There are no reported cases specifically determining whether a person lawfully administering a health or social care direct payment is exercising 'lawful authority to make arrangements' on behalf of the person. However, our view (shared with Arianna in her book, 'Social Care Charging') is that a lawfully-appointed direct payment holder may employ unregistered personal assistants to provide personal care with a direct payment without breaching the Regulations above. The holder of the direct payment is chosen by the health or social care body, and relevant statutory frameworks govern their authority to act. So long as the personal assistants are 'working under the direction and control' of the 'related third party,' this does not appear to breach the CQC Regulations.

PDF accreditation

The Professional Deputies Forum has launched a voluntary, multi-tiered accreditation programme for its members following extensive collaboration with a range of specialists working in the Court of Protection area.

The programme aims to elevate standards and demonstrate that accredited professional deputies have the expertise and a foundation of knowledge in a range of areas when looking after the property and affairs of vulnerable clients.

Arianna and Alex, together with Ian Brownhill, have all contributed to the work of the accreditation scheme.

For more details, see here.

PRACTICE AND PROCEDURE

Delays, delivery and deprivation of liberty

Cardiff and Vale University Health Board v NN [2024] EWCOP 61 (T3) (Victoria Butler-Cole KC, sitting as a Deputy Tier 3 Judge)

CoP jurisdiction and powers – costs

Summary[5]

NN was a 32-year-old woman with a history of substance abuse and schizophrenia, repeatedly detained under the Mental Health Act 1983 from the age of 17 and homeless since 2023. She experienced a coercive, abusive relationship leading to a relapse and became pregnant before being detained under MHA 1983 s.3. There was no dispute that she lacked capacity to conduct the proceedings and to make decisions as to termination, and that she should have a termination if she chose to proceed with it. But the hospital applied for authorisation to deprive liberty if, having taken the first doses of medication she tried to leave the hospital at which point physical and chemical restraint would be required. By the time of the hearing, under the time limits of the Abortion Act 1967 there were only a few days left.

Considering *Ferreira*, the court agreed that since a capacitous woman would be able to leave the hospital and refuse surgery for any reason, the treatment proposed for NN was materially different to that which would be given to a person of sound mind. Moreover, given the treatment would be given in the general hospital, outside the psychiatric unit, she was not ineligible to be deprived of liberty. Sitting as a Deputy Tier 3 Judge, Victoria Butler-Cole KC declared that NN lacked such capacity, no best interests decision was required, and the authorisation to deprive liberty was granted if required. Ultimately, NN accepted the medical treatment, did not try to leave so the authorisation did not have to be relied upon. She stayed in the general hospital for just under 24 hours then returned to the psychiatric unit.

Departing from the general costs rule, the Judge ordered the Health Board to pay the Official Solicitor's full costs because of a month's unreasonable delay in bringing the application. NN would have been saved a month of waiting and wondering why her expressed wishes were not being acted upon, where the procedure would have had lower risks of physical or mental harm. The delay had a negative impact on both her and her mother, who said this had been the worst experience of her life and that it was '*absolutely barbaric*'. She was traumatised by watching her daughter having to continue her pregnancy well into the second trimester despite having requested a termination, and then supporting her through a late medical termination which resulted in the baby being born alive. The Judge observed:

> *43* […] *It is incumbent on those concerned with obstetric cases to give the most careful scrutiny at the earliest possible stage to whether orders are actually required from the Court of Protection, and if so, the substance of those orders. In this case, the minutes of various professionals meetings held in June and July 2024 suggest that there was a mistaken belief that any best interests decision about termination of pregnancy for a person without capacity required court authorisation. If there is a professional consensus about the treatment proposed, no intention to impose treatment on P against her wishes, and no disagreement from those concerned with P's welfare such as close*

[5] Tor having been the judge in the case, she has played no part in writing this summary or comment.

family members, the provisions of s.5 and s.6 MCA 2005 permit medical best interests decisions to be taken without court involvement, having followed the requirements of the MCA and any associated professional guidance: An NHS Trust v Y [2018] UKSC 46.

44. If aspects of a treatment plan may constitute a deprivation of liberty, serious thought must be given to how likely it is that those measures will be needed. Is there evidence suggesting that the particular patient, if they have chosen to undergo a medical procedure in hospital, and are in need of pain relief and support from medical professionals, will suddenly refuse help even if they are told their health and potentially their life are at risk? Where the patient is in agreement with the underlying treatment, and, as here, is not suffering from persecutory delusions or an ingrained fear of hospitals or medical professionals, what is it that suggests the risk of needing to take such steps is materially different than for a patient who does not have a diagnosed mental disorder and is not detained under the MHA 1983?"

Comment

This case is of interest for two reasons. The first is that, despite lacking capacity to decide on termination, whether the termination was in her best interests remained NN's choice. Her 'will and preferences' determined the outcome. In UN CRPD terms, despite lacking *mental* capacity it could be said she retained *legal* capacity as a rights-holder to determine the outcome. The court was only required if, having expressed her will and beginning the process, her subsequent preferences conflicted with her will, at which point her right to life and health would necessitate physical and chemical restraint.

The second area of interest relates to an issue which perhaps calls for a more general debate: for Article 5 ECHR purposes, do these types of medical treatment cases in fact amount to deprivations of liberty rather than liberty restrictions under MCA ss.5-6? The facts fell outside the *Ferreira* exception, because more restrictive arrangements would be necessitated because of mental disorder. But the relevant treatment lasted for less than 24 hours. If a deprivation of liberty means non-consensual confinement in a particular place for more than a negligible period of time, should such short-term physical and chemical restraint engage Article 5? If so, why should the statutory DoLS scheme not be used, rather than a court authorisation? Or are these in reality significant Article 8 interferences which, if disputed, require judicial determination?

The case is also usefully, finally, for reminding people (at paragraph 45) that, despite a persistent urban myth to the contrary, s.4B MCA 2005 does not provide a standalone detention authority in an emergency. It only provides such authority where a court order is being sought. If the Government were to bring into force the relevant part of the Mental Capacity (Amendment) Act 2019, s.4B would give such an emergency detention power, but, as yet, we do not have any indication that implementation of any part of that Act is on the cards.

Capacity and cross-border protection

The Health Service Executive of Ireland v SM [2024] EWCOP 60 (T3) (Hayden J)

Mental capacity – assessing capacity

Summary

This case is the sequel to a decision in 2020 concerning SM, an Irish citizen with a number of complex mental health needs. The application was for recognition and enforcement of a further order of the Irish High Court, made by the President of that court, providing for her continued detention and treatment at an English mental health facility, Ellern Meade. Materially, the order made by the President of the High Court provided substantively for the Medical Director of Ellern Mede, to be permitted to detain SM for the purpose of providing assessment, treatment, welfare, and therapeutic services for her, pending further Order. The Order also permitted the Medical Director to:

> *take all necessary and/or incidental steps (including the provision of consent for any medical psychiatric psychological or other assessment treatment or assistance whether at Ellern Mede or (if necessary and appropriate) at some other location or facility) and to use such reasonable force and/or restraint as may be necessary in so doing to promote and/or ensure the care protection safety and welfare circumstances of [SM] and to provide [SM] with such hydration, sustenance, medication and treatment as may be clinically and /or medically indicated in accordance with the operational policies of Ellern Mede, including for the avoidance of doubt the provisions of nasogastric feeding.*

At a hearing in January 2024 before the Irish High Court, Heslin J had noted that:

> *this is an application to ensure the continuation of vital treatment in the context of a necessary care regime for [SM], plainly in her best interests and the evidence makes clear, looking at it through the lens of the inherent jurisdiction that this is someone who lacks capacity and that the orders sought today constitute a necessary and proportionate response by the court to ensure that [SM]'s fundamental and constitutionally protected rights are vindicated and protected.*

Hayden J identified that:

> *29. Evaluating capacity "through the lens of the inherent jurisdiction" appears to be a very different exercise from that required by the MCA in this jurisdiction. I emphasise 'appears' because the jurisprudence regulating the application of the inherent jurisdiction in the Irish Court may serve, as I strongly suspect it does, to deliver a similar approach to our own.*

Hayden J identified that he had, in 2020, been "*exercised about the highly intrusive nature of the order (broadly replicated here) and its continuing duration*." He noted that:

> *42. In my judgement, the obligation to act compatibly with ECHR Convention Rights when recognising and/or enforcing a foreign order exists both independently from and as a facet of public policy. Whilst, to repeat Munby LJ's phrase, "the test in stringent, the bar is set high", the obligation to evaluate compatibility remains, and is not perfunctory.*
>
> *43. SM's welfare has been unswervingly in focus during the Irish High Court's exercise of its inherent jurisdictional powers. It is clear, however, that SM's capacity has fluctuated over the last 6 months and may well continue to do so. Some of her recent recorded observations are, as I have commented, both measured and insightful. I consider that, in such circumstances, having emphasised both the duration and the draconian nature of the order that I am invited to recognise and enforce, I am required, properly respecting SM's rights, to satisfy myself that she continues to lack capacity in the sphere of decision taking surrounding her medical treatment. This I regard as my obligation, both under the Human Rights Act 1989 and in ensuring that this order remains*

compatible with public policy in England and Wales. As the papers presently stand, I am not yet able to undertake this exercise in the way that is required, as analysed above. For this reason, I propose to direct an up-to-date assessment of SM's capacity to understand and consent to her continuing treatment. For the avoidance of doubt, I do not require any assessment as to whether such treatment remains in her best interests. Like the Irish High Court, I am entirely satisfied that it is.

44. Having foreshadowed my concerns in respect of capacity, Mr Setright indicated that the HSE would instruct a psychiatrist to assess SM's current capacity relating to her treatment and extending this to litigation capacity. I am grateful to him for adopting that collaborative approach, which if I may say so, has been a feature of the history of this difficult case. That report is to be filed by 21st November 2024. For the avoidance of doubt, I am satisfied that the evidence as it presently stands, enables me to continue to recognise and enforce the orders of the Irish High Court.

Comment

As set out in this article written by Alex and Chiara Cordone, securing distributed rights protection – especially in the context of compulsory admission and treatment – is a complex matter, but is vital in circumstances where, in effect, a corner of an English mental health hospital becomes for a sustained period of time a patch of foreign soil. Whilst we cannot pre-empt the evidence that may be forthcoming as to SM's capacity, it is perhaps worth highlighting that Hayden J was (mostly) correct to identify that the approach to capacity under the inherent jurisdiction of the High Court of Ireland reaches a similar end point to that under the MCA. Since the coming into force of the Assisted Decision-Making (Capacity) Act 2015 (and, indeed for some little time prior), the High Court takes its approach to capacity from that contained in the 2015 Act.[6] That approach is a purely functional one – i.e. it looks very much like the functional test contained in the MCA 2005, but does not have any requirement for the functional inability to process the information to be caused by an impairment of or disturbance in the functioning of the mind or brain. That may give rise in some cases to interesting questions of:

(1) Whether a person lacking capacity for purposes of the 2015 Act lacks capacity for purposes of the MCA 2005 (an interesting example would be a victim of domestic abuse who cannot use and weigh the risk that they are at if they return home – in Ireland, they could arguably be found to lack capacity to make the decision to return; in England & Wales, they could not be found to do so unless their inability to use and weigh the risk was caused by an impairment or disturbance in the functioning of their mind or brain);

(2) Whether, even if they do not lack capacity for purposes of the MCA 2005, they nonetheless fall within the scope of Schedule 3, which does not talk of incapacity, but talks of a person who "as a result of an impairment or insufficiency of his personal faculties, cannot protect his interests" (paragraph 4(a) of Schedule 3).

[6] See, in particular, *In the Matter of KK* [2023] IEHC 565 at paras 22-25.

MENTAL HEALTH MATTERS

Mental Health Bill first reading

The Government introduced the Mental Health Bill into Parliament on 6 November. It draws on the work of the independent Review of the Mental Health Act 1983, chaired by Sir Simon Wessely, that reported in 2018 (to which Alex was the legal adviser).

The draft Mental Health Bill brought forward by the previous Government can be found here. Alex's unofficial annotated version of the current Mental Health Act 1983 if it were to be amended by that Bill can be found here; he will update that as soon as possible.

The Parliamentary Office of Science and Technology has published two reports on mental health reform, one on improving patient choice and on autistic people and people with learning disability. They have also published a wider report on racial inequalities in the mental health context. The House of Commons Library has published a wider research briefing here.

A Joint Committee of both Houses of Parliament was convened to scrutinise the draft Bill published in 2022, and its report can be found here (together with Alex's walkthrough of it). The previous Government responded to that report here.

The Bill now introduced is very similar to the draft Bill. No doubt reflecting recent high-profile cases such as that Valdo Calocane, the Bill also includes measures designed (in the words of the press release) to recognise that "safety is paramount" – including a requirement that the patient's responsible clinician consults with another person before discharging them; the press release also says that "[d]ischarge processes will be reviewed more broadly and will include a safety management plan for the patient, to keep themselves and others safe."

Amongst the measures that the Bill includes are:

- An updating of the principles to be contained in the statutory Codes of Practice in both England & Wales.
- The removal of learning disability and autism from s.3 MHA 1983.
- Statutory care and treatment plans for all patients.
- Advance choice documents, including provision for NHS England and ICBs to make arrangements for making information about advance choice documents available to those for whom they are responsible, and "helping" such people as they consider appropriate to make advance choice documents.
- Replacing nearest relatives with nominated persons.
- For advocacy provision to be extended in England (as is already the case in Wales) to all informal patients, not just those detained under the MHA 1983.
- Greater access to Second Opinion Appointed Doctors.

- Shorter periods of detention under s.3 and greater access to the Tribunal.
- The power for Tribunals to recommend (but not direct) service provision in the community.
- Tightening the criteria for Community Treatment Orders.
- The prohibition on the use of police and prison cells for those experiencing mental health crisis.

What the Bill does not include are:

- Any provisions preventing the detention of autistic people or those with learning disability under the MCA 2005 (including in psychiatric hospitals) in the event that they are considered to lack capacity to consent to their admission and confinement.
- Statutory principles appearing on the face of the legislation, in the way that principles appear in s.1 MCA 2005.
- Any provision for addressing the legal powers to hold individuals in Accident and Emergency departments pending admission under the MHA.
- Any reference to the interface between the MHA and the MCA 2005.
- Any reference to advance consent to confinement in psychiatric settings, the DHSC having taken the position in response to the Independent Review's consideration of this issue that the law already provided that people could give such consent so as to avoid the need for formal detention when in crisis.
- Measures allowing patients to challenge their treatment before the Mental Health Tribunal, meaning that they will continue to have to rely upon judicial review to obtain a judicial determination of whether they can compelled to receive a specific treatment.

THE WIDER CONTEXT

Short note: was the Supreme Court wrong in the *Maguire* case?

The decision of the European Court of Human Rights in *Validity Foundation on behalf of TJ v Hungary* [2024] ECHR 796 is a significant decision in its own right, not least for highlighting the continuing invaluable work of the Validity Foundation in championing the rights of those with cognitive impairments in Central and Eastern Europe and in Africa.

This case concerns the death in a residential care home of a woman (Ms TJ) who had a severe intellectual disability.

Between 2015 and 2017 a team of monitors visited Ms TJ to discover that she was emaciated, and unresponsive, with an open wound to her forehead and a black eye. She was tied to her bed with a steel hoop at the waist. The care home did not consider this to be a restriction, but a nursing aid to prevent her from falling out of bed.

The team of monitors published a report, and the Government also inspected the care home and published a report into its failings. On 18 May 2017 the Hungarian Commissioner for Fundamental Rights published a report on the care home, concluding that the institution lacked adequate care facilities, that the fundamental rights of the residents were being violated, and the living conditions could give rise to inhuman and degrading treatment.

In the Spring of 2018, Ms TJ died in hospital having been admitted there with pneumonia. An autopsy confirmed the cause of death as bacterial pneumonia.

The monitoring organization lodged both a criminal complaint with the local police department, alleging amongst other allegations, that Ms TJ's death had occurred because of the professional misconduct of the staff, and a collective complaint in the civil courts. The criminal complaint was eventually dismissed. The civil complaint eventually led to the Budapest High Court giving a judgment in February 2024 in which it concluded that that the Directorate of Social Affairs and Child Protection, the Pest County Government Authority, and the legal successor of the Ministry of Human Resources, the Ministry of Culture and Innovation had failed to carry out their statutory obligation to supervise and manage the care home. Thereby they had infringed the personality rights, including the right to equal treatment and the right to dignity of the residents. They had maintained a humiliating and degrading environment, restrained the liberty of the residents in an inhuman manner, exposed the residents to indecent sanitary conditions, had not provided human living conditions, had not provided education, rehabilitation, participation in sport, cultural and social life, had not provided appropriate care and development and had not ensured the resident' right to access to healthcare.

The European Court of Human Rights concluded that Mrs TJ was under the exclusive control of the State. It placed particular reliance (in finding that the Article 2 duty to secure life was engaged) on three aspects of her background:

> *75. It first points out that since the age of ten, Ms T.J. had lived in the hands of the domestic authorities: she had grown up in Topház, where she had continued to live as an adult in the female*

ward until her death at the age of forty-five on 25 August 2018. She had been placed in the social care home since she needed constant assistance, which apparently could not be provided by her family. Her intellectual disability was considered to compromise her ability to make an informed choice about remaining in the social care home.

76. In practice, she was fully dependent on the institution for her most basic human needs including her place of residence, her medical treatment, her daily activities, and her interaction with the outside world. The Court also considers that Ms T.J.'s long-term institutionalisation and her ensuing loss of contact with the outside world necessarily made such dependence even greater. Thus, contrary to the Government's argument, even if her guardian had sought her release from the social care home, Ms T.J. would have had no possibility - in any meaningful sense - of leaving the institution.

77. Secondly, the Court emphasises the particularly vulnerable situation of Ms T.J., as a person with disability (see Z.H. v. Hungary, no. 28973/11, § 29, 8 November 2012, and Shtukaturov v. Russia (just satisfaction), no. 44009/05, § 18, 4 March 2010) which has been recognised as a relevant consideration when assessing a State's responsibility under Article 2 (see Centre for Legal Resources on behalf of Valentin Câmpeanu, cited above, § 131, with further references).

78. Thirdly, it is also significant that the domestic authorities considered, apparently because of her disability, that Ms T.J. lacked legal capacity to act for herself and appointed a legal guardian for her.

79. While in theory Ms T.J.'s guardian was supposed to represent her interests, take decisions about her placement and medical care, and provide legal assistance if necessary, no evidence has been produced by the parties to show that her guardian was notified of or consulted about the decisions on her medical treatment in the care home or her various admissions to hospital. The Court further notes that there is no evidence that Ms T.J. was ever informed about her care or assisted in understanding such information, apparently because the guardian herself considered that she was unable to communicate with her. Although there is no indication that Ms T.J.'s guardian acted in bad faith, there were serious shortcomings in the manner in which the guardianship system was implemented with respect to vulnerable patients admitted to social care institutions, who in practice were left without effective legal assistance or protection (see paragraph 31 above).

80. For the Court, the above elements indicate that Ms T.J. was under the exclusive control of the State authorities who therefore assumed direct responsibility for her welfare and safety and were under an obligation to account for her treatment and to give appropriate explanations concerning that treatment (see Centre for Legal Resources on behalf of Valentin Câmpeanu, cited above, § 140, and Nencheva and Others, cited above § 119).

The Court noted the many serious deficiencies in Mrs T J's care found by the domestic courts and came to the view that the Government had failed to account for the treatment of Ms T.J., who was under the exclusive control of the State, and failed to demonstrate that the domestic authorities had had the requisite standard of protection that would have enabled them to prevent the deterioration in health and untimely death of Ms T.J. This amounted to a breach of article 2.

It might be said that the conclusion the ECtHR reached in this case is at odds with the decision of the Supreme Court in the case of *R (Maguire) v His Majesty's Senior Coroner for Blackpool & Fylde* [2023]

UKSC 20. In that case, the court held that when an individual is placed in a care home, a nursing home or a hospital, the state does not assume responsibility for all aspects of their physical health. Placing considerable reliance on the admissibility decision in *Dumpe* (not referred to by Strasbourg in the *TJ* case), the Supreme Court had sought to identify that the deprivation of liberty to which Ms Maguire was subject, in a care home, authorised under DoLS, was in some way different in character to deprivation of liberty in (for instance) a mental health hospital. In so doing it placed considerable emphasis on the fact that the care home's responsibility was said to be to look after the woman on behalf of the State in substitution for her family. Paragraph 80 of the judgment in *TJ* suggests, one might think, that the Supreme Court had moved too quickly to downgrade the scope of Article 2 in the context of DoLS.

Calibrating the definition of ill-treatment by reference to the victim: an important clarification from the Court of Appeal

R v Banner; R v Bennett [2024] EWCA Crim 1201 (Court of Appeal (Criminal Division) (Singh LJ, May and Griffiths JJ))

Summary

Whorlton Hall hospital housed patients with longstanding learning disabilities and significant additional psychological and behavioural needs, who required specialist care. Some were detained under s.3 Mental Health Act 1983. Over 38 days, an undercover reporter, Olivia Davies, filmed footage of abuse and mistreatment at the hospital for a BBC *Panorama* documentary. In consequence, 9 members of staff were charged; 5 were cleared, and 4 were convicted on a number of counts of ill-treatment of a person in care, contrary to s.20 Criminal Justice and Courts Act 2015. Two of those convicted, Matthew Banner and Paul Bennett, both of whom held senior healthcare roles there, appealed to the Court of Appeal against their convictions. The Court of Appeal's judgment in *R v Banner; R v Bennett* [2024] EWCA Crim 1201, provides an important addition to the (small) stock of reported cases concerning s.20 Criminal Justice and Courts Act 2015.

The material incidents bear setting out in full, relating to two patients, AD (a 20 year old autistic woman) and LH (an autistic woman with communication challenges).

> *10. The incident in Count 2 occurred on 6 January 2019. AD was agitated and the appellants went to her room and told her that, unless she calmed down, the female carers would not come back and three males would be supervising her: this was the subject of count 1, on which the appellants were acquitted. Whilst AD was screaming, Bennett "twanged" a balloon in her room. Although not caught on camera, he asked her if she liked balloons and was showing/describing different coloured balloons to her. When she said "No", he continued to talk about balloons, asking who had brought the balloons in for her. She said that her mother had and he asked her if that was cruel of her mother, if she did not like balloons.*
>
> *11. Counts 3, 4 and 8 related to incidents that occurred on 11 January 2019. AD was distressed and screaming. Banner had pushed her back into her room in an appropriate manner. Once AD had calmed down, another defendant told her that if the calm behaviour did not continue, then the female carers would be sent away and she would have male carers: this was the subject of count 8, on which the other defendant was acquitted. Banner asked AD if he should tell the other defendant that she wanted two male carers and she continued to scream. Once she had calmed*

down Banner, from outside the room, asked if she liked balloons. Banner then left and when he returned he asked her again if she liked balloons (the subject of count 4). She continued to scream and he asked whether she wanted three, four, five or six men before saying "we can keep going" (the subject of count 3).

12. The incident in count 5 happened on 28 January 2019. AD had been intermittently screaming and, when Banner entered the room, AD screamed and said "No". Notwithstanding this Banner remained in the room and danced to the words that AD was repeating. He kept asking her whether she wanted him to stay and told her that he and another defendant would remain if she did not calm down. He asked her about balloons as that would take her mind off things. He pretended to forget her name and fist pumped when she screamed and repeated words. He left the room saying that he would not listen to her and singing "Olivia knows she likes to muff dive".

13. The incident in count 6 happened on 21 February 2019 when AD was distressed. Banner told a female carer to come out and turn the room light off. He asked AD if she liked balloons because, he told Olivia Davies, he was curious.

14. The incident in count 7 happened on 22 February 2019. AD was screaming and Banner stood at her open door and asked her if she liked balloons to which she said 'sorry' and he laughed, said it was weird and left.

15. The incident in Count 13, which concerned LH, happened on 28 February 2019. When LH was using sign language, Bennett spoke French to her and when she came out of the room he "bounc[ed] suddenly towards her, causing her fear".

Distilled to their essence, the appellants' cases, as set out at paragraph 32 of the judgment, were that:

(1) The Judge failed to give an adequate definition of the term "ill-treatment". For example, the Judge made no reference to adjectives such as "cruel" or "abusive", although those had featured in the Crown's opening to the jury. The appellants submit that it is one thing to engage in what may be regarded as unprofessional behaviour but that does not mean that Parliament intended it to be criminal. They also submit that the various dictionary meanings of the term "ill-treatment" are so broad that, without further assistance, the jury may have applied a meaning which was so broad that it would unacceptably cover conduct which ought not to be regarded as criminal. For example, the Oxford English Dictionary gives the following definition: "bad or unfavourable treatment; rough handling; harsh or unsympathetic feelings". The Cambridge Dictionary gives the following definition: "the act of treating someone badly, especially by being violent or by not taking care of them". The Collins Dictionary gives the following definition: "harsh or cruel treatment".

(2) The second main submission advanced on behalf of the appellants is that, however wide the definition of ill-treatment may be, there was insufficient evidence before the jury upon which they could reasonably convict and therefore the case should have been stopped at half time on the relevant counts. For example, in relation to Count 2, it is submitted on behalf of Bennett that there was unchallenged evidence from his wife, Sarah Bennett, at the trial, to the effect that AD clearly had a desire to possess balloons on several occasions and therefore any reference to balloons by Bennett could not amount to ill-treatment, as it was commonly known that she chose to engage with balloons. In relation to Count 13, it is submitted that there was no reference in LH's care plan that she should not be spoken to in any language other than English. There is no other basis to conclude that speaking in a foreign language for only a few words would amount to ill-treatment

on any interpretation. The same is submitted in relation to Bennett rising from his chair as LH advanced towards him.

The Court of Appeal had little truck with both of these:

33. We reject the first way in which the submissions for the appellants are put. There was no requirement for the Judge to define the term "ill-treatment" beyond what he had said in his written and oral directions of law.

34. First, the term is an ordinary one of the English language and should not be given any judicial gloss. Parliament has used the term in a number offences of this type, going back at least to section 1 of the Children and Young Persons Act 1933 ("the 1933 Act"). The same term appears in section 127 of the 1983 Act. It has not been suggested that this has caused difficulty to juries or otherwise in the many decades that they have had to apply similar legislation. As the term "ill-treatment" is an ordinary one of the English language, juries can be expected to understand what it means and apply it without the need for dictionary definitions.

35. Secondly, it is clear that the Judge carefully drafted his direction of law on the offence by reference to the decision of this Court in R v Newington (1990) 91 Cr App R 247, at 254, where Watkins LJ said:

"All of those considerations demanded a very careful direction as to mens rea. In our judgment the judge should have told the jury that for there to be a conviction of ill-treatment contrary to the Act of 1983 the Crown would have to prove (1) deliberate conduct by the appellant which could properly be described as ill-treatment whether irrespective of [this is a typographical error in the law report and should read 'irrespective of whether'] this ill-treatment damaged or threatened to damage the health of the victim and (2) a guilty mind involving either an appreciation by the appellant at the time that she was inexcusably ill-treating a patient or that she was reckless as to whether she was inexcusably acting in that way."

36. Both the elements of the offence, including the mental element, need to be proved by the prosecution. The words "properly" and the word "inexcusably" are important in this context. They will constrain the potential breadth of the term "ill-treatment" to proper bounds, as intended by Parliament. In Newington the Court deprecated attempts by the Judge in that case to go beyond the wording used by Parliament. We also would deprecate such attempts.

37. It is also notable that there is an important distinction between the wording of section 1 of the 1933 Act and the later legislation such as section 127 of the 1983 Act and section 20 of the 2015 Act. Parliament has chosen not to include the further requirement, which does appear in section 1 of the 1933 Act, that the treatment must be likely to cause injury or harm. This was a significant distinction in the wording as between the 1933 Act and the 1983 Act, to which this Court drew attention in Newington, which was decided in 1990. When Parliament came to enact the 2015 Act, it can be taken that it was content to legislate on the basis of the interpretation which had been given by this Court in Newington to the materially identical provision in the 1983 Act.

38. Thirdly, what counsel say in speeches, including here the opening speech by the Crown, does not constitute either evidence or a direction of law to the jury. Directions of law come

from the judge. In this case they were given to the jury in written form, as was a written route to verdict. Helpfully, the written directions of law were given to the jury at the outset of the trial. This was done with the agreement of all parties. The defence did not suggest at that stage that any further definition of "ill-treatment" needed to be given to the jury. We can see no reason why the Judge should have done so. To the contrary, we consider that the way in which the Judge handled this sensitive case was exemplary.

39. Turning to the second main way in which the submissions are put on behalf of the appellants, these squarely raise issues of fact which were classically for the jury to decide and not for the Judge nor for this Court. The jury had the whole of the evidence before them. This included the film footage, the relevant parts of which we have also seen. They could make their own mind up, for example, about what the appellant Bennett's motivation was when he rose from his chair towards LH. There was certainly a case for him to answer. In due course he did give evidence at the trial and gave his explanation, which was clearly rejected by the jury in light of his conviction on Count 13.

40. Similarly, in relation to the incident concerning balloons, there was an issue of fact for the jury to decide at the trial as to whether what was done by way of "twanging" the balloon was an effort in good faith to use a distraction technique so as to calm AD down or whether it was inexcusable ill-treatment, with the requisite mental element, either knowledge or recklessness. Again, there was a case for the appellants to answer and they had the opportunity to give evidence in response to the prosecution case after the Judge had rejected the submission that there was no case to answer.

41. In our judgement, the questions which this case raised on the relevant counts against these appellants were classically ones for the tribunal of fact (the jury) to decide after hearing all the evidence. The trial Judge cannot be criticised for leaving these issues to the jury in accordance with the judgment of this Court in R v Galbraith [1981] 1 WLR 1039, at 1042 (Lord Lane CJ).

42. Finally, we note that the jury clearly took their task seriously in this trial. They acquitted the appellants on Count 1. This illustrates the point that they were well able to decide for themselves whether what they saw and heard in the evidence as a whole constituted the offence of ill-treatment in accordance with the direction of law which they had been given by the Judge.

Comment

The Court of Appeal's approach is helpful and important in confirming that conduct which might on its face appear to be entirely innocent – 'twanging' balloons or speaking French – could, depending upon the circumstances, amount to ill-treatment. There is a separate point, not before the Court of Appeal, as to whether the sentences that both men got (a suspended sentence of 4 months imprisonment, and unpaid work requirement of 280 hours) appropriately reflects the seriousness of the harm that they caused to AD and LH.

Book Review

Anselm Eldergill, Matthew Evans and Eleanor Sibley, *European Court of Human Rights and Mental Health* (Bloomsbury, 2024, 1301 pp, paperback / ebook c £150)

This has three authors and is three books in one. The three authors are Professor Anselm Eldergill, very recently retired as a Court of Protection judge; Matthew Evans, a solicitor and director of the indispensably important AIRE Centre; and Eleanor Sibley, a barrister at Garden Court and the AIRE Centre. They are an authoritative trio.

The three books include two expressly identified as such, and one which lurks beneath the surface.

The first book, in Part 1, is a detailed thematic analysis of the key issues that arise where the ECHR and mental disability (broadly defined)[7] intersect, covering such matters as hospitals, treatment and social care; legal capacity and civil rights; and, importantly, criminal law and extradition / deportation. It is very useful for those wanting to understand the general approaches of the Strasbourg court to these areas, and, even for those familiar with them, to be stimulated and challenged.

The second book, in Part 2, is a comprehensive review of the case-law concerning mental disability and Articles 2, 3, 5, 6, 8 and 12 ECHR (together with briefer summaries of other articles). Part 2 is particularly valuable for its detailed analysis of a whole range of cases broken down in a very practitioner-friendly way, including summaries of the more important ones; particularly helpful is the giving of the date in the body of the text each time a case is mentioned, which gives the reader a sense of where it sits on the Strasbourg court's evolving journey.

And, like *Pale Fire*, the Nabokov novel in which an entirely separate story starts to be told in the commentary to the poem which forms its alleged subject, the book contains woven throughout a third tale. This third tale is a sustained critique of the way in which business is done in England & Wales, in particular as regards the approach to deprivation of liberty, and the work of the Court of Protection. The critique is particularly powerful because so much of it clearly reflects the views and experiences of Professor Eldergill, a very recent 'insider' within the judicial system.

At times, I must confess that I wished that this third book could have been broken out and published separately, for two reasons. The first, negative, one was that focusing so much on one jurisdiction made me want to see the experiences of other jurisdictions brought out so as to compare them with the Anglo perspective (those jurisdictions could even have been very close to home, because Scotland's experiences of mental health and (in)capacity law are very different to those in England & Wales).[8] The second, more positive, one was that I would like to have seen the

[7] To this end, the title is misleading, insofar as it suggests that the book is focused on those with mental health conditions; it is just as concerned with those with cognitive impairments such as learning disability or dementia.

[8] This is perhaps particularly on my mind having just returned from a symposium to celebrate the 80th birthday of Adrian Ward, instrumental in the development of adult incapacity law in Scotland. In this regard, those new to the deprivation of liberty wars would also be well-advised to start with the discussion in Part 2 of Article 5 before turning

monograph pulling together all the disparate challenges to be found throughout the book into one place.

Some of the choices made in the book are ones that challenge in other ways. As the authors recognise, the fact that they are looking both to draw out themes and to address the case-law on an article by article basis means that there is a degree of repetition, although extensive and helpful cross-referencing mean that it is generally easy to identify where the most detailed discussion of a particular issue is to be found. And, whilst the authors explain why they use the term "commit suicide," (on the basis that as a matter of plain language, it is an act of commission, nor omission; p.3), it is one that many will find jarring as it has the connotation of the commission of a criminal offence, which suicide has not been in England & Wales since the Suicide Act 1961.

But the authors are not in the business of pulling their punches, as can be seen in their approach to the debates around the UN Convention on the Rights of Persons with Disabilities, and, in particular, the approach adopted by the UN Committee on the Rights of Persons with Disabilities. They are robust in their dismissal of that approach, at a legal, democratic and ethical level and, in effect, urge the Strasbourg court to hold the line in the face of demands to move towards greater compliance with the Committee's interpretation of the Convention. Before readers more sympathetic to the Committee's approach rush too quickly to dismiss the book in consequence, it is worth setting out in full footnote 137 to chapter 1, a footnote which is itself an important and powerful statement: "One of the authors, Judge Eldergill, has a long-standing diagnosis of depression, with a differential diagnosis of bipolar disorder. It is both an important part of who he is an individual and an illness. Both these things – the individuality and the illness – are true and to be respected. Psychiatric or psychosocial illnesses no less than physical illnesses have unwanted consequences and must be respected."

Overall, this is a magisterial work which is essential reading for those practising in the area of mental disability. I just hope that the authors have the energy for further editions to keep pace with the continuing evolution of Strasbourg case-law.

[Full disclosure: I was provided with a review copy by the publishers. I am always happy to review books in the fields of mental capacity, mental health law and healthcare law].

Alex Ruck Keene

back to the detailed discussion of deprivation of liberty in Chapter 2, which is in significant part a challenge to the UK Supreme Court's decision in *Cheshire* West, and also delves deep into specifically English problems in response to the decision.

SCOTLAND

AWI reform: will Scottish Government deliver?

We undertook to continue to report relevant developments as they come to our notice, when we reported in the October Report the inclusion of a Bill described as "a first step to update and modernise the Adults with Incapacity (Scotland) Act 2000" in the Programme for Government 2024-2025 announced by First Minister John Swinney on 4th September 2024. In the September Report we reported on the publication on 25th July 2024 of Scottish Government's "Adults with Incapacity Amendment Act Consultation". We followed that with Jill Stavert's more detailed observations on deprivation of liberty aspects of the consultation in the October Report.

We have nothing of substance on which we may yet report further, but consideration of relevant timescales does point to the relevance of the questions: "will Scottish Government deliver?"; "what will Scottish Government deliver?"; and – lying behind these – "how will Scottish Government deliver?". The timescales, now, are daunting. We understand that to achieve the promise in the Programme for Government it will be necessary by the beginning of February 2025 for policy work to have been completed, full instructions given to parliamentary draftsmen, their work to be completed, and the Bill to be ready for presentation to the Parliament.

The only existing draft legislation on any aspect of relevant reforms that must now be delivered is the "Draft Adults with Incapacity (Scotland) Bill" in Appendix A to Scottish Law Commission Report No 240 on Adults with Incapacity published in October 2014, 100 months before the deadline which we now have of February 2025. The deadline for responses to the Amendment Act Consultation was 17th October 2024. We understand that a substantial number of responses was received. It will have been a remarkable achievement if Scottish Government was able to review and assess those responses within 14 days of the deadline, so as to take appropriate account of them in addressing the work to be completed by the beginning of February 2025; but even if that was achieved, that will have left just three months (3% of the total time since publication of the Scottish Law Commission draft) for the tasks outlined above to be completed and – with at least minimally adequate opportunity for consultation during that period – a Bill that is at least minimally adequate presented to the Parliament. However, even minimally adequate does not mean a short Bill. With all the straightforward, but now urgent and essential, reforms identified over the years, it will be – as described in the October Report – a "quite massive Bill".

Fortunately, most of the groundwork to enable such a minimally adequate Bill to be lodged was done some time ago, in the form of the Scottish Law Commission 2014 Report, the Three Jurisdictions Report by the Essex Autonomy Project in June 2016, responses to relevant Scottish Government consultations in 2016 and 2018, and above all the Report of the Scottish Mental Health Law Review published two years ago on 26th October 2022. Together, these should now speed progress on the essentials for updating, including in relation to the principles in the Adults with Incapacity (Scotland) Act 2000; putting in place an adequately lawful deprivation of liberty regime; addressing questions of how powers of attorney and advance directives (advance choices) would correlate with that regime, including transitional provisions; adequate updating of the guardianship and intervention order

provisions of Part 6 of the 2000 Act; and the long list of so-called "technical improvements" to the 2000 Act that have been awaiting attention for some years now.

While we, and no doubt our readers, look forward to what of greater substance we shall be able to report in our December issue, readers should be warned to watch out for further consultations by Scottish Government as they occur, inevitably with short deadlines for responses: do not wait for us to tell you about them, because deadlines may have passed in the meantime!

Adrian D Ward

Adult disability payments: Upper Tribunal decisions

During October 2024 two decisions of the Upper Tribunal were published, both determining appeals from the First Tier Tribunal for Scotland in relation to adult disability payments. This brief note refers to both, as well as to an earlier similar determination by the Upper Tribunal issued in July. Points of interest in relation to general questions of capacity/incapacity arose in all three.

Social Security Scotland v AM

This was an Upper Tribunal decision by Lord Fairley dated 23rd July 2024 and now reported at 2024 SLT (Tr) 165. Social Security Scotland refused AM's application for adult disability payment on the grounds that AM scored insufficient points on the descriptors set out in Schedule 1 to the Disability Assistance for Working Age People (Scotland) Regulations 2022. AM appealed successfully to the First Tier Tribunal, which found that he had some physical conditions, alcohol addiction issues, and although not diagnosed as having a learning or cognitive disability, had attended a special needs secondary school and struggled with reading and writing. The First Tier Tribunal made findings by reference to various descriptors, in consequence of which the First Tier Tribunal held that he was entitled to adult disability payment.

Social Security Scotland appealed to the Upper Tribunal on the grounds that AM's difficulties would have required to have arisen from a clinically recognised illness, disease or other health condition in order to qualify for the awards of points. Put briefly, the key issue in the appeal was whether relevant references in the Disability Assistance for Working Age People (Scotland) Regulations 2022 (SSI 2022/54) to a "physical or mental condition or conditions" meant conditions arising from a clinically recognised illness, disease or other health condition. In other words, Social Security Scotland argued for adoption of a medical model of disability, moreover such a model restricted to a clinical diagnosis. Unsurprisingly for anyone aware of modern concepts of disability, Lord Fairley disagreed with that approach:

> *"[23] The requirement for there to be [a] 'mental condition' for these purposes means no more than there must be a physical or mental cause of the relevant effect. In other words, the claimant must lack the physical or mental power or capability to perform the activity in question. It is not essential that the absence of power or capability should arise from a clinically recognised illness, disease or other health condition."*

Social Security Scotland v HK

This was an Upper Tribunal decision by Lord Lake dated 1st October 2024 and now reported at 2024 SLT (Tr) 161. The factual background to this case was a re-determination of HK's ongoing entitlement to adult disability payment upon deterioration in HK's condition. The obligation to carry out a re-determination fell upon Scottish Ministers, upon them becoming aware of a change of circumstances which might result in an alteration to the component or rate of benefit payable, regardless of whether Scottish Ministers received an application (Regulation 48(a) of the 2022 Regulations). HK was dissatisfied with the determination by Social Security Scotland, and appealed to the First Tier Tribunal. Social Security Scotland then appealed to the Upper Tribunal against the finding of the First Tier Tribunal that HK was entitled to increased benefit. The principal point at issue was whether the First Tier Tribunal could determine the entitlement itself on the information before it, or whether its powers were limited to quashing the decision by Social Security Scotland and referring the matter back for them to make a fresh determination. One may or may not be correct to draw an inference that deterioration had continued between the time of the original assessment by Social Security Scotland, and the consideration of the matter by the First Tier Tribunal.

Lord Lake held that the First Tier Tribunal was entitled to proceed as it had done. The purpose of the relevant Regulations was to ensure that the assessment of entitlement remained up to date. That was not dependent on an applicant taking any steps. It was an obligation on Social Security Scotland. It would be highly artificial and at odds with the apparent intention behind the Regulations for the First Tier Tribunal to decide on a basis which no longer reflected the up-to-date entitlement. The determination by the First Tier Tribunal was one which it had the power to make, and the appeal was refused.

Social Security Scotland v BM

This was an Upper Tribunal decision by Lady Poole dated 14th October 2024 and now reported at 2024 SLT (Tr) 157. In this case, Social Security Scotland was successful in an appeal against a determination by the First Tier Tribunal. The question at issue was the calculation of points for various descriptors, in the manner referred to in the account of the AM case above. The reasons for finding points to be scored by the First Tier Tribunal were that because BM was an undischarged bankrupt he was not permitted to operate his bank account, and his partner did so; and although he had osteoarthritis in his hips and a diagnosis of depression, these considerations did not demonstrate that BM's budgeting skills were limited by a relevant disability. Lady Poole held that the First Tier Tribunal had in these matters made an error of law, and that the error was material because its award of points took BM over the threshold for entitlement to adult disability payment. She allowed the appeal, quashed the decision of the First Tier Tribunal, and remitted the matter to the First Tier Tribunal for re-consideration by a differently constituted Tribunal.

Adrian D Ward

A symposium focused on adult capacity: Past Present and Future, and celebrating Adrian Ward's 80th birthday

On 25th October, we celebrated Adrian Ward's 80th birthday with a symposium on adult capacity in Glasgow, and what a happy, interesting and entertaining day it was, with around 60 people attending, all colleagues and/or friends and family of Adrian from across Scotland and beyond and from all sectors and walks of life.

The programme was designed to generate discussion amongst invitees around the topic of adult capacity law and practice, with speakers being asked, and all excellently delivering on this request, to say a few words on a particular topic before the wider conversation started. It also provided a very apt opportunity to highlight and celebrate Adrian's significant lifetime commitment to this area of law and practice. To mark the occasion the discussion sessions' titles were largely taken from the titles of Adrian's publications.

Jan Killeen and Hilary Patrick ('Scots Law and the Mentally Handicapped and The Power to Act'), both with notable and well-respected experience in policy and law reform, started the day with a fascinating discussion of the chronology and activism leading to the enactment of the Adults with Incapacity (Scotland) Act 2000. Their talk included describing how Adrian as a young solicitor discovered that there was no recognised area of law to specifically cover adult incapacity matters and how the 2000 Act came about as the result of the dedication of Adrian and a small group of supporters. We were also reminded that the Adults with Incapacity Act was the first piece of ordinary legislation enacted by the Scottish Parliament!

In the second session ('A New View: Adults with Incapacity Legislation') Lynda Towers, formerly a government lawyer and solicitor and now Convenor of the Law Society of Scotland's Mental Health and Disability Sub-Committee (taking over recently from Adrian after his 30+ year stint as convenor), provided an interesting insight into actual and potential legal developments since the enactment of the Adults with Incapacity Act, and how, propelled by human rights developments, this has changed and is changing. She was accompanied by Professor Kees Blankman of Vrije Universiteit in Amsterdam who spoke to Europe's adult capacity legal landscape, and finally, much to everyone's amusement, in jest suggesting that Adrian may well be Dutch on the basis that ice skates bearing the name 'Ward' appear to have historically been made in the Friesland province of the Netherlands. He concluded by presenting Adrian with a pair of the aforementioned ice skates.

The second session was followed by a 'Fireside Chat' session in which Alex Ruck Keene in a brilliantly relaxed but incisive manner encouraged Adrian to talk about his life and interests. Those who had hitherto assumed that Adrian has lived and breathed adult capacity law and nothing else all of his life

were disabused of this belief! His enthusiasm and skillset have extended to sporting and musical activity too.

The afternoon started with a session on 'International Protection of Adults' where Alex Ruck Keene discussed cross-border issues with a particular focus on the complex issue of deprivation of liberty. Professor Katja Karjalainen from the University of Lapland pointed out that different laws and human rights interpretation may be applied to the same person who moves, or is moved, from one country to another causing confusion and inconsistencies in protection.

The last discussion session of the day looked to the future. During 'The Legal Rights of Persons with Disabilities: ECHR, CRPD and beyond' Professor Colin McKay, of the Centre for Mental Health Practice Policy and Law Research at Edinburgh Napier University, discussed how the law should be about actively enabling individuals to live life on our own terms. Professor Wayne Martin, from the University of Essex, asked us three questions, namely: (1) what do we mean by the universality of rights; (2) how do we measure the success of rights realisation; and (3) how do we see the Scottish direction of travel in terms of rights realisation. Lord John Scott KC, who was Chair of the Scottish Mental Health Law Review (2019-2022) immediately followed these speakers saying a few words on the review and also mentioning Adrian's kindly offered, and very much fulfilled, role as an informal 'critical friend' to the review.

The day's proceedings were rounded off by closing words from Sandra McDonald, former Public Guardian for Scotland and now independent adviser and author on adult capacity matters, who was also the overall Chair for the day. Her address included reading a touching message from Adrian's brother David, an Emeritus Professor of Medicine living in the USA, and who, amongst other things, exhorted his brother that at 80 he should consider whether he needs to work 60 hours a week. I am probably not alone in wondering whether Adrian will take his brother's advice! Sandra's conclusion was completed by a moving Vote of Thanks from Adrian himself before a drinks reception and, for many, dinner.

The conversation throughout the day and evening never appeared to cease. The passion from all there for this area of law and practice and genuine warmth towards, and regard and affection for Adrian and appreciation of his being a massive driving force in the field was very evident.

Thanks go to the Royal Faculty of Procurators in Glasgow for their kind loan of the venue for the day, and to our generous sponsors, Estate Research, 39 Essex Chambers and Policy Hub Scotland. I would also like to acknowledge and thank my fellow symposium 'organising team' members Sandra McDonald, Jill Carson, Kate Fearnley and Alison Hempsey for all their incredibly hard work in bringing this to fruition. The eagled eyed amongst you will notice that this team is identical to the World Adult Capacity Congress 2022 organising team but minus Adrian who this time, rather than being its chair, was firmly told (once we had ascertained, of course, that he was in agreement with us holding the event) that his role would be that of a 'constitutional monarch' only!

And last, but not at all least, thank you Adrian for being such an inspiration for and mentor to us all, and for your 80th birthday giving us the excuse to hold such an event for this purpose.

Jill Stavert

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Conferences

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

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

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

Advertising conferences and training events

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

Our next edition will be out in December. Please email us with any judgments or other news items which you think should be included. If you do not wish to receive this Report in the future please contact: marketing@39essex.com.

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