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Mental Capacity Law Newsletter December 2015: Issue 61

Compendium

Editors
Alex Ruck Keene
Victoria Butler-Cole
Neil Allen
Annabel Lee
Anna Bicarregui
Simon Edwards (P&A)

Guest contributor
Beverley Taylor

Scottish contributors
Adrian Ward
Jill Stavert

Introduction

Welcome to the December 2015 Newsletters. Highlights this month in a bumper set include:

(1) In the Health, Welfare and Deprivation of Liberty Newsletter: landmark best interests and capacity decisions in the medical treatment sphere, more on the cross-over between the MHA and the MCA, forced marriage, and the CQC's latest DOLS report;
(2) In the Property and Affairs Newsletter: gratuitous care, conflicts of interest and the OPG's new guidance on safeguarding;
(3) In the Practice and Procedure Newsletter: a very important decision on fact-finding (and when it is and is not necessary), and guidance – by analogy – from the Supreme Court on the 'urgency' cross-border jurisdiction of the Court of Protection;
(4) In the Capacity outside the COP Newsletter: DNACPRs notices and capacity, a College of Police Consultation on Mental Health practice, a coroner fully grasping capacity, the inaugural UK Mental Disability Law Conference and a book corner;
(5) In the Scotland Newsletter: important amendments to the Education (Scotland) Bill, an important – and troubling – judicial review decision on ordinary residence in the cross-border context and guidance from the MWC on hidden surveillance.

And remember, you can now find all our past issues, our case summaries, and much more on our dedicated sub-site here. 'One-pagers' of the cases in these Newsletters of most relevance to social work professionals will also shortly appear on the SCIE website.

We are taking a break over the holiday period so (those of you who get them) happy holidays, and we will return in February from our new COP Towers in Chancery Lane.

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Placing the individual at the heart of decision-making even in an MCS

M v Mrs N & Ors [2015] EWCOP 76 (Hayden J)

Best interests – medical treatment

Summary

[Editorial Note: the judge, Hayden J, expressly debated with himself whether it was necessary to review the progress of Mrs N's condition, his instinct being to give priority to her privacy and the protection of her dignity. He ultimately decided that he had to set out some of the key features of the progression of the disorder and Mrs N's responses as part of the broad canvas of evidence which informed his ultimate decision. Whilst he needed to do so – he considered – so as to make clear that his reasoning was both transparent and uncompromised – the editors are not so bound and we therefore do not give those details in this judgment, which received wide publicity at the time. We also mindful of the – characteristically thoughtful – observations of Lucy Series as to the level of detail given in the judgments in both this case and the *C* case also covered in this newsletter].

This case is the first one in which the court has expressly sanctioned the withdrawal of Clinically Assisted Nutrition and Hydration ('CANH') from a person who is in – or was treated by the court as being – in a Minimally Conscious State.[1] It was brought by a woman, M, in respect of her mother, Mrs N, who profoundly impaired both physically and cognitively in consequence of the progressive degenerative impact of Multiple Sclerosis.

Hayden J undertook a careful and comprehensive of the law starting – rightly – with the principles in ss. 1 and 4 MCA 2005. He endorsed the 'admirably succinct' submissions of the Official Solicitor recorded at paragraph 27, namely that:

> *"(a) The court is the decision maker and thus has to make the decision by:*
>
> *(i) considering all relevant circumstances; and*
>
> *(ii) Taking the steps set out in section 4(3) to (7): see section 4(2);*
>
> *(b) There are no limits placed on the nature or type of circumstances which may be relevant to the decision. It all depends on the facts of the case. However, in order to take a decision properly which considers all relevant circumstances, the decision maker must undertake a proper inquiry into <u>both:</u>*
>
> *(i) P's circumstances; and*
>
> *(ii) the type of decision that the decision maker is being called upon to make;*
>
> *(c) Baroness Hale explains in Aintree at §24 that the Act does not propose a totally objective best interests decision making process but a compromise which is under the label of "best interests" but nonetheless is a compromise which contains a "strong element of substituted judgment". This compromise ensures that P as a human being remains at the very centre of decision-making concerning* [them]*;*
>
> *(d) The compromise is achieved by requiring the decision maker to 'consider' (i.e. take fully into account) both P's past and present wishes and feelings: see section 4(6)(a). Whilst particular attention must be paid to expressions of P's wishes and feelings that were written down by P at a time when P had capacity, the decision maker must inquire into and then consider all other evidence of wishes and feelings before taking the decision: see §5.18 to 5.20 of the Code of Practice. That other evidence can include evidence from relatives about P's wishes and feelings which may assist the decision maker to understand P;*
>
> *(e) Separately to considering P's wishes and feelings, the decision maker must also consider 'the beliefs and values that would be likely to influence his decision if he had capacity'. This means that the decision maker must inquire into P's beliefs and values. This is not limited to religious beliefs but beliefs and values about what matters were important to P, how they affected P's view of the world and the factors which P thought were important in*

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[1] Strictly, it should be noted that the court in *United Lincolnshire Hospital NHS Trust v N* [2014] EWCOP 16, in which a woman in an MCS continually sought to pull a PEG tube out, Pauffley J declared that it was lawful and in her best interests for the clinicians (a) not to make any further attempt to secure a means of providing artificial nutrition; (b) to withdraw the provision of intravenous fluids and dextrose; and (c) to provide such palliative care and related treatment (including pain relief) as considered appropriate to ensure she suffers the least distress and retains the greatest dignity until such time as her life comes to an end. The case seems to have been treated subsequently as a 'withholding' rather than a 'withdrawal' case but in particular in light of declaration (b) was a combination of both. It is perhaps more accurate to say that this case represented the first case in which withdrawal was considered in a case where, absent such withdrawal, it would be expected that the individual would continue to live for an appreciable period of time.

> *taking decisions for himself or herself. This part of the statutory process asks the decision maker to inquire into and reach views about the general approach that P had to making decisions for himself or herself and to ask what factors were important to P in P's own capacitous decision making as a prelude for asking what decision P would have made for himself or herself if P still had capacity;*
>
> *(f) The court also needs to look beyond P's 'beliefs and values' by considering any other factors that would, assuming P retained capacity, be have been likely to have influenced P in making the relevant decision: see section 4(6)(c)."*

Hayden J further highlighted the observations of Baroness Hale in *Aintree* at paragraph 39, namely that:

> *"39. The most that can be said, therefore, is that in considering the best interests of this particular patient at this particular time, decision-makers must look at his welfare in the widest sense, not just medical but social and psychological; they must consider the nature of the medical treatment in question, what it involves and its prospects of success; they must consider what the outcome of that treatment for the patient is likely to be; they must try and put themselves in the place of the individual patient and ask what his attitude to the treatment is or would be likely to be; and they must consult others who are looking after him or interested in his welfare, in particular for their view of what his attitude would be."*

and *Re S (Protected Persons)* [2010] 1 WLR 1082, in HHJ Hazel Marshall QC had held:

> *"55 In my judgment it is the inescapable conclusion from the stress laid on these matters in the 2005 Act that the views and wishes of P in regard to decisions made on his behalf are to carry great weight. What, after all, is the point of taking great trouble to ascertain or deduce P's views, and to encourage P to be involved in the decision-making process, unless the objective is to try to achieve the outcome which P wants or prefers, even if he does not have the capacity to achieve it for himself?*
>
> *56. The 2005 Act does not, of course, say that P's wishes are to be paramount, nor does it lay down any express presumption in favour of implementing them if they can be ascertained. Indeed the paramount objective is that of P's 'best interests'. However, by giving such prominence to the above matters, the Act does, in my judgment, recognise that having his views and wishes taken into account and respected is a very significant aspect of P's best interests. Due regard should therefore be paid to this recognition when doing the weighing exercise of determining what is in P's best interests in all the relevant circumstances, including those wishes."*

Hayden J noted that he had given these passages very considerable thought, but that:

> *"28. [...] I draw from them only this: where the wishes, views and feelings of P can be ascertained with reasonable confidence, they are always to be afforded great respect. That said, they will rarely, if ever, be determinative of P's 'best interest's'. Respecting individual autonomy does not always require P's wishes to be afforded predominant weight. Sometimes it will be right to do so, sometimes it will not. The factors that fall to be considered in this intensely complex process are infinitely variable e.g. the nature of the contemplated treatment, how intrusive such treatment might be and crucially what the outcome of that treatment maybe for the individual patient. Into that complex matrix the appropriate weight to be given to P's wishes will vary. What must be stressed is the*

> *obligation imposed by statute to inquire into these matters and for the decision maker fully to consider them. Finally, I would observe that an assessment of P's wishes, views and attitudes are not to be confined within the narrow parameters of what P may have said. Strong feelings are often expressed non-verbally, sometimes in contradistinction to what is actually said. Evaluating the wider canvass may involve deriving an understanding of P's views from what he may have done in the past in circumstances which may cast light on the strength of his views on the contemplated treatment. Mr Patel, counsel acting on behalf of M, has pointed to recent case law which he submits, and I agree, has emphasised the importance of giving proper weight to P's wishes, feelings, beliefs and values see Wye Valley NHS Trust v B [2015] EWCOP 60; Sheffield Teaching Hospital Foundation Trust v TH and TR [2014] EWCOP 4; United Lincolnshire Hospitals NHS Trust v N [2014] EWCOP 16."*

Having cited paragraph 5.31 of the Code of Practice (addressing when it is proper for steps not to be taken to prolong life, Hayden J noted that:

> *"30. It is clear, therefore, that the framework of the Act and the scheme of the Code of Practice place great emphasis on the importance of personal autonomy and the obligation to be alert to direct or indirect discrimination against those who lack capacity. Decisions taken in the 'best interests' of an incapacitous individual must factor in the recognition that respect for an individual's past and present (where relevant) wishes and identifiable codes and beliefs by which he has lived are a crucial part of promoting best interests. To subvert these to a substitution of an objective evaluation i.e. to superimpose what the Court thinks best, may result in indirect discrimination. <u>The central objective is to avoid a paternalistic approach and to ensure that the incapacitous achieve equality with the capacitous</u>."* (emphasis added)

From the legislative structure relating to Advance Decisions to Refuse Treatment (contained in ss.24-26 MCA 2005) Hayden J noted that: "[p]*erhaps the most significant impact of these provisions is that they illustrate that the presumption of life, predicated on what is often referred to as the 'sanctity of life' or the 'intrinsic value of life', can be rebutted (pursuant to statute) on the basis of a competent adult's cogently expressed wish. <u>It follows, to my mind, by parity of analysis, that the importance of the wishes and feelings of an incapacitated adult, communicated to the court via family or friends but with similar cogency and authenticity, are to be afforded no less significance than those of the capacitous</u>*" (paragraph 32, emphasis added).

Hayden J analysed in detail both the competing medical evidence as to whether Mrs N was in an MCS or a Vegetative State, noting that there was agreement between the doctors as to the clinical findings and disagreement as to the correct nomenclature to be applied. Which category she was in had important consequences legally, but was (he found) an arid debate clinically given that all ultimately agreed on the medical facts.

Hayden J noted that it was well-established that, if Mrs N was in an MCS, then any evaluation of her best interests must involve a proper identification of the advantages and disadvantages of each proposed course: i.e. the 'balance sheet,' noting – importantly – that "the balancing exercise is qualitative rather than quantitative." He usefully reminded practitioners of the observation of McFarlane LJ in *Re F (A Child) (International Relocation Cases)* [2015] EWCA Civ 882 that, whilst some form of balance sheet may be of assistance to judges in seeking to assess competing welfare issues [in that case relating to a child]:

> "52. […] *its use should be no more than an aide memoire of the key factors and how they match up against each other. If a balance sheet is used it should be a route to judgment and not a substitution for the judgment itself. A key step in any welfare evaluation is the attribution of weight, or lack of it, to each of the relevant considerations; one danger that may arise from setting out all the relevant factors in tabular format, is that the attribution of weight may be lost, with all elements of the table having equal value as in a map without contours."*

By contract, and citing *A Hospital v SW* [2007] Med LR 273, Hayden J noted that, if she was in a VS, the balance sheet itself did not apply, the very diagnosis establishing the futility of further intervention.

Hayden J set out in detail and with care the evidence that he had heard as to the views and attitudes of Mrs N, noting that it left him with little doubt that:

> "60 […] *Mrs. N would have been appalled to contemplate the early pain, increasing dependency and remorseless degeneration that has now characterised her life for so long. I have no difficulty in accepting the family's view that she would not wish to continue as she is. More than that, she would have wished to have discontinued her treatment some considerable time ago.*
>
> *61. For one who has set such store by outward appearance and who has been so attentive to the impression she created on others, her decline, in the way I have outlined, is particularly poignant. Some might well have endured all that Mrs. N has with phlegmatism and fortitude. Mrs. N is simply not such a person. I am satisfied, as the family say, that some considerable time ago now she had simply had enough and that, as they see it, to force nutrition and hydration upon her is to fail to respect the person she is and the code by which she has lived her life."*

Hayden J noted that the Official Solicitor had, until the conclusion of the family's evidence, taken the view that the strong presumption in favour of the benefit of the continuance of life had not been displaced, but that, following careful consideration, the Official Solicitor had concluded that it would be wrong for him to continue to oppose the application. Whilst he did not criticise the Official Solicitor for so doing, he noted:

> "64. […] *the Court was then left in the position of contemplating a serious and important development in the evolution of the case law in the absence of opposing arguments. I was instinctively uncomfortable with that situation. Accordingly, as is by now clear from this judgment, I required each of the experts to give evidence as well as those conducting the SMART assessment. Mr Lock, notwithstanding the change of position, continued to act, in effect, as amicus to the Court, testing the evidence as it evolved.*

Hayden J emphasised the case was not concerned with the right to die, as no such right existed. Rather:

> "70. […] *What is in focus here is Mrs. N's right to live her life at the end of her days in the way that she would have wished. I am required to evaluate the 'inviolability of life' as an ethical concept and to weigh that against an individual's right to self determination or personal autonomy. Not only do these principles conflict, they are of a fundamentally different complexion. The former is an ideological imperative found in most civilised*

> *societies and in all major religions, the latter requires an intense scrutiny of an individual's circumstances, views and attitudes. The exercise is almost a balance of opposites: the philosophical as against the personal. For this reason, as I have already indicated, I consider that a formulaic 'balance sheet' approach to Mrs. N's best interests is artificial.*
>
> *71. As I have already set out and at some length, I am entirely satisfied that Mrs. N's views find real and authoritative expression through her family in this courtroom. I start with the assumption that an instinct for life beats strongly in all human beings. However, I am entirely satisfied that Mrs. N would have found her circumstances to be profoundly humiliating and that* ***she*** *would have been acutely alert to the distress caused to her family, which* ***she*** *would very much have wanted to avoid. LR told me that Mrs. N would not have wanted to have been a burden; that I also believe to be entirely reliable.*
>
> *72. There is an innate dignity in the life of a human being who is being cared for well, and who is free from pain. There will undoubtedly be people who for religious or cultural reasons or merely because it accords with the behavioural code by which they have lived their life prefer to, or think it morally right to, hold fast to life no matter how poor its quality or vestigial its nature. Their choice must be respected. But choice where rational, informed and un-coerced is the essence of autonomy. It follows that those who would not wish to live in this way must have their views respected too.*
>
> [....]
>
> *75.* […] *Ultimately, I have concluded that her wishes, so thoughtfully presented by her family, coupled with the intrusive nature of the treatment and its minimal potential to achieve any medical objective, rebut any presumption of continuing to promote life. Quite simply, I have come to the conclusion that it would be disrespectful to Mrs. N to preserve her further in a manner I think* ***she*** *would regard as grotesque."* (emphasis added).

Comment

It is difficult to know whether to be pleased or be concerned that it is now only in the 10th year of the MCA's life that we are having such a spate of decisions that so squarely seek to place the individual at the heart of the process, whether that be as regards the assessment of capacity (the *C* case also reported in this issue) or in the determination of best interests. Let us take the former course, and celebrate the fact that the courts are now determined to make such efforts to identify and (even if being careful not to say that they are being governed by) to respect the wishes of the individuals concerned where they can be identified.

As with the *Wye Valley* case, this is a model of best interests decision-making. That it may have represented an extension of the court's jurisdiction into new areas is – frankly – neither here nor there because it did soon the basis of so careful an analysis and application of the core principles of the Act.

One final procedural point should be noted. N's case was different to those previously considered by the courts in another way: her prolonged disorder of consciousness was caused not by a sudden onset acquired brain injury, but as a result of a degenerative disease. The RCP Guidelines on Prolonged Disorder of Consciousness is very firmly focused upon those who have sustained a sudden onset profound acquired brain injury. However, none of the experts who gave evidence before Hayden J (all of whom had been involved in drafting the Guidelines) suggested that they were not relevant to the diagnostic issues before the court. Nor was there anything in Hayden J's judgment to suggest that M's application was anything other than appropriate or necessary – i.e. he did not dissent in any way from the clear statement made by Baker J (endorsed by the President) in *W v M* that applications to withhold or withdraw ANH from a person in VS or MCS must be referred to the court. Treating Trusts and CCGs must therefore consider carefully whether they are required to bring applications for withdrawal of CANH from those in MCS (and indeed PVS) however caused. That having been said, the editors hope that in due course the attention of the courts will be drawn firmly back to the observations of the Court of Appeal in *Burke v GMC* [2005] EWCA Civ 1003 as to the extent to which applications to court are required by law as opposed to being good practice where the legality of the proposed course of action is in doubt (see paragraphs 70-80).

Capacity at the limits

Kings College NHS Foundation Trust v C and V [2015] EWCOP 80 (MacDonald J)

Mental capacity – assessing capacity – medical treatment

Summary

[Editorial note: this case has attracted much media coverage, which has used much of the judge's description of C's unconventional and 'sparkly' life-style. Whilst we consider that the picture painted by MacDonald was one that sought – properly and sensitively – to examine C's entire personality so as to be able to assess whether she had capacity to make the decision in question, we are conscious that there are ongoing proceedings as to whether C's name should be revealed, and one of the points made on behalf of C's family is as to the impact upon them of the case. We also have some reservations about the extent to which the details of C's lifestyle require wider circulation so as to be able to summarise the principles of law in play. We have therefore taken a deliberate decision not to rehearse them in detail here, but instead to focus upon the law].

The question for MacDonald J was whether a woman, C had the capacity to decide whether or not to consent to the life-saving treatment that her doctors wished to give her following her attempted suicide, namely renal dialysis. Without such treatment the almost inevitable outcome was the death of C. If the treatment were to have been administered the likelihood was that it would save C's life, albeit that there remained an appreciable and increasing possibility that C would be left requiring dialysis for the rest of her life. C refused to consent to dialysis and much of the treatment associated with it. She was supported in that decision by her family, and in particular her two elder daughters G and V, who considered that she had the requisite capacity. Along with the psychiatrists who had examined C on behalf of the treating clinicians (including by way of a second opinion), an independent expert jointly instructed by the Trust and the family considered that she lacked the material capacity (although his evidence was given very little weight by the court in light of serious shortcomings in his report). C, who was 'present' before the court by way of attendance notes of meetings with the representatives of the Official Solicitor, maintained she had the requisite capacity.

MacDonald J began his judgment by reminding us of the clear – and long-established – principle that a capacitous individual is entitled to decide whether or not to accept medical treatment, including treatment. As he noted at paragraph 2 "[t]*his position reflects the value that society places on personal autonomy in matters of medical treatment and the very long established right of the patient to choose to accept or refuse medical treatment from his or her doctor (voluntas aegroti suprema lex). Over his or her own body and mind, the individual is sovereign (John Stuart Mill, On Liberty, 1859),*" such that *"where a patient refuses life saving medical treatment the court is only entitled to intervene in circumstances where the court is satisfied that the patient does not have the mental capacity to decide whether or not to accept or refuse such treatment. Where the court is satisfied, on the balance of probabilities, that the patient lacks capacity in this regard, the court may take the decision as to what course of action is in the patient's best interests."*

MacDonald J took the opportunity to restate in clear form the principles relating to the assessment of capacity, which merit reproduction as a very useful tour d'horizon of the case-law decided since the MCA 2005 came into force:

> *"25. The following cardinal principles flow from the statute (PH v A Local Authority [2011] EWHC 1704 (COP) at [16]). First, a person must be assumed to have capacity unless it is established that they lack capacity (Mental Capacity Act 2005 s 1(2)). The burden of proof lies on the person asserting a lack of capacity and the standard of proof is the balance of probabilities (Mental Capacity Act 2005 s 2(4) and see KK v STC and Others [2012] EWHC 2136 (COP) at [18]).*
>
> *26. Second, determination of capacity under Part I of the Mental Capacity Act 2005 is always 'decision specific' having regard to the clear structure provided by sections 1 to 3 of the Act (see PC v City of York Council [2014] 2 WLR 1 at [35]). Thus capacity is required to be assessed in relation to the specific decision at the time the decision needs to be made and not to a person's capacity to make decisions generally.*
>
> *27. Third, a person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success (Mental Capacity Act 2005 s 1(3)).*
>
> *28. Fourth, a person is not to be treated as unable to make a decision merely because he or she makes a decision that is unwise. It is important in this regard to recall the words of Peter Jackson J in Heart of England NHS Foundation Trust v JB [2014] EWHC 342 (COP) at [7]:*
>
> > *"The temptation to base a judgment of a persons capacity upon whether they seem to have made a good or bad decision, and in particular on whether they have accepted or rejected medical advice, is absolutely to be avoided. That would be to put the cart before the horse or, expressed another way, to allow the tail of welfare to wag the dog of capacity. Any tendency in this direction risks infringing the rights of that group of persons who, though vulnerable, are capable of making their own decisions. Many who suffer from mental illness are well able to make decisions about their medical treatment, and it is important not to make unjustified assumptions to the contrary."*

29. Likewise, the outcome of the decision made is not relevant to the question of whether the person taking the decision has capacity for the purposes of the Mental Capacity Act 2005 (see R v Cooper *[2009] 1 WLR 1786 at [13] and York City Council v C [2014] 2 WLR 1 at [53] and [54]).*

30. Within these contexts, the fact that a decision not to have life saving medical treatment may be considered an unwise decision and may have a fatal outcome is not of itself evidence of a lack of capacity to take that decision, notwithstanding that other members of society may consider such a decision unreasonable, illogical or even immoral, that society in general places cardinal importance on the sanctity of life and that the decision taken will result in the certain death of the person taking it. To introduce into the assessment of capacity an assessment of the probity or efficacy of a decision to refuse life saving treatment would be to introduce elements which risk discriminating against the person making that decision by penalising individuality and demanding conformity at the expense of personal autonomy in the context of a diverse, plural society which tolerates a range of views on the decision in question (see Mental Incapacity (1995) (Law Comm No 231) (HC 189), [1995] EWLC 231, para 3.4).

31. Fifth, pursuant to s 2(1) of the 2005 Act a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain (the so called 'diagnostic test'). It does not matter whether the impairment or disturbance in the functioning of the mind or brain is permanent or temporary (Mental Capacity Act 2005 s 2(2)). It is important to note that the question for the court is not whether the person's ability to take the decision is impaired by the impairment of, or disturbance in the functioning of, the mind or brain but rather whether the person is rendered unable *to make the decision by reason thereof (see Re SB (A Patient: Capacity to Consent to Termination) [2013] EWHC 1417 (COP) at [38]).*

32. Sixth, pursuant to s 3(1) of the 2005 Act a person is "unable to make a decision for himself" if he is unable (a) to understand the information relevant to decision, (b) to retain that information, (c) to use or weigh that information as part of the process of making the decision, or (d) to communicate his decision whether by talking, using sign language or any other means (the so called 'functional test'). An inability to undertake any one of these four aspects of the decision making process set out in s 3(1) of the 2005 Act will be sufficient for a finding of incapacity provided the inability is because of an impairment of, or a disturbance in the functioning of, the mind or brain (see RT and LT v A Local Authority [2010] EWHC 1910 (Fam) at [40]). The information relevant to the decision includes information about the reasonably foreseeable consequences of deciding one way or another (Mental Capacity Act 2005 s 3(4)(a)).

33. The order in which the relevant terms of the Mental Capacity Act 2005 are drafted places the 'diagnostic test' in s 2(1) before the 'functional test' in s 3(1). However, having regard to the wording of s 2(1), namely, "he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain" (emphasis added), the order in which the tests are in fact applied must be carefully considered. In York City Council v C [2014] 2 WLR 1 at [58] and [59] McFarlane LJ (with whom Richards and Lewison LJJ agreed) held as follows:

> *"It would be going too far to hold that in approaching matters in this way Hedley J plainly erred in applying the law. His judgment refers to the key provisions and twice refers to the nexus between the elements of an inability to make decisions set out in s 3(1) and mental impairment or disturbance required by s 2(1). There is, however, a danger in structuring the decision by looking to s 2(1) primarily as requiring a finding of mental impairment and nothing more and in considering s 2(1) first before then going on to look at s 3(1) as requiring a finding of inability to make a decision. The danger is that the strength of the causative nexus between mental impairment and inability to decide is watered down. That sequence - 'mental impairment' and then 'inability to make a decision' - is the reverse of that in s 2(1) – 'unable to make a decision … because of an impairment of, or a disturbance in the functioning of, the mind or brain' [emphasis added]. The danger in using s 2(1) simply to collect the mental health element is that the key words 'because of' in s 2(1) may lose their prominence and be replaced by words such as those deployed by Hedley J: 'referable to' or 'significantly relates to'…Approaching the issue in the case in the sequence set out in s 2(1), the first question is whether PC is 'unable to make a decision for herself in relation to the matter', the matter being re-establishing cohabitation with NC now that he is her husband and now that he is has regained his liberty.".*

34. Within this context, it is important to remember that for a person to be found to lack capacity there must be a causal connection between being unable to make a decision by reason of one or more of the functional elements set out in s 3(1) of the Act and the 'impairment of, or a disturbance in the functioning of, the mind or brain' required by s 2(1) of the Act.

35. In this case the Trust bases its submissions regarding the 'functional test' squarely on section 3(1)(c) of the 2005 Act, which provides that a person is unable to make a decision for himself if he is 'unable to…use or weigh' the relevant information as part of the process of making the decision (as the disjunctive 'or' comes after the negative, 'unable to' in s 3(1)(c) the subsection requires the person asserting a lack of capacity to demonstrate an inability on the part of the individual to use and *weigh the relevant information).*

36. In PCT v P, AH and The Local Authority [2009] COPLR Con Vol 956 at [35] Hedley J described the ability to use and weigh information as "the capacity actually to engage in the decision making process itself and to be able to see the various parts of the argument and to relate one to another".

37. Within the context of s 3(1)(c) it is not necessary for a person to use and weigh every detail of the respective options available to them in order to demonstrate capacity, merely the salient factors (see CC v KK and STCC [2012] EWHC 2136 (COP) at [69]). Even though a person may be unable to use and weigh some information relevant to the decision in question, they may nonetheless be able to use and weigh other elements sufficiently to be able to make a capacitous decision (see Re SB [2013] EWHC 1417 (COP)).

> *38. It is important to note that s 3(1)(c) is engaged where a person is unable to use and weigh the relevant information as part of the process of making the decision. What is required is that the person is able to employ the relevant information in the decision making process and determine what weight to give it relative to other information required to make the decision. Where a court is satisfied that a person is able to use and weigh the relevant information, the weight to be attached to that information in the decision making process is a matter for the decision maker. Thus, where a person is able to use and weigh the relevant information but chooses to give that information no weight when reaching the decision in question, the element of the functional test comprised by s 3(1)(c) will not be satisfied. Within this context, a person cannot be considered to be unable to use and weigh information simply on the basis that he or she has applied his or her own values or outlook to that information in making the decision in question and chosen to attach no weight to that information in the decision making process.*
>
> *39. Finally, whilst the evidence of psychiatrists is likely to be determinative of the issue of whether there is an impairment of the mind for the purposes of s 2(1), the decision as to capacity is a judgment for the court to make (see Re SB [2013] EWHC 1417 (COP)). In PH v A Local Authority [2011] EWHC 1704 (COP) Baker J observed as follows at [16]:*
>
>> *"In assessing the question of capacity, the court must consider all the relevant evidence. Clearly, the opinion of an independently-instructed expert will be likely to be of very considerable importance, but in many cases the evidence of other clinicians and professionals who have experience of treating and working with P will be just as important and in some cases more important. In assessing that evidence, the court must be aware of the difficulties which may arise as a result of the close professional relationship between the clinicians treating, and the key professionals working with, P. In Oldham MBC v GW and PW [2007] EWHC136 (Fam) [2007] 2 FLR 597, a case brought under Part IV of the Children Act 1989, Ryder J referred to a "child protection imperative", meaning "the need to protect a vulnerable child" that for perfectly understandable reasons may lead to a lack of objectivity on the part of a treating clinician or other professional involved in caring for the child. Equally, in cases of vulnerable adults, there is a risk that all professionals involved with treating and helping that person – including, of course, a judge in the Court of Protection – may feel drawn towards an outcome that is more protective of the adult and thus, in certain circumstances, fail to carry out an assessment of capacity that is detached and objective.'"* (emphases in original)

The first question for the court, MacDonald J held, was whether:

> *71. […] the Trust has established on the balance of probabilities C is unable to make a decision about the matter in hand having regard to the matters set out in s 3(1) (the so called 'functional test'). The Trust accepts that C is able to understand the information relevant to the decision, to retain that*

> *information and to communicate her decision. In relation to the remaining element of the functional test I am not satisfied that the Trust has proved to the requisite standard that C is unable to use and weigh the information relevant to the decision in question.*
>
> *72. Notwithstanding the submission of the Trust, I am not satisfied that C lacks belief in her prognosis or a future that includes her recovery to the extent she cannot use that information to make a decision, or that C is unable to weigh her positive prognosis and the possibility of a future recovery in the decision making process. In my judgment, the evidence in this case, when viewed as a whole, is indicative of C acknowledging that her prognosis is positive, that there is a possible future in which she survives and of her weighing that information in her decision making process.*

MacDonald J then reviewed that evidence in detail, noting that it was important to have regard that, in addition to the position that she had taken with regard to her prognosis, C had given a range of reasons for reaching the decision that she had regarding further treatment, and that she had undertaken the decision-making exercise on the basis of "*placing into the balance many factors relevant to her decision*" (paragraph 91).

As it was conceded by the Trust that C met the other criteria comprising the functional test, MacDonald J pronounced himself satisfied that C was not a person unable to make a decision for herself for the purposes of s.3(1) MCA and, accordingly, did not lack capacity to decide whether or not to accept dialysis. He went on:

> "*93.* [h]*aving found that C is not a person unable to make a decision for herself for the purposes of s 3(1) it is not necessary for me to go on to consider the so called 'diagnostic test'. It is right to record that, as I observed at the conclusion of the hearing, had I been satisfied that C was unable to use and weigh information in the manner contended for by the Trust, I believe I would have had difficulty in deciding that this inability was, on the balance of probabilities, because of an impairment of, or a disturbance in the functioning of, the mind or brain. Whilst it is accepted by all parties that C has an impairment of, or a disturbance in the functioning of, the mind or brain, the evidence as to the precise nature of that impairment or disturbance was far from conclusive. Further, and more importantly, with regard to the question of causation, and in particular whether what was being seen might be the operation of a personality disorder or simply the thought processes of a strong willed, stubborn individual with unpalatable and highly egocentric views the evidence was likewise somewhat equivocal. However, as I say, I need say no more about this in light of my conclusions as set out above.*"

MacDonald J noted that his conclusion did not accord with the considered opinion of two very experienced psychiatrists, but was careful to make clear that this was "*in large part a product of this being a finely balanced case in which a number of reasonable interpretations of the information available are possible*" (paragraph 94).

In concluding, MacDonald J noted that

> "*97. The decision C has reached to refuse dialysis can be characterised as an unwise one. That C considers that the prospect of growing old, the fear of living with fewer material possessions and the fear that she has lost, and will not regain, 'her sparkle' outweighs a prognosis that signals continued life will alarm and possibly horrify many, although I am satisfied that the ongoing discomfort of treatment, the fear of chronic illness and the fear of lifelong treatment and*

> *lifelong disability are factors that also weigh heavily in the balance for C. C's decision is certainly one that does not accord with the expectations of many in society. Indeed, others in society may consider C's decision to be unreasonable, illogical or even immoral within the context of the sanctity accorded to life by society in general. None of this however is evidence of a lack of capacity. The court being satisfied that, in accordance with the provisions of the Mental Capacity Act 2005, C has capacity to decide whether or not to accept treatment C is entitled to make her own decision on that question based on the things that are important to her, in keeping with her own personality and system of values and without conforming to society's expectation of what constitutes the 'normal' decision in this situation (if such a thing exists). As a capacitous individual C is, in respect of her own body and mind, sovereign.*
>
> *98. In circumstances where I have decided that C has at this time the capacity to make the decision in question, this court has no jurisdiction to interfere with the decision making process. Accordingly, although rightly brought, I dismiss the application of the Trust for declarations under the Mental Capacity Act 2005.*
>
> *99. As I said at the conclusion of this hearing, my decision that C has capacity to decide whether or not to accept dialysis does not, and should not prevent her treating doctors from continuing to seek to engage with C in an effort to persuade her of the benefits of receiving life saving treatment in accordance with their duty to C as their patient. My decision does no more than confirm that in law C is entitled to refuse the treatment offered to her for her benefit by her dedicated treating team. Nothing I have said prevents them from continuing to offer that treatment."*

It was subsequently reported that C had died some days after the hearing but before the judgment was handed down.

Comment

It is understandable perhaps that this case attracted significant media attention. Standing back from it, however, it is primarily important for two reasons:

1. As a very clear statement of the law relating to the assessment of capacity which was both admirably succinct and (with one exception noted below, admirably accurate);

2. As a deeply sympathetic application of those principles to a real person viewed, above all, as a person. It is therefore absolutely of a piece with the approach adopted by Peter Jackson J in *Wye Valley* (and indeed with that adopted by Hayden J in the *Re N* case discussed in this Newsletter).

In its – frank – recognition at paragraph 94 of the fact that capacity assessment in complex cases such as this represents no more than the attempt to place a reasonable interpretation upon the information available, the case also stands as a reminder of:

1. The difficulty of imposing a necessary 'binary' black and white legal framework upon the realities of human beings; and therefore

2. How careful assessors must be to make sure that they have obtained all the relevant information and seek to approach

– insofar as possible – the person that they are assessing on that person's own terms.

The one area in which we would – respectfully – quibble with MacDonald J's summary of the law is his assertion at paragraph 35 that a person seeking to prove that another lacks capacity has to show that they lack the capacity to both use and weigh the relevant information. As discussed in greater detail in the guest note which follows prepared by Wayne Martin and Fabian Freyenhagen of the University of Essex, we would respectfully doubt that this in fact represents a correct statement of the law. We should emphasise that we do not consider that applying the correct approach (i.e. that a person lacks the relevant capacity if they cannot either use or weigh the information) would have made any different on the facts of this particular case.

It should be noted, finally, that MacDonald J appeared to take it as axiomatic that – at least in the case before him – it was necessary to approach the test for capacity on the basis of the functional aspect first (i.e. in line with the approach suggested by the Court of Appeal in *PC*, and contrary to the approach suggested in the Code of Practice). Parker J in *NCC* doubted whether the Court of Appeal had in fact intended to reverse the two, and this case may well therefore re-open the debate. As suggested in our guidance note on the assessment of mental capacity, the way through this debate may well be:

1. To note that it may be a question of the focus upon the particular aspect of the test that is most relevant in the circumstances facing the assessor; and

2. In all cases to ask the vital third question – whether the apparent inability to take the decision is because of the relevant impairment of or disturbance in the mind or brain.

Use *or* Weigh? or Use *and* Weigh? A Note on the Logic of MCA sec. 3(1)

[This guest note is prepared by Wayne Martin and Fabian Freyenhagen of the Essex Autonomy Project]

In *Kings College Hospital NHS Trust Foundation Trust v C and V* [2015] EWCOP 80, MacDonald J made an observation, almost in passing, about the framing of the definition of mental capacity in the *Mental Capacity Act 2005* (MCA). The particular matter at issue concerns the logical relationship between the concepts of *use* and *weigh* as they figure in that definition. It is not our purpose here to assess MacDonald J's ruling in this important and difficult case, which is discussed elsewhere in this issue of *The Mental Capacity Newsletter*. But on the particular point concerning the logic of the capacity test, we respectfully submit that MacDonald J's analysis is incorrect.

Rather than turning directly to MacDonald J's analysis, we begin from the language of the statute itself. As is well-known, the MCA relies on a functional definition of the notion of "decision-making capacity." One quirk of the statute is that its definition of this central concept is negative: the relevant section of the statute defines not the *possession* but the *absence* of the ability to make a decision for oneself. In particular, MCA sec. 3(1) establishes that:

> *For the purposes of section 2, a person is unable to make a decision for himself if he is unable—(a) to understand the information*

> *relevant to the decision, (b) to retain that information, (c) to use or weigh that information as part of the process of making the decision, or (d) to communicate his decision (whether by talking, using sign language or any other means).*

The matter at issue for us here concerns the logical form of this definition. Notice in particular that it is presented as a list of four functional abilities, but that the third of these has a disjunctive character: to use *or* weigh information in making a decision. MacDonald J's logical observation concerned the significance of the logical connective: *or*.

What should we make of the "or" in MCA sec. 3(1)(c)? Our own approach in answering this question begins with the observation that there are in fact two occurrences of the word "or" in the relevant clause. One appears between the word "use" and the word "weigh"; the second appears at the end of the clause, serving as the logical connective linking 3(1)(c) to 3(1)(d). In fact, we submit, there is an implicit "or" at work at each step in the functional definition. In effect what it says is that a person lacks the ability to make a decision for themselves if and only if they *either* lack the ability to understand … , *or* lack the ability to retain … , *or* lack the ability to use … , *or* lack the ability to weigh … , *or* lack the ability to communicate.[2]

Once again, it is worth keeping in mind that this disjunctive logical form appears in the context of statutory language that defines a *negative* trait (the *inability* to make a decision for oneself) in terms of the *absence* of certain psychological capacities. If we turn that around in order to define the *positive* trait (the *ability* to make a decision for oneself) in terms of the *possession* of certain psychological capacities, then all these occurrences of "or" become so many occurrence of "and." A person *has* the ability to make a decision of themselves in a matter if they *have* the ability to understand … , *and* the ability to retain … , *and* the ability to use … , *and* the ability to weigh … , *and* the ability to communicate. This transposition follows as a matter of logic.[3] Independent evidence in its support can be found in the *Explanatory Notes* that accompanied the MCA, which included just such a positive transposition of the statutory definition. The

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[2] These implicit occurrences of "or" can be seen explicitly in the original Law Commission draft of what was then called *The Mental Incapacity Bill*:

> *For the purposes of this Part of this Act a person is at the material time unable to make a decision by reason of mental disability if the disability is such that at the time when the decision needs to be made – (a) he is unable to understand or retain the information relevant to the decision, including information about the reasonably foreseeable consequences of deciding one way or another or of failing to make the decision; or (b) he is unable to make a decision based on that information. (The Law Commission, Mental Incapacity Report LC No. 231, page 223; emphasis added)*

It should be noted that the Law Commission report was drafted at a time when the common law definition of incapacity was being refined, coming as it did between the decisions in *Re C* [1994] 1 WLR 290 and *Re MB* [1997] 2 FLR 426. In the latter case, Lady Justice Butler-Sloss wrote that:

> [The] *inability to make a decision will occur when (a) the patient is unable to comprehend and retain the information which is material to the decision, especially as to the likely consequences of having or not having the treatment in question. (b) the patient is unable to use the information and weigh it in the balance as part of the process of arriving at the decision. … . (Re MB* [1997] 2 FLR 426, para. 30.4., emphasis added.)

In this passage from *MB*, the conjunctive form ("use *and* weigh") is used in the context of a definition of the *inability* to make a decision. It is important to note, however, that Lady Justice Butler-Sloss was not offering an interpretation of a statute adopted by Parliament, as there was not yet a statute to interpret.

[3] Logically, the crucial theorem is $(\sim p \leftrightarrow (\sim q \vee \sim r)) \leftrightarrow (p \leftrightarrow (q \;\&\; r))$. That this formula is indeed a tautology can be proved by constructing a truth table.

relevant portion of the positive definition, which takes an explicitly conjunctive character, reads as follows.

> *To make a decision, a person must first comprehend the information relevant to the decision … , secondly retain this information … and thirdly use and weigh it to arrive at a choice. If the person cannot undertake one of these three aspects of the decision-making process then he is unable to make the decision.* [4]

On our reading, therefore, a person must have all *five* abilities (i.e. to be able to understand, retain, use, weigh, communicate) in order to pass the functional test for decision-making capacity.

With all this in mind, then, let us consider MacDonald J's recent ruling in the *C* case. In para. 35, MacDonald J writes:

> *In this case the Trust bases its submissions regarding the 'functional test' squarely on section 3(1)(c) of the 2005 Act, which provides that a person is unable to make a decision for himself if he is 'unable to...use or weigh' the relevant information as part of the process of making the decision (as the disjunctive 'or' comes after the negative, 'unable to' in s 3(1)(c) the subsection requires the person asserting a lack of capacity to demonstrate an inability on the part of the individual to use and weigh the relevant information).*

On the analysis we have offered, this is not correct. The requirement of MCA sec. 3(1)(c) can be satisfied *either* by establishing that a person is unable to use *or* by establishing that a person is unable to weigh. One way of exhibiting the error in MacDonald J's reasoning is to return to double occurrence of the word "or" in section 3(1)(c). As we have seen, one occurrence links "use" and "weigh;" the second links section 3(1)(c) and section 3(1)(d). *Both* occurrences come, as MacDonald J puts it, "*after the negative, 'unable to.'*" If we were to apply MacDonald J's reasoning consistently, we would have to conclude that the person asserting a lack of capacity must demonstrate an inability to communicate as well as an inability to use/weigh. Indeed, a proof of incapacity would have to establish that all five abilities are absent. Since such a conclusion is plainly incorrect, we respectfully suggest that the principle informing MacDonald J's interpretation of the first "or" in section 3(1)(c) cannot be accepted.

Does any of this really matter? Much depends, of course, on how the other words in MCA 3(1)(c) are interpreted. What, in particular, is meant by the terms *use* and *weigh*? If those two terms are effectively synonyms (or irredeemably ill-defined), then it does not much matter whether they are linked conjunctively or disjunctively. But if they are distinct concepts, then our interpretation of the functional test has the effect of setting the bar higher for decision-making capacity. In order to have the ability to make a decision for oneself in a particular matter at the material time, a person must be able *both* to use *and* to weigh the information relevant to the decision. Simply having one of the two abilities does not suffice. Our own view, which we shall not seek to defend here, is that "use" is best understood as a broader category than "weigh." A person can *use* information in a variety of different ways: for example in hypothetical reasoning, in subsuming particular information under a general rule, or simply by paraphrasing information in their own words. *Weighing* treatment information is a more specific deliberative task; it characteristically involves

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[4] Department of Health, 2005: *Explanatory Notes to the Mental Capacity Act*: emphasis altered. See also the MCA's *Code of Practice*, 4.21.

considering the pros and cons of different options in the process of reaching a decision. On our understanding of MCA 3(1)(c), a capacity assessment should consider *both* a person's broad ability to use information, *and* the more specific ability to "weigh up," comparing the advantages and disadvantages of different options.[5]

Medical treatment, the MCA and the MHA

A Hospital NHS Trust v (1) CD (2) A Mental Health Trust [2015] EWCOP 74 (Mostyn J)

Best interests – medical treatment – MHA 1983 – interface with MCA

Summary

The issue in this case was whether it was in the best interests of a 43 year old woman, CD, who suffered from paranoid schizophrenia to have a total abdominal hysterectomy in circumstances where she lacked capacity to make that decision for herself.

CD had an established diagnosis of schizoaffective disorder and was detained under section 3 of the Mental Health Act 1983. Her illness had a remitting and relapsing course and her mental capacity had fluctuated in the past. She had a long history of aggression and violence. The evidence showed that CD's delusional beliefs impaired her ability to weigh up the advantages and disadvantages of medical treatment. Mostyn J had no difficulty in finding that that CD manifestly lacked capacity to make the relevant decision.

The object of the surgery was to remove two very large ovarian growths or masses. All the medical experts and all the parties, including the Official Solicitor who represented CD, agreed that it was in CD's best interests to have the operation. CD strongly expressed the wish to have the operation. Based on the totality of the medical evidence, and on CD's wishes and feelings, Mostyn J concluded that it was in CD's best interests that the operation must take place.

Ancillary to the operation taking place, it was necessary for Mostyn J to authorise a deprivation of CD's liberty which engaged the difficult interface between the MHA and MCA. The question was whether CD was ineligible to be deprived of her liberty because the surgical removal of the ovarian masses was not in accordance with the MHA regime. There were two ways of reading this which gave rise to directly contradictory results. Mostyn J adopted a purposive (rather than literal) reading of paragraph 3(2) to schedule 1A to the MCA which permitted him to make the orders sitting in the Court of Protection under the MCA rather than in the High Court exercising power under the common law inherent jurisdiction. As an aside, Mostyn J commented that it was "*counterintuitive*" that someone going freely and enthusiastically to hospital to have an operation performed under general anaesthesia was deprived of her liberty. However, as it was not a decision that CD could make, and if she changed her mind she would be operated on nonetheless, Mostyn J was satisfied that the state of affairs fell within the acid test in *Cheshire West* (as to which he had a number of distinctly acerbic comments).

Comment

Following on from the recent and moving judgment in *Wye Hospital NHS Trust v B* [2015] EWCOP 60, Mr Justice Mostyn concentrated on

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[5] We wish to thank Alex Ruck Keene for his assistance in the preparation of this note.

CD's own wishes and feelings. However, he emphasised *"it is vital that wishes and feelings are strictly confined to the best interests analysis and do not act subtly to undermine a capacity assessment. Where, as here, there is no doubt about incapacity when the wishes and feelings of the protected person cannot alter that fact even if they happen to align exactly with a rational, "capacitous", decision."*

In reaching his conclusion on CD's deprivation of liberty, Mostyn J reaffirmed the purposive and pragmatic approach in his earlier decision of *An NHS Trust v A* [2015] EWCOP 761 reported briefly upon in our November newsletter. This puts another nail in the coffin for *Re AB* [2015] EWCOP 31 where a contrary approach was taken.

Readers with a classical education (or ready access to Google Translate) will no doubt appreciate Mostyn J's observations as to the views of hoplites as to the meaning of deprivation of liberty.

Constrained choice can be true choice

MM v WL Clinic and MHS [2015] UKUT 0644 (AAC) UT (AAC) (Charles J)

Article 5 – deprivation of liberty – MHA 1983 – conditional discharge

Summary

The patient was 32 years old with a diagnosis of mild learning disability, autistic spectrum disorder and pathological fire starting. Convicted of arson, the Crown Court imposed a restricted hospital order (MHA ss37/41). He sought a conditional discharge on the basis that his capacitous consent to a care regime in the community would render lawful what would otherwise be a deprivation of his liberty.

The crux of the appeal was whether the threat of recall to hospital from the community meant that the patient's consent was not free and therefore invalid. Applying his analysis and obiter comments in *Secretary of State for Justice v KC and C Partnership NHS Foundation Trust* [2015] UKUT 0376 (AAC), Charles J held that:

> *"63. The points made in paragraphs 56 to 62 above, show that conditions relating to a placement outside a hospital which when implemented will create on an objective assessment a deprivation of liberty:*
>
> *i) cannot be lawfully imposed on a restricted patient under the MHA,*
>
> *ii) can be part of the terms and conditions of a conditional discharge that is, or which a restricted patient can reasonably conclude is, in his best interests because it is the least restrictive option and one that enables him to demonstrate that (a) it is no longer necessary for him to be in hospital or liable to recall to hospital to receive treatment for a mental disorder for the purposes set out in the MHA and so that (b) he should be given an absolute discharge,*
>
> *iii) can promote the underlying purposes of the MHA and a conditional discharge (see paragraphs 85 to 89 of my decision in the KC case), and*
>
> *iv) can only be made a lawful option or alternative for a capacitous restricted patient if he gives a valid consent to it.*
>
> *64. The factors set out in the last paragraph show that:*

> i) *a capacitous restricted patient (like the Court of Protection or a DOLS decision maker in respect of a restricted patient who lacks the relevant capacity) has a real choice founded on the advantages and disadvantages and so the merits of the proposed placement assessed through the eyes of the restricted patient to consent to such conditions, and that*
>
> ii) *any such decision is most unlikely to be driven by a threat that he might be recalled to hospital.*
>
> *This is because he is not being presented with a choice between two alternatives that can be imposed on him and the driver for his consent would be a move from hospital (albeit one that might end with an imposed recall) to a placement outside hospital which he has concluded is in his best interests because, for example, in his view that would be a step towards his absolute discharge into the community."*

Accordingly, the patient's consent to the proposed conditional discharge arrangements meant that he would forego his Article 5 right and could lawfully be discharged.

Comment

The decision in *KC* enabled those lacking capacity to be lawfully discharged from hospital into a community deprivation of liberty. This eminently sensible decision enables those with capacity to similarly do so where they consent to the arrangements. Both decisions appear to settle the law, but where does this leave the Court of Appeal's decision in *Secretary of State for Justice v RB* [2012] 1 MHLR 131? Doubts may linger unless and until that decision is put to bed by the appeal courts. As Charles J noted at paragraph 8, *"… as a matter of good administration, the Secretary of State should "put up or shut up…"* as regards his position relating to patients in this position (as to which see further, perhaps, the response to *No Voice Unheard* outlined in the Capacity outside the Court of Protection Newsletter).

Capacity, marriage and consent

Luton Borough Council v (1) SB (2) RS (by his litigation friend, the Official Solicitor) [2015] EWHC 3534 (Fam) (High Court Family Division (Hayden J))

Summary

RS was a 25 year old man with an intellectual disability and autism spectrum disorder. He lived with his mother (SB) and six of his seven siblings.

Proceedings were commenced by the local authority seeking a Forced Marriage Protection Order. The application was designed to forestall an anticipated marriage. However, it subsequently transpired that a marriage between RS and W had taken place in Pakistan. The proceedings were reconstituted under the inherent jurisdiction of the High Court.

The issues included:

- Did RS lack capacity to consent to marriage?
- Did RS lack capacity to consent to sexual relations?
- If RS lacked capacity to consent to marriage and/or sexual relations, should the court exercise its discretion under the inherent jurisdiction to make a

> declaration that the marriage was not recognised at English law?

Applying the tests in Re M (An Adult) (Capacity to Consent to Sexual Relations) [2015] Fam 61, and *Re E (An alleged patient): Sheffield City Council v E* [2005] 1 FLR 965, to the facts, Hayden J had little difficulty concluding that RS lacked capacity to marry and consent to sexual relations, and that there was no real prospect of RS gaining the capacity.

Following his findings that RS lacked capacity to consent to marriage and sexual relations, Hayden J was invited to make a declaration of non-recognition of the Pakistani marriage. Hayden J gave careful consideration to various competing interests. In respect of M, he said:

> *"Having heard all the evidence in this case I am convinced that the objective of this marriage was to provide RS with care and security for the remainder of his life. M, in particular, had been shocked and disturbed by her son's isolation and unhappiness in the residential unit. She found it difficult to manage her distress as she told me about this period in her son's life. As the records at the time reveal, even then, M contemplated marriage as a solution for her son's predicament. I think that she considered the options for her son's future and found them, by the standards of her hopes and expectations as a mother, to be bleak."*

In respect of W, Hayden J said:

> *"In her evidence to me W was respectful to the family, to her husband and to the Court. I formed the impression that she had made a utilitarian calculation of her own interests in this marriage. From a purely western perspective that might appear to be a critical observation. I do not intend it to be regarded as such. W has different cultural expectations; social priorities which are influenced by her upbringing in Kashmir and by her own understandings of the responsibilities and obligations expected of women in her society. She was articulate in her assertion that she had entered this marriage of her own free will. Despite the highly personal nature of the inevitable and proper questions she confirmed with some robustness, that the marriage had been consummated. She also told me that at the time of her menstruation her new husband had shown sensitivity and forbearance. In short, I have absolutely no sense that she had entered this marriage under duress or in consequence of any abusive pressure. On her part I am entirely satisfied that she gave free consent."*

However, the decisive factor in granting the declaration sought was RS's inability to consent. Hayden J said:

> *"Ultimately however, I have come to the conclusion that capacity, at least in the circumstances here, is an intrinsic, indivisible facet of both psychological and moral integrity. The absence of RS's capacity to consent either to sexual relations or to marriage ultimately compromises the ability of this couple to forge the mutual and reciprocal commitment which, in my judgement, is an essential component of a marriage, perhaps even universally so."*

Comment

This judgment demonstrates a careful and sensitive application of the law to the facts. Hayden J echoed the words of Mostyn in D Borough Council v B [2011] EWCOP 101 where he said that the restriction of sexual relationship engages a very profound aspect of an individual's civil liberties and personal autonomy, and recognised *"the development of psychological* *and moral integrity and relationships with other human beings as key aspects of individual human rights*." Although granting the declaration of non-recognition, and expressing the view that in most cases the court will be required to make a declaration of non-recognition, Hayden J made clear that there may be circumstances in the interests of justice, fairness and respect of individual autonomy where discretion could be exercised against any such declaration.

Article 5 and conditions of detention

R (on the application of Idira) v Secretary of State for the Home Department [2015] EWCA Civ 1187 (Court of Appeal (Master of the Rolls, The President of the Queen's Bench Division, and Lord Justice McCombe))

Article 5 – deprivation of liberty

Summary

This case, from the immigration context, concerns a claim for unlawful detention contrary to Article 5(1) ECHR.

The appellant was an Algerian national whose leave to remain in the UK had expired. He was sentenced to a term of imprisonment for theft and sent to a prison. Once the custodial part of his sentence was over, he remained in prison before being moved to an immigration detention centre. The issue was whether the applicant's continued detention in a prison, rather than an immigration removal centre, was unlawful and in breach of his rights under article 5(1).

The Court of Appeal, interpreting the authorities, reached the view that the task of the national court is to decide whether the place and conditions of detention are suitable and appropriate. In this particular context, the Court of Appeal held that immigration detention in a prison rather than an immigration removal centre was not generally contrary to article 5(1).

Comment

This case is interesting for what it says about the conditions of detention under Article 5(1). The appropriateness of place and conditions are relevant criteria for determining whether detention is arbitrary. This reasoning applies equally to detention in the context of, for example, a care home or hospital setting, under Article 5(1)(e) (lawful detention of persons of unsound mind). Indeed, in reaching its conclusion on the law, the Court of Appeal referred to a number of Article 5(1)(e) cases including *Ashingdale v United Kingdom*(1985) 7 EHRR 528. In that case, the European Court of Human Rights made clear that *"there must be some relationship between the ground of permitted deprivation of liberty relied on and the place and conditions of detention. In principle, the "detention" of a person as a mental health patient will only be "lawful" for the purposes of sub-paragraph (e) of paragraph 1 if effected in a hospital, clinic, or other appropriate institution authorised for that purpose…"* The Article 5 obligation to ensure that the place and conditions of detention are suitable and appropriate chimes with a basic principle in the MCA that, in making arrangements for a deprivation of liberty, regard must be had to whether it can be achieved in a way that is less restrictive of P's rights and freedoms.

Short Note: St George's and the powers of the court

Newton J has authorised the publication of the order he made in *St George's Healthcare NHS*

Trust v P & Q [2015] EWCOP 42 (discussed here). The order makes clear what we had suspected must have been the case (but was made inadvertently ambiguous in the judgment), namely that he did not order the Trust to continue providing P with renal replacement therapy; rather he declared that it was lawful (being in his best interests) for him to continue receiving it. Had Newton J ordered the Trust to continue providing such treatment, that would have represented a very significant step over the well-respected dividing line between the roles of the court and clinicians. For those who want to read more about this, an article by Alex should be appearing in the next issue of the Medical Law Review.

Establishing necessity in deprivation of liberty – Strasbourg speaks again

Hadžimejlić and Others v. Bosnia and Herzegovina (Application no 3427/13) ECtHR (Fourth Section)

Article 5 ECHR – deprivation of liberty – DOLS authorisations

Summary

Three citizens in Bosnia and Herzegovina were deprived of their legal capacity and deprived of their liberty in a social care home because their families were not prepared to take care of them and they needed social assistance. The Constitutional Court had previously decided that this breached Articles 5(1) and 5(4) because such psychiatric detention had to be authorised by a decision of the civil courts and there was a lack of judicial review of the lawfulness of the detention. When the deprivation of liberty was reviewed, the relevant civil court decided that their state of health did not warrant continued confinement in the care home. However, they were not released because their continued placement was considered to be in their best interests for reasons of social protection.

The ECtHR repeated its well-rehearsed principles regarding Article 5(1)(e), cited the 2007 report of the European Committee for the Prevention of Torture etc (which criticised the process of admission to social care homes in the country), and referred to Articles 14 and 19 of the CRPD as well as Recommendation No. Rec(2004)10. In light of the Constitutional Court's decision, the ECtHR had no difficulty in concluding that there had been a breach of Article 5(1) in not securing the citizens' release from detention (paras 54-59).

Comment

This is another ECtHR decision that confirms that deprivation of liberty in a care home can only be justified if the unsoundness of mind is of a kind or degree to warrant it. Sadly missing from the judgment are details as to what less restrictive alternatives to the care home were available. The Constitutional Court had ordered the social work centre (which placed them there) to "take measures to ensure respect for the applicants' rights" under Article 5. The government contended that their continued placement was in their best interests. However, the ECtHR took the unusual step of ruling that the State "must secure … release from the Drin social care home without further delay". Perhaps such muscular flexing of the Article 5 protection in the absence of concrete alternatives demonstrates the paramountcy of physical security.

BIA Time Survey

In July 2015 Cornwall Council DoLS team started a BIA Time Survey looking at how long DOLS assessments take. The link to the report is now available here. The headline finding is that The average time taken per DOLS assessment by the 507 respondents to this survey is 12.1 hours, but we would recommend that the full study is read carefully to see precisely how the assessors in question approached their tasks.

Emma Goodall and Paul Wilkins are to be congratulated on undertaking a really valuable piece of work which gives an actual evidence base upon which to build policies in the future.

CQC 6th annual report on monitoring DOLS

The 6th annual reporting on monitoring DOLS is now available.

The key findings are reproduced below.

> ***There has been a tenfold rise in Deprivation of Liberty Safeguards applications in 2014/15***
>
> *Since their introduction in 2009, numbers of applications to use the Deprivation of Liberty Safeguards were consistently low. However, this changed in March 2014 following the ruling of the Supreme Court which clarified the test for when people are deprived of their liberty. Since then, applications have increased tenfold from 13,715 in the year ending March 2014 to 137,540 by March 2015.*
>
> ***Providers' use of the Deprivation of Liberty Safeguards is variable***
>
> *Through our inspections in 2014/15, we found that staff training and awareness of the Deprivation of Liberty Safeguards varies across providers, as do the existence and implementation of policies and processes. We found examples where some providers may be unlawfully depriving people of their liberty.*
>
> ***Improvement is needed across the health and social care sector***
>
> *We believe that the current pressures on the system are unsustainable. We welcome the Law Commission's consideration on the process for authorising deprivations of liberty and await its final proposals for reforming the system. It is also important that providers and local authorities follow the current legislation and Codes of Practice to the Mental Capacity Act and the Deprivation of Liberty Safeguards to ensure that people's rights are protected.*
>
> *We will continue to monitor the response of providers and the wider system going forward. We will continue to use our inspections and reports to encourage improvements in practice, and challenge providers if they are not meeting legislative requirements which may include taking enforcement action.*

There is also a useful – and revealing – map indicating visually just how rates of applications vary across England and Wales.

In the body of their report, the CQC give their initial reaction to the Law Commission's provisional proposals thus:

> *We agree that the proposed 'protective care' scheme should better serve the needs of people affected, and provide a better framework for their families and representatives to become involved in the care being offered. However, we are concerned that some aspects of the current proposals are complex, and may not be easily understood by everyone who will be affected by them, including those involved in their implementation. We look forward to the Law Commission's recommendations for reform after they have considered the consultation feedback. A draft Bill is expected to be published in 2016*

The CQC recommend, in the interim, that "[l]*ocal authorities must not advise providers to delay or inappropriately minimise their applications as this increases the likelihood of people being unlawfully deprived of their liberty*."

Gratuitous care and deputies

Re HNL [2015] EWCOP 77 (Senior Judge Lush)

Best interests – property and affairs

Summary

In this case Senior Judge Lush had to consider the issue of gratuitous care allowances paid to lay deputies or members of P's family.

The deputy in this case was P's brother and had been appointed receiver in relation to P's clinical negligence damages award before the MCA came into effect.

When appointed, Master Lush (as he then was) authorised a gratuitous care allowance to be paid to the receiver for his care and case management services in the sum of £23,000 per year. That payment continued after the receiver became the deputy.

The Public Guardian required the deputy to apply to court for retrospective authorisation of the payments and an order permitting further payments on the ground that such payments were not permitted by section 19(7) MCA. The Senior Judge agreed that such authorisation was needed as section 19(7) only allows reimbursement of deputies for performing deputy's functions as such, see paragraph 41.

The Senior Judge authorised all past payments and directed a case manager's report into future payments.

Unsurprisingly, given the extent of P's disabilities, the report concluded that a professional case manager would charge far more than was being paid to the deputy. Thus, the payments were authorised for the future with the option of indexation, see paragraphs 50 and 51. He also provide for review in 2022, see paragraph 55.

So far as the amount of such payments is concerned, the Senior Judge reiterated that the Court of Protection approaches that in the same way as does the court in a damages claim, namely to ascertain the commercial value and discount it by 20% to reflect the fact that the payment is tax and NI free, see paragraphs 37 – 39.

The Senior Judge emphasised that a deputy must apply for authority to pay himself a care allowance, see paragraphs 43 and 44. He also stated that if a lay deputy wished to pay such an allowance to a family member the court must authorise this too, see paragraph 44.

Finally, he noted that professional deputies are now being required by the OPG to seek authorisation of such allowances when made to P's family (seemingly as part of a general review of such payments). He stated that he had had a meeting with the OPG to discuss this issue in the light of the administrative and financial burden that such applications would cause. The result of this will soon be published. See paragraphs 3, 52, 53 and 54.

Comment

The decision in this case is uncontroversial; the position currently being adopted by the OPG is more so. We await with interest news of whether this policy will continue in light of the meeting foreshadowed in the judgment.

Managing conflicts of interest

Re JW [2015] EWCOP 82 (Senior Judge Lush)

Best interests – property and affairs

Summary

In this case Senior Judge Lush had to consider the issue of who should be P's deputy, P's son or the local authority authorised officer.

The local authority authorised officer was the existing deputy and the matter started as the son's application to be a joint deputy. Unfortunately, the local authority stated that they would not agree to being a joint deputy in any circumstances (as a matter of policy not anything to do with the applicant or P's situation). That led to the son amending his application so that he should replace the local authority authorised officer and be sole deputy.

The Senior Judge eventually decided that it was in P's best interests that her son be her sole deputy and the importance of this case does not concern that part of the decision.

One of the grounds put forward by the local authority for opposing the amended application was that the son was in a position of conflict of interest as he proposed that P's house (where she no longer lived) should be renovated before sale and he (being a builder) should carry out the project. Thus, said the local authority, he stood to gain from his deputyship.

The Senior Judge accepted that but pointed out that potential conflicts of interest were endemic and included local authorities when they were providing care and assessing contributions, see paragraphs 28 – 49 where there is a very useful survey of the law in in both its historical context and the context of Article 12(4) CRPD.

The court's task was to manage any inevitable conflict of interest and in this case the Senior Judge made detailed provisions as to how the son was to carry out the building work to protect P's interests.

Comment

It is clear that Senior Judge Lush is particularly interested in working through some of the practical implications of Article 12(4) of the UNCRPD and, in particular, what securing against undue influence and conflicts of interest in relation to the exercise of legal capacity actually means. One gets the impression that paragraphs 28-49 of the judgment were intended to have a rather wider (and indeed different) audience than either the local authority or P's son.

The OPG publishes its new Safeguarding Policy

On 1st December, the OPG released its new Safeguarding Policy dated November 2015.

Of particular relevance in the area of property and affairs is section 11 that sets out some particular signs of potential financial abuse. Section 16 also has a useful summary of some of the circumstances when the OPG can and cannot become involved and the options in the latter case.

Fact-finding – when (and when not) to undertake it

Re AG [2015] EWCOP 78 (Sir James Munby P)

Practice and procedure (Court of Protection) – fact-finding

Summary

Sir James Munby P has given important guidance as to when (and when not) to hold a fact-finding hearing.

The context of the decision is one that is – sadly – not altogether unfamiliar. It concerned a young woman, AG, with a moderate learning disability and autism spectrum disorder. She alternated between living in her own property and living with her mother, DG, in respect of whom there were a number of allegations by AG (and others), but in respect of whom no conclusive findings had been reached in the context of safeguarding investigations. In November 2011, after a number of allegations relating to both AG and her mother the local authority with responsibility for AG moved her into a placement at a care home (no prior order having been sought from the Court of Protection). The local authority applied shortly after the move to the Court of Protection for declarations and decisions as to AG's welfare and best interests. By the time of the final hearing, DG had moved into semi-independent living. A final order was made granting the relief sought by the local authority, including supervision of contact between AG and her mother.

DG appealed on four grounds, the major thrust being that the judge, HHJ Rogers, failed to make findings of fact in relation to the events in 2011 that had triggered the proceedings.

In relation to this ground, Sir James Munby P expressly endorsed the pre-MCA 2005 decision of Wall J (as he then was) in *Re S (Adult's Lack of Capacity: Care and Residence)* [2003] EWHC 1909 (Fam), in which he had emphasised that unlike in the case of care proceedings in relation to a child, there is no requirement to establish 'threshold' in the case of proceedings in relation to an adult, whether the proceedings are brought in the High Court under the inherent jurisdiction or, as here, in the Court of Protection, such that the absence of any threshold criteria equivalent to those contained in section 31 of the Children Act 1989, "*raises the question as to the extent to which (if at all) it is necessary, for the purposes of exercising the jurisdiction and deciding which course of action is in the best interests of S, to make findings of fact relating in particular to disputed historical issues*." Sir James Munby P expressly endorsed the answer given by Wall J at paragraphs 18 and 21 of that decision, namely that:

> "*18 … I agree that there must be good reason for local authority intervention in a case such as the present. Equally, if there are disputed issues of fact which go to the question of Mr S's capacity and suitability to care for S, the court may need to resolve them if their resolution is necessary to the decision as to what is in S's best interests. Findings of fact against Mr S on the two issues identified in para* [16] *would plainly reflect upon his capacity properly to care for S. But it does not follow, in my judgment, that the proceedings must be dismissed simply because the factual basis upon which the local authority instituted them turns out to be mistaken, or because it cannot be established on the balance of probabilities. What matters (assuming always that mental incapacity is made out) is which outcome will be in S's best interests. There will plainly be cases which are very fact specific.*

> *There will be others in which the principal concern is the future, and the relative suitability of the plans which each party can put forward for both the short and long-term care of the mentally incapable adult. The instant case, in my judgment, is one of the cases in the latter category.*
>
> *21 Whilst I acknowledge that in a relatively untried jurisdiction there are dangers in too relaxed an approach to historical issues, I am unable to accept the proposition that the approach to best interests is fettered in any way beyond that which applies to any judicial decision, namely that it has to be evidence based; that it excludes irrelevant material; and that it includes a consideration of all relevant material. In a field as complex as care for the mentally disabled, a high degree of pragmatism seems to me inevitable. But in each case it seems to me that the four essential building blocks are the same. First, is mental incapacity established? Secondly, is there a serious, justiciable issue relating to welfare? Thirdly, what is it? Fourthly, with the welfare of the incapable adult as the court's paramount consideration, what are the balance sheet factors which must be drawn up to decide which course of action is in his or her best interests?"*

Sir James Munby P held that the decisions of McFarlane J in *A County Council v DP, RS, BS (By the Children's Guardian)* [2005] EWHC 1593 (Fam) and in *Re W (Care Proceedings)* [2008] EWHC 1118 (Fam), and the decision of Cobb J in *LBX v TT (By the Official Solicitor as her Litigation Friend), MJ, WT, LT* [2014] EWCOP 24, had to be read in light of the "overarching principles" identified by Wall J.

On the facts of the instant case and, in particular, given that HHJ Rogers was careful to spell out the consequences of there having been no fact finding hearing (in particular that he did not "*hold them in the background as it were by way of a suspicion lurking over DG*"), Sir James Munby P had little hesitation in dismissing the appeal.

The case is also of some note for confirming that where there is no new evidence (whether by way of expert evidence or observable events), there is no need for a judge to return to a determination of capacity made (in the present case) over a year previously before making a final order: see paragraph 17.

Finally, and returning to a consistent theme, Sir James Munby P noted that:

> *"56. Ms Khalique submits, and I am inclined to agree, that the local authority acted unlawfully in removing AG from OG in November 2011 and placing her at HH without having first obtained judicial sanction. Local authorities must seek and obtain appropriate judicial authority before moving an incapacitous adult from their home into other accommodation. Local authorities do not themselves have power to do this.*
>
> *57. Local authorities also need to appreciate and take appropriate steps to minimise the understandable distress and anger caused to someone in DG's position when initial relief is obtained from the court on the basis of allegations which are not thereafter pursued."*

Comment

Alex is somewhat reassured by this case because it represents endorsement of precisely the approach identified in the Court of Protection Handbook (which provides a neat opportunity to highlight that a revised first edition including the updated rules is now available).

More seriously, the approach set out by the President undoubtedly represents the correct way in which to proceed in cases where the key focus must be upon P and the factual basis upon which the court is being invited to make decisions about P. Only where it is necessary to make findings of fact in order to make those decisions should the court embark upon such a fact-finding procedure.

The only caveat that we would note is that whilst it is undoubtedly correct that the court does not apply a threshold akin to s.31 Children Act 1989, it is a very salutary exercise for local authorities considering making applications to the Court of Protection for what are the functional equivalent of adult care orders to proceed as if it does.

In other words, applying the same forensic rigour as would be applied were a care order to be sought in respect of a child will – we suggest – ensure that elementary steps are taken to ensure that there is proper, substantiated, evidence upon which to seek orders which will have the effect of interfering dramatically with the rights of P and (frequently) those close to them. As Hedley J recognised in *LBB v JM, BK and CM* [2010] COPLR Con Vol 779:

> *"7. The local authority took the view that since the intervention of the court would engage a potential breach of the Article 8 rights of the parties, that it may be incumbent upon them to establish on a factual basis why it was that the court's jurisdiction should be exercised. Broadly speaking, I would endorse that approach and recognise that where an Article 8.2 justification is required then the case should not be dealt with purely as a welfare case if there are significant factual issues between the parties which might bear on the outcome of the consideration under Article 8.2 as to whether state intervention was justified.*
>
> *8. The Mental Capacity Act does not contain provisions equivalent to the threshold provisions under s.31.2 of the Children Act. Nor should any such provisions be imported in it as clearly Parliament intended that they should not be, but an intervention with parties' rights under Article 8 is a serious intervention by the state which requires to be justified under Article 8.2. If there is a contested factual basis it may often be right, as undoubtedly it was in this case, that that should investigated and determined by the court."*

In other words, if local authorities (or indeed other public authorities) proceed on the basis that they need to be prepared – if needs be – to establish any and allegations made as to the risks faced by P (whether from others or from themselves), many of the car-crashes recently seen in the Court of Protection can be avoided.

Short Note: 'Urgency' and the cross-border jurisdiction of the Court of Protection

In *Re J* [2015] UKSC 70, the Supreme Court has considered Hague 34 (or, as family law practitioners call it, the 1996 Hague Convention on the Protection of Children) for the first time. The decision is relevant to those concerned with cross-border cases before the Court of Protection because of how Lady Hale (giving the judgment of the court) approached the construction of Article 11 of Hague 34. In all cases of urgency, this article gives jurisdiction to the authorities of the Contracting State in whose territory the child or property belonging to the child is present have jurisdiction to take any necessary measures of protection, which will lapse as soon as the authority with primary jurisdiction have taken the measures required by the situation (or where measures taken by a non-Contracting State where the child is habitually resident have been recognised and enforced).

A materially identical provision appears in Article 11 appears also in Article 10 of Hague 34's younger brother, Hague 35 (i.e. the 2000 Convention on the International Protection of Adults), with an additional requirement that the state that has taken the measures inform, if possible, the authorities of the state of the adult's habitual residence. There are other (for these purposes irrelevant) limits on the circumstances under which Article 11 of Hague 34 can be invoked which do not apply in relation to Article 10.

Bringing matters closer to home, despite the fact that (unlike Hague 34) the UK has not ratified Hague 35 in respect of England and Wales, the provisions of Article 10 find their way into English law by way of paragraph 7(1)(c) of Schedule 3 to the MCA 2005, which provides that the Court of Protection may exercise its functions under the Act (in so far as it cannot otherwise do so) in relation to an adult present in England and Wales or who has property there, if the matter is urgent. This is clearly the statutory implementation into English law of the provisions of Article 10(1) of Hague 35. The Court of Protection is bound to seek to interpret the term 'urgency' in Paragraph 7(1)(c) in line with the meaning given in Hague 35 given the requirement in paragraph 2(4) of Schedule 3 to construe expressions appearing in the Schedule and in Hague 35 in accordance with the Convention. It is important to recall that the – deeply curious – wording of the MCA means that the CoP exercises its cross-border jurisdiction on an 'all-comers' basis, regardless of whether or not the other relevant state is a Contracting State to Hague 35. When Hague 35 is ratified in respect of England and Wales, then, as between Contracting States, the provisions of paragraph 7 will have to be read subject to paragraph 8 (which will then give effect to the provisions of Article 10 in particular as regards the lapsing of such urgent measures where the state of primary jurisdiction has taken the necessary measures); this will not alter the position vis-à-vis non-Contracting States or the interpretation of paragraph 7(1)(c).

Lady Hale made clear in relation to Article 11 of Hague 34 (and hence – by analogy – with the position that should prevail in relation to the COP) that there is no pre-condition to the exercise of jurisdiction that it be impossible for the court of the home jurisdiction to take action. As she made clear at paragraphs 33-4, the 'holistic' approach to the exercise of the jurisdiction demanded by Article 11 (and hence by paragraph 7(1)(c) of Schedule to the MCA) means that measures of protection which the individual needs now should not be delayed, provided they are in support of rather than in opposition to the jurisdiction of the home country, as the jurisdiction is a secondary, rather than a primary jurisdiction.

Lady Hale also emphasised that, whilst that approach did not emerge from either the *Explanatory Report* to Hague 34 of Professor Paul Lagarde in 1996 or from the *Practical Handbook* on the operation of the 1996 Convention (a Handbook to which there is no equivalent under Hague 35), these texts should not be treated as if they were words in the Convention. Previous judges have expressed similar caution in treating Explanatory Reports as quasi-statutory (see, in particular, *R v R (Residence Order: Child Abduction)* [1995] Fam 209, concerning the Report accompanying the 1980 Convention, in which Stuart-Smith J held that "*whilst no doubt the report is a permissible, useful and indeed authoritative aid to construction of the Convention if the language of the Convention is* *unclear, on this point* [Article 16] *it seems to me that the language of the Convention is perfectly clear – indeed distinctly clearer than that of the report.*") There may well in due course be cases before the Court of Protection where similar caution may need to be exercised in relation to the report accompanying Hague 35.

DNACPR notices – applying the principles

Elaine Winspear v City Hospitals Sunderland NHS Foundation Trust [2015] EWHC 3250 (QB) High Court (QBD) (Blake J)

Other proceedings – civil

Summary

Facts

Carl Winspear was twenty-eight years old when he died shortly after 11.00 pm on the 3 January 2011. He had suffered all his life from cerebral palsy, epilepsy, spinal deformities and other associated health conditions. At the time of his death and all other relevant times he lacked capacity within the meaning of the MCA 2005. Carl had been unwell for a few days beforehand and suffered from chest infections. He was admitted to his local hospital on 2 January 2011 around 3.00 pm. His mother, Elaine, stayed with Carl from his arrival at the hospital until about 9.00pm. When she left she had no particular concern for his future. Before she went to bed that night she contacted the hospital around 10.00pm and was told that Carl was the same.

In the middle of the night, a specialist registrar placed on Carl's clinical record a notice to the effect that cardio-pulmonary resuscitation should not be attempted (DNACPR). This was done without consultation with Ms Winspear or any other family member or person representing Carl's interests. The registrar recorded in Carl's medical record "*DNAR. Speak to family in the morning*." The printed DNACPR notice itself was not fully filled in; the sections dealing with the date of order, with whom the decision was discussed and the counter signature by the consultant were not completed. The decision was to last 48 hours.

The registrar made the decision regarding the placement of the DNACPR notice on clinical grounds as a result of information he had about Carl's condition. He noted that Carl had cerebral palsy, limited communication and was bed-bound. He had pyrexia and hypoxia on arrival at A&E; he had a severally deformed spine (kyphosis); it was considered that he was likely to be suffering pneumonia and was in a frail state. He concluded that CPR would be inappropriate in the event of a cardiac arrest because Carl's severe kyphosis and contractures in his arm made effective performance of it impossible.

In a subsequent witness statement the registrar explained that that he did not want to inflict on Carl a treatment that was distressing, painful, undignified and futile because it had no chance of success. The doctor did not think that there was an imminent risk of cardiac or respiratory collapse but made the decision that he did to avoid the possibility of the nursing staff being obliged to administer CPR, even if the chance of it needing to be administered was remote.

The registrar did not discuss matters with Carl's mother:

> *"firstly because I did not think that the deceased was at high risk of unexpected deterioration over the next five hours and in my view was, although unwell, in a stable condition. Secondly because the decision was not based on a judgement about his quality of life at the time but rather the futility and ineffectiveness of CPR as a intervention in his case. In these circumstances I did not think that it was necessary or appropriate to call his next of kin at that time. It is correct that the form was not fully completed. My intention was that the missing part would be completed*

> *the following morning after discussion with the next of kin."*

Carl's condition was reviewed by the registrar and a consultant at 8.30 am shortly before the registrar went off night duty. No further completion or variation of the DNACPR notice occurred. The medical notes of that meeting set out five items for the treatment plan of which point four reads "speak to family later re res(uscitation) status."

Ms Winspear contacted the hospital at 11.00am and was told again that Carl was stable and was on his oxygen. Shortly after this call she received a further call and was told that the doctors wanted to speak to her before visiting hours had started. She did not have the impression that this meeting was urgent because of a deterioration in Carl's health. She arrived later that morning and had a conversation with a Dr Farrer, a consultant cardiologist and Clinical Director of the directorate of emergency care of the hospital. The precise terms of that conversation were a matter of dispute, there is no doubt that the question of cardiopulmonary resuscitation arose in the course of it. Ms Winspear expressed her strong disagreement with the suggestion that if Carl stopped breathing resuscitation should not be attempted. Although he was severely disabled she did not want him treated differently from any other patient and considered he enjoyed a reasonable quality of life at home with her. Following Ms Winspear's discussion with Dr Farrer, the DNACPR notice was cancelled. Carl was moved to an intensive care unit later that day, where he died in the evening.

In December 2011 the claimant issued proceedings by way of a Part 7 claim form for a declaration under the HRA. She argued that placing the DNACPR notice on Carl's medical record from 3.00 am until it was cancelled sometime after 12.30 without any consultation with a person who had been caring for or representing his interests was a procedural failure and has resulted in Carl's right to respect for private life under Article 8(1) of the European Convention on Human Rights (ECHR) being interfered with without justification. The proceedings were stayed pending the determination by the Court of Appeal of the *Tracey* case, and then restored for trial.

The issue

The Court of Appeal in *Tracey* made clear that, absent convincing reasons to the contrary, an adult patient with capacity has to be involved in the process that leads to the completion of a DNACPR notice, and that the very decision to complete a notice (whether or not it actually had any material difference to the treatment given) represented an interference with the patient's private life under Article 8 ECHR.

The issue for Blake J was the extent to which the principles in *Tracey* could be read across to a case of an adult patient without capacity; this then led him into a detailed consideration of the role of s.4(7) MCA 2005.

Blake J's decision

As Blake J noted: "[t]*here is nothing in the case of Tracey or the Strasbourg case law to suggest that the concept of human dignity applies any the less in the case of a patient without capacity*" (paragraph 45). He therefore accepted the claimant's case that the core principle of prior consultation before a DNACPR decision is put into place on the case file applies in cases both of capacity and absence of capacity.

Blake J also accepted the Trust's submission that the practical exigencies relating to communication differ if the patient who is being treated by a doctor cannot communicate his wishes and beliefs. However,

> "*46.*[…] [i]*n my view, those considerations go to the question whether there is a convincing reason to proceed to implement a DNACPR decision without prior consultation. In the case of persons who lack capacity, the MCA spells out when and with whom a decision taker must consult; if it is not 'practicable or appropriate' to consult a person identified in s.4 (7) before the decision is made or acted on, then there would be a convincing reason to proceed without consultation.*
>
> *47.If, on the other hand, it is both practicable and appropriate to consult then in the absence of some other compelling reason against consultation, the decision to file the DNACPR notice on the patient's medical records would be procedurally flawed. It would not meet the requirements of s.4(7) MCA; it would accordingly not be in accordance with the law. It would be an interference with Article 8(1) that is not justified under Article 8(2) for two reasons:-*
>
> *i) a decision that is not taken 'in accordance with law' cannot justify an interference with the right to respect afforded under Article 8(1);*
>
> *ii) if consultation was appropriate and practicable there is no convincing reason to depart from it as an important part of the procedural obligations inherent in Article 8.*
>
> *48. The discharge of this procedural obligation is not a matter of challenging a clinical judgment as to the appropriate treatment for a patient. The formation of such a judgment is a necessary first step in the decision making process before a DNACPR notice is placed on file but not generally a sufficient one.*

On the facts of the case before him, Blake J was not satisfied that it was other than practicable and appropriate to have attempted to contact Ms Winspear before the DNACPR notice was affixed to Carl's records. He was therefore satisfied that there was was a breach of the s.4(7) MCA 2005, such that no s.5(2) MCA 2005 defence existed to this claim, and also that there was a violation of the procedural duty under Article 8(2) ECHR. Blake J granted her a declaration reflecting the procedural breach of Article 8(2) ECHR, a declaration alone (on the facts of this case) representing just satisfaction.

Comment

This decision is significant, firstly, for confirming that the principles set down in *Tracey* apply across the board. It is likely to mean that the most recent iteration of the guidance on Decisions Relating to Cardiopulmonary Resuscitation (updated after *Tracey*) will need to be modified further so as to make express reference to the procedural requirements of s.4(7) MCA 2005 when it comes to decisions made in the context of those who do not have capacity to participate in the discussions relating to DNACPR notices.

The decision is also significant far beyond the (narrow, but important) context of DNACPR notices. The question of what, precisely, the impact of a failure to comply with s.4(7) MCA 2005 means in relation had been touched upon previously but not conclusively determined by the Court of Appeal in *ZH v Cmr of the Police for the Metropolis* [2013] EWCA Civ 3021 (at paragraph 41, not 51 as noted by Blake J). Blake J has made clear that:

1. Section 4(7) imposes a duty to consult those identified in the section unless it is not practicable and appropriate to do so (i.e. active steps must be taken to consult, rather than simply passively taking into account views that the decision-maker may be aware of);

2. A failure to comply with that duty will mean that the decision-maker cannot then rely upon s.5 MCA in any claim brought for breaches of the ECHR (or, logically, at common law, for instance for trespass to the person where a procedure is carried out upon them).

This decision therefore shows that s.4(7) is – and should – have teeth. It is important also in this context to remember the purpose of consultation – it is not merely to obtain the views of relevant individuals as to what they would like, but "*in particular* [to obtain] *their view of what* [P's] *attitude would be*," as a vital component in making the decision that is "*right for P as an individual human being*" (*Aintree* at paragraphs 39 and 45).

Short note: capacity and coroners

In a case illustrating that an understanding of mental capacity is necessary for coroners, it is reported that an inquest in Staffordshire recorded that a 58 year old man, David Walwyn, committed suicide by refusing to eat. In reaching that conclusion, it is reported that assistant coroner for Staffordshire South, Margaret Jones, aid: "*He made it clear he had chosen to die and refused support. It was his right to refuse to eat as he had the mental capacity*."

Mr Walwyn died on 2 July 2015 after he stopped eating on 28 March 2015. The inquest heard he had left a suicide note with his cousin and had made it clear that he wanted to die.

A representative for South Staffordshire and Shropshire Healthcare NHS Foundation Trust gave evidence at the inquest. She said Mr Walwyn, who lived alone, had a longstanding history with mental health services but that in relation to the decision not to eat he had been assessed as having capacity: "*a psychiatrist and his GP met with his cousin. The Trust assessed his capacity to make a decision that he wanted to die by stopping eating and we had to respect that. He had mental capacity throughout*."

College of Policy Consultation on Mental Health Practice

The College of Policing has launched a consultation on its mental health authorised professional practice to provide guidance to the police service in England and Wales. It is wide ranging in its scope, covering strategic considerations, mental vulnerability, capacity and illness, detention, crime and criminal justice. This is a great opportunity for those with a view on mental health and policing to express those views to inform the final version of the guidance. The consultation closes on 1 January 2016.

Insofar as the mental capacity provisions are concerned, we note there are a number of legal inaccuracies which will hopefully be ironed out during this consultation stage. For example, of some concern (not least as it reflects a misunderstanding that we regularly encounter) is the indication that the police can deprive liberty using MCA s4B. It is important to understand that this provision, relating to deprivation of liberty necessary for life-sustaining treatment or vital acts, is only available *"while a decision as respects any relevant issue is sought"* from the Court of Protection. It cannot therefore be used by the police (or anyone else) outside court proceedings.

No voice unheard no right ignored: the government response

In November the government published its response to "*No voice unheard, no right ignored - a consultation for people with learning disabilities, autism and mental health conditions*"

The response states that the consultation is aimed at accelerating progress to achieve four things:

- people in charge, supported by family and friends;
- inclusion and independence in the community;
- the right care in the right place, and
- very clear accountability and responsibility throughout the system.

The consultation response is structured around 5 key aims, intended to make differences between now and 2020 so that people should:

1. expect to be supported to live independently as part of a community and in a home they have chosen;
2. know their views will be listened to and be able to challenge decisions about them and about their care;
3. have clearly stipulated rights within the Mental Health Act;
4. be able to exercise control over the support they receive with a personal budget, and expect that different health and local services will organise themselves around their needs, and
5. know that professionals are looking out for their physical health needs as well as their mental health needs.

The government proposals for the 5 aims are as follows:

Aim 1: people should expect to be supported to live independently as part of a community and in a home they have chosen.

Proposals:

- guidance for commissioners of health and social care services on:
    - promoting wellbeing, and factors to take into account when considering living arrangements, including how to support people to live independently, in the community and respecting their wishes and desires;
    - exercise of *Care Act 2014* local 'market-shaping' duties to further aid the development of a diverse market of community-based provision, and
    - the need to ensure sufficiency of supply of community-based provision.
- amend Mental Health Act regulations to change the information required on

admission so that Approved Mental Health Professionals have to consider and record whether assessment and treatment could be provided without detention in hospital.

Aim 2: people should know their views will be listened to and be able to challenge decisions about them and about their care.

Proposals:

- consider how Care and Treatment Review principles/processes can (i) be extended to local authority-led and other placements and (ii) be strengthened, including if necessary by statutory force;
- consider how learning from implementation of CTRs can inform the Care Programme Approach (CPA), and whether this guidance could helpfully be updated/expanded (subject to the Law Commission's consultation in the context of Deprivation of Liberty safeguards) consider introduction of a single advocacy model bringing together existing statutory schemes (including Independent Mental Health Advocates and Independent Mental Capacity Advocates) and providing these on an opt-out (rather than opt-in) basis;

- pilot access to a named social worker who will provide professional advice and support, be the primary point of contact for the service user and their family/carers wherever the person is being supported, and provide a professional voice across the system;

- strengthen work being undertaken as part of the Transforming Care Programme's 'empowering people' workstream and/or the Department's strategic partner programme to:

  - build on the new accessible information standard to ensure that people receive information in formats that they can understand, and that they receive appropriate support to help them to communicate;

  - build on the proposal of a (nonstatutory) 'Charter of Rights' to provide definitive and accessible information on their rights, and how to access support to exercise them, and promote use of advance statements;

- guidance for commissioners of health and social care services on involving people with learning disabilities/ autism/mental health conditions in the design, development and delivery of services;

- monitor implementation of the new service model for commissioners of health and social care services, and of Care and Treatment Reviews on care planning, admissions, transfers and discharges and consider the need for further legislative proposals in response to a review of impact.

Aim 3: people should have clearly stipulated rights within the Mental Health Act.

Proposals:

- recognising the issues for people with learning disabilities, autism and mental health conditions in the criminal justice system:

  - an end to the use of police cells as a place of safety for children and young people detained under sections 135 or 136 of the Mental Health Act 1983

  - no one detained under sections 135 or 136 to be held in a 'place of safety' for more than 24 hours without being assessed by a relevant professional and either discharged or admitted (this and the above to be achieved via the Policing & Criminal Justice Bill together with other changes resulting from the review of sections 135/136)

- subject to further consultation, make changes to the Mental Health Act 1983:
  - enabling patients and families to challenge whether their wishes and feelings were appropriately considered when making applications for detention;
  - amending provisions regarding "nearest relative" to ensure this meets the wishes and needs of people subject to the Act;
  - making the Mental Health Act Code of Practice statutory guidance for NHS commissioners as it is for professionals, local authorities and providers;
- review safeguards regarding renewals of detention (e.g. expansion of requirement for an independent second doctor's opinion);
- propose amending the Act to make provisions about the discharge of patients to community placements amounting to a deprivation of liberty;
- further consideration in principle of whether and how the Mental Health Act should apply to people with learning disabilities and/or autism and if this remains appropriate.

Aim 4: people should be able to exercise control over the support they receive with a personal budget, and expect that different health and local services will organise themselves around their needs.

Proposals:

- review data available for local and national transparency and accountability with metrics including:
  - delayed discharges;
  - personal budgets/integrated budgets;
  - integrated personal commissioning;
- work with NHS England and the Local Government Association to develop guidance and tools (e.g. consent templates) to ensure information is shared legitimately and in accordance with professional standards and good practice; and
- consider what further actions are required to embed solutions to generic data governance issues, especially where data sharing is currently impeded in relation to the care of people with learning disabilities, autism and mental health conditions, where this would meet aims of good commissioning practice and improved patient care.

Aim 5: people should know that professionals are looking out for their physical health needs as well as their mental health needs.

Proposals:

- guidance to commissioners of health and social care services to clarify responsibilities for ensuring physical healthcare needs are met alongside mental health needs;

- subject to further consultation, make changes to the Mental Health Act 1983 regarding responsibility to ensure physical care needs are met for mental health inpatients/detained patients to ensure the individual is registered with a general practitioner and is able to benefit from programmes such as individual health checks, screening tests and health action plans.

A very considerable degree of skepticism has been expressed on social media and elsewhere as to the extent to which any of the above will actually be translated into legislation (or otherwise be brought to bear so as to make real changes). It will be necessary to ensure that pressure continues to be brought to bear to ensure that the document does not simply start to gather dust on the shelves in Whitehall.

Inaugural UK Mental Disability Law Conference

The Inaugural UK Mental Disability Law Conference is to be held at Nottingham on 30 June and 1 July 2016. This conference is intended to bring together academics and other scholars with an interest in mental disability law for the first meeting of what it is hoped will be an ongoing academic association or network. Unlike the SLSA, this is a specific conference devoted to mental disability law (including issues relating to mental health/psychosocial disability, learning disability, disabilities associated with old age and mental capacity). The inaugural conference is sponsored jointly by the School of Law at the University of Nottingham and the Institute of Mental Health, with the endorsement of the Human Rights Law Centre at the University of Nottingham.

The Nottingham conference will combine plenary and breakout sessions. It is expected that half the presenters at plenary sessions will be people with lived experience of mental health/mental disability services. It is also hoped that at least one fifth of the delegates to the conference will have such lived experience.

The Nottingham conference organisers invite offers of papers for the breakout sessions from scholars of any discipline relevant to law and governance relating to mental disability (including psychosocial disabilities/mental health problems, learning disabilities, and dementia and related disorders of old age). There is no restriction on methodology: papers may be empirical, policy-centred, historical, analytic, traditional legal, or theoretical, in approach. The deadline for offers of papers for the breakout sessions is 1 May 2016.

A pre-conference is planned for post-graduate students, prior to the Nottingham conference.

For further information please email karen.sugars@nottshc.nhs.uk.

Book corner

For all those looking for Christmas gifts, we have gathered together three book reviews (two by Alex, one by Annabel) for your consideration.[6]

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[6] Full disclosure: we grateful to the author and publishers respectively for providing us with copies of the three works reviewed. We are always happy to review works in the field of mental capacity (broadly defined).

Care Act Manual: 2nd edition: Tim Spencer-Lane (Sweet & Maxwell, 2015, paperback, £72)[7]

In between trying to sort out the law relating to deprivation of liberty, Tim Spencer-Lane has done us all an enormous favour by updating his invaluable Care Act Manual. He knows more about this topic than anyone else, having led the Law Commission project leading ultimately to the Care Act. In the first edition of the book, published in 2014, he shared that knowledge with us at a time when we had yet to have the statutory guidance and most of the necessary secondary legislation. The first edition, therefore, of necessity represented to some extent speculation as to what might happen, in circumstances where, as we all know, the devil is in the detail.

We now know much of the detail (not all of it good). This second edition therefore includes expert commentary on the secondary legislation, as well as the statutory guidance (running, alone, to some 500 pages). It is therefore a very much a book that is in every way much bigger than the last edition. What the book loses in portability, however, it more than makes up for in the width and depth of its coverage of Part 1 of the Care Act, the relevant schedules, and the supporting apparatus.

As with the previous edition, the Manual does not seek to address the other parts of the Act, and to this extent the title is misleading. However, for anyone who needs to grapple with the new regime for the provision of social services in England, this book is absolutely invaluable.

Deprivation of Liberty: A Handbook: HHJ Nasreen Pearce and DJ Sue Jackson (Jordan Publishing, 2015, £45; paperback; ebook)[8]

This timely book, published by Jordans, seeks to distil the substantive and procedural law relating to deprivation of liberty in the health and social care sectors down to manageable proportions (both in terms of complexity and in terms of length). As to the latter, the handbook succeeds excellently – commentary, relevant statutory provisions, guidance and forms are all to be found in 250 pages (of which just over 100 pages represents commentary). As to the former, the authors – a retired Circuit Judge and current District Judge – have succeeded in substantial part in pulling together the various complex threads in a clear and simple (but not simplistic) fashion. They have, however, been somewhat hampered by the fast-moving pace of developments in the area; whilst they managed (just) to lever in the *NRA* decision of Charles J in September, they opined that it would be likely to be appealed, which has not happened; they were also unable to include coverage of the *LF* decision relating to deprivation of liberty in the ICU setting. The law is therefore very much (and very clearly stated as being) as at September 2015.

With that caveat, though, the book stands as an extremely useful primer for those new to the area and, in particular, for lawyers needing to navigate their way around the provisions. In terms of other professionals, I might respectfully suggest it could usefully be read alongside the Law Society's Practical Guide to Deprivation of Liberty, which includes significantly greater coverage of what deprivation of liberty actually looks like on the ground. It is perhaps only because I was so involved in this Guide that I

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[7] Review by Alex.

[8] Review by Alex.

regretted the absence of any mention of it in the book – notwithstanding the fact that it was commissioned by the Department of Health to stand as an informal update to Chapter 2 of the DOLS Code of Practice (which is also – perhaps curiously – also missing.

There are a couple of minor quibbles that I might have with some of the authors' commentary (in particular, the comment at 6.5.4 as to new COP Rule 3A(1)(a)(e) is, with respect, just plain wrong: it is not a meaningless provision but is, rather, the provision that enables the COP to dispense with joining P in the vast majority of applications to it – i.e. uncontested property and affairs). However, overall, and with the caveat that it will be necessary for those reading the book to ensure that they take steps to keep themselves updated as the law continues to involve, the authors are to be commended on an extremely useful introductory guide to this bewilderingly complex area of the law which fits well into the Jordan's stable of practitioner texts.

A Practical Guide to the Mental Capacity Act 2005: Putting the Principles of the Act into Practice: Matthew Graham and Jakki Cowley (Foreword by Alex Ruck Keene) (Jessica Kingsley Publishers, 2015, £19.99, paperback, ebook)[9]

This succinct book concentrates less on the theory of mental capacity law and more on the practice. Starting with a chapter on "A New Culture of Care", the book sets mental capacity issues in a wider practical context. In navigating the key topics in mental capacity law, covering capacity, advocacy, care planning, best interests and liberty, the book offers helpful practical tips and guidance throughout.

The spirit of the Mental Capacity Act resonates throughout the text. For example, in addition to the chapter on "Assessing Capacity", there is a chapter on "Maximising Capacity" which emphasises the importance of providing appropriate support so that a person may be able to make their own decisions. The themes of independence, liberty and empowerment are recurrent throughout the guide and the emphasis is very much on the support that can be offered to individuals.

There are a number of useful practical tools which feature in this guide, such as a sample report for IMCAs, sample agenda for best interests' meetings and a checklist for supported decision-making. The case studies, based on real life examples, are particularly useful for exploring various scenarios in which the Act plays a part.

In summary, this book is a useful resource for practitioners. It is an excellent plain-English guide to the Mental Capacity Act 2005. The points are neatly broken down into bitesize sections (often in bullet-points) which makes the text easy to read and digest, or handy as a quick reference guide.

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[9] Review by Annabel.

Education (Scotland) Bill – "best interests" no more

In the September Newsletter we reported concerns about aspects of the Education (Scotland) Bill, and described the submission of the Mental Health and Disability Sub-Committee of the Law Society of Scotland. We are pleased to report that 64 amendments lodged by Scottish Government on 23rd November 2015, and duly passed, met those concerns.

Concerns centered on the proposed "capacity" and "best interests" tests as to whether it would be appropriate that children and young persons (young persons being 16 and 17-year olds) should themselves participate in procedures. The Committee argued that the proposed "maturity" element of the capacity test should be eliminated in the case of 16 and 17-year olds. A new definition of "lacking capacity" has been introduced in the case of young persons, namely that "a young person lacks capacity to do something if the young person does not have sufficient understanding to do it". A large number of amendments delete references to young persons altogether.

As we and others commented, the introduction of a "best interests" test in Scots law – bearing in mind that such a test was explicitly rejected for the purposes of adult incapacity law – seemed particularly inappropriate at a time when the concept of a paternalistic "best interests" test had been rejected in General Comment No 1 (2014) "Article 12: Equal recognition before the law" of the Un Committee on the Rights of Persons with Disabilities. The Mental Health and Disability Sub-Committee submitted that if the purpose of the "best interests" test was to allow children to be shielded from potentially harmful information, then the approach should not be that a "best interests" test should be satisfied, but rather a question of whether application of safeguards to prevent any such apprehended harm would be justified. There will no doubt be a general welcome to the removal, by these Scottish Government amendments, of all references to "best interests". The amendments replace "is in the best interests" with "would adversely affect the wellbeing".

It is important to understand that both "capacity" and any adverse effect upon wellbeing are not automatic bars to participation. They are matters which the education authority is required to take into account. These are also matters to be considered by the Additional Support for Learning Tribunal in relation to proceedings before the Tribunal.

Some of the adjustments achieve consistency with existing legislation, and in some places it is proposed that there be regulatory powers to change criteria. The reason for this is that if criteria – particularly outcome criteria – are altered in future across a range of legislation, in practical terms it will be much easier to do that by regulation rather than by a raft of amending provisions to fixed statutory criteria. It has been confirmed that this will be covered in the Explanatory Notes. It is also understood that, in accordance with a subsequent suggestion by the Mental Health & Disability Sub-Committee, an obligation upon Scottish Ministers will be inserted in Stage 3 amendments to require them to consult before exercising such regulatory powers.

The willingness of Scottish Government to consult meaningfully and accept reasoned proposals is to be commended.

Adrian D Ward

[editorial note: these developments also show the power of cross-border working: it was concerns raised by Paul Skowron on Lucy Series' website which alerted Alex to the issues, and, in turn, led to work being done by the Scottish Law Society MHDC, led by Adrian and, ultimately, to these amendments].

Out of step across the borders

On 17th November 2015 Lord Armstrong dismissed a petition by Milton Keynes Council for review of a decision by Scottish Ministers determining the ordinary residence of a lady identified as Mrs JR: Decision [2015] CSOH 156, available here.

According to the Judgment, Mrs R was born on 19th March 1932. She formerly lived in her own home in Milton Keynes. In 2005 she was diagnosed with dementia. Her mental and physical health deteriorated, and on 20th December 2008 she was admitted to an assessment unit, still within the local authority area of Milton Keynes Council. On 7th January 2009 the Court of Protection appointed the Council's finance manager as Mrs R's property and affairs deputy. A mental capacity assessment at that time determined that "she lacked the capacity to decide for herself where she should live".

Mrs R's daughter decided that she would like her mother to reside close to her, in or near Edinburgh. She identified a care home in Musselburgh, within the area of East Lothian Council. Milton Keynes Council advised the daughter to approach East Lothian Council about funding, as Milton Keynes Council was of the view that Mrs R might be entitled to free personal and nursing care. On 25th February 2009 Mrs R was discharged from the care centre in the Milton Keynes area and driven by her daughter to the care home in Musselburgh, all on the same day. Mrs R has lived in the care home in Musselburgh ever since. East Lothian Council had no involvement in the placement of Mrs R in the care home in Musselburgh, nor initially did that Council make any payments in relation to her accommodation there. Financial matters were arranged privately between the home in Musselburgh and the daughter.

By order dated 2nd June 2009, taking effect on 2nd July 2009, the daughter was appointed property and affairs deputy in place of Milton Keynes Council's finance manager. On 10th July 2009 Mrs R's needs for community care services were assessed by East Lothian Council (under section 12A of the Social Work (Scotland) Act 1968). Mrs R was assessed as being in need of residential accommodation with nursing. East Lothian Council accordingly assumed responsibility as "authority of the moment" for the funding of her care placement, and made payments to the Musselburgh home from 8th July 2009. Mrs R's former home in Milton Keynes was sold in 2010. A reference in the Judgment (paragraph 38) to "East Kilbride" would appear to be a typographical error.

Under section 86 of the 1968 Act, where one local authority incurs expenditure under that Act in the provision of accommodation for a person ordinarily resident in the area of another local authority, that expenditure is recoverable from such other local authority, expressly including a local authority in England & Wales. Section 86 also provides that any question as to the ordinary residence of a person under that section shall be determined by Scottish Ministers.

On 26th March 2015, Scottish Ministers determined that there had been no change in Mrs R's ordinary residence for the purposes of section 86, and that she accordingly remained ordinarily resident in Milton Keynes. Scottish Ministers had regard to the decision of the House of Lords in *Shah v London Borough of Barnet* 1983 2 AC 309 ("*Shah*") and to Scottish Government Guidance Circular 3/2010. Milton Keynes Council challenged that determination on the following grounds, namely (1) that Scottish Ministers applied the wrong legal test; (2) they erred in law by failing to consider the correct periods of residence; (3) they erred in their consideration of what constitutes a voluntary act; (4) perversity; and (5) in reaching their decision, they acted in a manner beyond their jurisdiction.

The application was opposed by Scottish Ministers. East Lothian Council entered the process as interested party. Remarkably, Mrs R was not represented in the proceedings and the Judgment does not narrate whether any consideration was given as to whether she, or at least her interests, should be represented. There also appears to have been no enquiry into whether she had ascertainable wishes and feelings (or, in the terminology of the UN Convention on the Rights of Persons with Disabilities, any will and preferences) at least to the extent of knowing whether she was content and settled in her placement in Musselburgh. One would have thought it appropriate for her and her interests to be central to the proceedings. Whether she should be deemed as having her settled home in one country or another is hardly unimportant, particularly in the circumstances that (as noted in the November Newsletter) whether she is subject to Scottish rates of income tax will now depend upon whether she has a "close connection to Scotland" or her "main place of residence" in Scotland. It might have been appropriate for the court to have heard submissions as to a possible scenario in which Scottish Ministers had determined that her ordinary residence remained in England, yet for purposes of any proceedings before the Court of Protection or alternatively under the Adults with Incapacity (Scotland) Act 2000 she would be regarded as habitually resident in Scotland, and for purposes of paying the Scottish rate of income tax (and thus contributing to the Scottish nursing and care payments denied to her if her ordinary residence remained in England) she were determined to be resident in Scotland under the tests for that purpose.

Lord Armstrong upheld the determination of Scottish Ministers. Although not disclosed in the Judgment, the hearing took place on 15th October 2015. By then, new Scottish Government guidance dated 1st June 2015 had been introduced – see "New guidance – old flaw?" in the July Newsletter and, following the decision of the Supreme Court in *Regina (Cornwall Council) Secretary of State for Health and Another* [2015] UKSC 46 ("*Cornwall*"), the further item "New guidance – old flaw – or new interpretation of the law?" in the September Newsletter. See those articles for our view on the core question of when ordinary residence changes where the adult in question may not be fully capable of making the relevant decision.

It is understood that only the 2010 Scottish Government circular was considered. However, it does not appear that the case was pled on the basis that Scottish Ministers had failed to follow their own guidance. On the face of matters, it appears that they did follow their own guidance. That is however irrelevant to the question of whether they applied the correct test. Of course, perhaps the English guidance is wrong and the Scottish guidance is correct, but it does seem relevant at least to consider a situation in which the guidance in the two countries, hitherto stated to have been derived from precisely the same (entirely English) case law, should produce a situation in which, as the 2015 Scottish guidance puts it: "The approach in England differs in that it encourages a broader view than in Scotland". Put bluntly, it would appear that the English guidance, if applied to the available facts in the case of Mrs R, would have produced the opposite outcome.

The decision itself should be referred to for its long and somewhat complex arguments. Here we focus on one feature. English case authority was for long based, and current English guidance is still based, on the two tests generally referred to as "Vale 1" and "Vale 2" set out in *R Waltham Forest London Borough Council, ex p Vale*, The Times, 25 February 1995 ("*Vale*"). As they are not set out in the Judgment, it is worth quoting them here:

> *Vale test 1: "Where a person was so mentally handicapped that she was totally dependent on a parent or guardian, her ordinary residence was that of the parent or guardian: Mr Justice Taylor proceeds to expand on this to state that it was clear from Lord Scarman's speech in Shah that the mind of the claimant was important in two respects in determining ordinary residence: the residence must be voluntarily adopted and there must be a degree of settled purpose. In this case however, the applicant was not capable of deciding where to live and it is unreal to speak of settled purpose: the decision as to where she should live was at all times her parents' decision".*
>
> *Vale test 2: "The Alternative Approach involves considering a person's ordinary residence as if they had capacity. All the facts of the person's case should be considered including physical presence in a particular place and the nature and purpose of that presence as outlined in Shah without requiring the person themselves to have adopted the residence voluntarily".*

Lord Armstrong disregarded any question of "habitual residence" on the basis that its interpretation is a doubtful guide in matters of "ordinary residence", a view taken in *Cornwall* and noted in our commentary on *Cornwall*. The Supreme Court in *Cornwall* confirmed that there are not, in fact, two separate Vale tests, but *"they were complementary, common-sense approaches to the application of the Shah test to a person unable to make decisions for herself; that is, to the single question whether her period of actual residence with her parents was sufficiently 'settled' to amount to ordinary residence" (paragraph 47)*.

There may be scope for discussion as to whether Lord Armstrong's decision accorded with what Lord Carnwath intended. Just as the 2010 Scottish guidance founds upon Vale test 1 and disregards Vale test 2, likewise Lord Armstrong's decision included the following passages:

> "[51] *I am satisfied that the analysis of the dicta in the cases cited, in particular those to be found in the decisions of Shah and Cornwall, as submitted for the respondents and the interested party, is correct. Whilst it must be recognised that the factual circumstances in these cases were not on all fours with the present case, on the basis of the reported cases cited to me, the dictum of Lord Scarman as quoted in Shah, remains the leading modern authority on the correct meaning of the expression 'ordinary residence'. His identification of the two requisite elements required in any assessment was neither overruled nor undermined by the dicta in Cornwall. To the extent that, in Cornwall, the two approaches considered in Vale were reviewed, the conclusion reached was that they were not separable but complementary approaches to the test in Shah. In that context, it is to be noted that the last three lines of paragraph 47 of the decision in Cornwall, viz: '… that is …the single question*

> *whether her period of actual residence with her parents was sufficiently settled to amount to ordinary residence.' should, in my view, be read as an expression of the issue which was to be determined, rather than as a reformulation of the test set out by Lord Scarman in Shah, or as a statement intended to define exhaustively the constituent parts of the relevant test.*
>
> "[52] *On that basis, the determination of whether there has been a change in ordinary residence must necessarily involve an assessment of the extent to which any adoption of a particular abode has been voluntary. In the case of a person lacking mental capacity, such an assessment must necessarily involve a consideration of the nature of such legal authority as there is in place. That is consistent with the legal framework in place in Scotland to protect the interests of those lacking full capacity. The respondents and the interested party were correct therefore to assert that the Scottish Government Circular sets out a correct statement of the law in that regard, and that it was appropriate for the respondents to follow the guidance contained within it.*
>
> "[53] *On that basis, given the lack of mental capacity on the part of Mrs R, the absence of any legal authority on the part of* [her daughter] *to make decisions regarding her mother's personal welfare was fatal to any prospect of a finding that, notwithstanding the duration of Mrs R's presence in Scotland, there had been a change of her ordinary residence from Milton Keynes to East Lothian."*

Perhaps it still remains relevant to take account of the view expressed by the Supreme Court in re LC (Children) [2014] UKSC 1, that "insofar as Lord Scarman's observation [in *Shah*] might be taken to exclude the relevance of a person's state of mind to her habitual residence, I suggest that this court should consign it to legal history, along with the test which he propounded".

The implications of this decision, and of the distinctive stance of Scottish Ministers which it endorses, are still being assimilated. There would appear to be a proliferation of widening fissures including in "ordinary residence" between England & Wales, and Scotland; between habitual residence and ordinary residence; between social care and taxation purposes (as suggested above); and even in "ordinary residence" between social care and health care purposes. For drawing that last point to our attention, we are indebted to delegates at a seminar for CCP Seminars in Edinburgh on 4th December 2015 at which Adrian's colleague with TC Young Alison Hempsey discussed this case (and at which Jill and Adrian also spoke – see "Conferences" below for the first repeat of that event): this point causes particular potential problems for integrated health and social care partnerships.

One can certainly say that whereas the Scottish guidance of 2010 and 2015 noted that there were no Scottish decisions on the interpretation of "ordinary residence" for the purpose of liability for social care costs, we do now have such a decision. At time of writing it is not yet known whether that decision may be appealed. Whether it is or is not, it is now unlikely to be the last exploration of these issues before the Scottish courts.

Adrian D Ward

Mental Welfare Commission for Scotland promotes awareness of powers of attorney

On 13 November, the Mental Welfare Commission commenced a campaign to promote knowledge and understanding of powers of attorney amongst hospital ward staff, care home staff and GPs in Scotland. The awareness raising includes guidance on important considerations both when someone is thinking of signing a power of attorney and also when someone within their care has granted one. It is supported by three leaflets that can be accessed here.

Such a campaign is to be very much welcomed. The granting of a power of attorney is an expression of an individual's autonomy and can be used to ensure, insofar as it is possible, that the person's will and preferences are respected and acted on in the event of their incapacity. This is underpinned by an increasing body of European Court of Human Rights rulings on Article 8 ECHR which might not yet have directly addressed the issue of powers of attorney but certainly reinforce the importance of respecting a person's legal capacity[10]. Moreover, on the face of it powers of attorney may arguably fulfil the requirements of Articles 12(3) and (4) of the UNCRPD[11] although whether they pass muster under the Committee on the Rights of Persons' General Comment No 1 interpreting Article 12[12], which not specifically refer to powers of attorney or similar arrangements[13], remains to be seen.

This development comes at the same time as yet another repetition of the successful joint campaign by Glasgow City Council and Greater Glasgow and Clyde Health Board (with technical support from TC Young) to encourage people to grant Powers of Attorney.

Jill Stavert

Mental Welfare Commission for Scotland: Advice on hidden surveillance

On 2 December 2015, the Mental Welfare Commission published advice on the use of hidden surveillance which can be accessed here

This advice has been publlished as a consequence of an awareness of covert surveillance being used to monitor care staff in various settings. There are clearly are implications for such staff and for those in their care and, of course, the Commission's primary concern relates to the latter with mental illness, learning disability, dementia, or related conditions.

The Commission acknowledges that such surveillance occasionally has very valid uses, such as exposing serious abuse of vulnerable people, but is also mindful that there are serious legal, human rights and ethical implications involved. A balance therefore needs to be achieved between protection and respect for privacy.

As the advice rightly points out, capacity is everything. If someone is able to give valid consent to the surveillance and they refuse to consent then this must be respected. If there are concerns that a person with capacity is subject to undue influence and abuse or exploitation then the matter ought to be referred to the local authority who may consider adult protection measures. It also reminds of the need to assess capacity to consent to such surveillance on a

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[10] *Shtukarutov v Russia*, paras 87-89; *X and Y v the Netherlands*, paras 102 and 109; *Sykora*, paras 101-103. See also Council of Europe Committee of Ministers Recommendation R(99) 4 *on principles concerning the legal protection of incapable adults*, paras 3, 6 and 9.

[11] J Stavert, 'The Exercise of Legal Capacity, Supported Decision- Making and Scotland's Mental Health and Incapacity Legislation: Working with CRPD Challenges' (2015) 4 *Laws* 296-313.

[12] Committee on the Rights of Persons with Disabilities General Comment No 1 (2014) *Article 12: Equal recognition before the law*, CROPD/C/GC/1, 19 May 2014.

[13] *Ibid*, para 17.

decision-specific basis[14]. It recognises that hidden surveillance is an intrusion of a person's privacy and the Article 8 ECHR (the right to respect for private and family life) issues surrounding this and need for proportionality. I would also add the potential Articles 5 (the right to liberty) and 3 (prohibition against inhuman and degrading treatment) ECHR engagement where such surveillance is excessive.

Practical considerations when considering hidden surveillance (for example, positioning of cameras, who images will be shared with and how they will be stored and the type of any recordings) are noted.

Importantly, the Commission acknowledges that surveillance can be conducted by a wide range of people and organisations and thus the need for the situation in terms of care homes and care providers, friends and families, welfare guardians and attorneys, criminal investigations and professional codes (medical and otherwise) to specifically address this.

The Commission is clear that it is not its place to advocate, or not, the use of hidden surveillance this is in the discretion of private individuals and employers but they must explore and exhaust all reasonable alternatives before proceeding with such measures which must be a last resort.

Jill Stavert

Scottish Government consultation on AWI anticipated

We understand that Scottish Government expects to issue by the end of this year a consultation document not only upon the Scottish Law Commission report referred to in the parliamentary answer reproduced below, but seeking responses also for the purposes of the wider review mentioned in the answer. Sandra McDonald, Public Guardian, has often referred publicly to the "wish list" of desired improvements to the 2000 Act which she has been accumulating for some time. She has published her thoughts about possible introduction of a system of "graded guardianship" (see the OPG website). The wider review proposed by Scottish government, which is much to be welcomed, should also facilitate consideration of adjustments to the Scottish legislation to achieve full compliance with the United Nations Convention on the Rights of Persons with Disabilities - on which the work of the "Three Jurisdictions Project"(see [insert links]) continues.

The full text of the relevant Parliamentary question and answer is as follows:

Question S4W-28230: Michael Russell, Argyll and Bute, Scottish National Party, Date Lodged: 30/10/2015
To ask the Scottish Government whether it plans to review the adults with incapacity legislation and, if so, what the timescale is and what consultation arrangements it is planning.

Answered by Paul Wheelhouse (12/11/2015):
We have committed to consulting on the Scottish Law Commission's Report on Adults with Incapacity. The report covers compliance of the Adults with Incapacity (Scotland) Act 2000 with

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[14] As promoted by, amongst others, the WHO and the European Court of Human Rights (e.g. *Shtukaturov v Russia* (2008) ECHR 223) although admittedly not the UN Committee on the Rights of Persons with Disabilities (Committee on the Rights of Persons with Disabilities, General Comment No. 1(2014) *Article 12: Equal recognition before the Law,* adopted 11 April 2014, para 15).

Article 5 of the European Convention on Human Rights, specifically in relation to deprivation of liberty issues. It is anticipated that a consultation paper will issue around the end of 2015, and it will be open to anyone with an interest to respond. Thereafter, a scoping exercise will follow in relation to a wider review of the adults with incapacity legislation.

Adrian D Ward

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Conferences at which editors/contributors are speaking

International Protection of Adults

Alex and Adrian will be participating in a seminar at the British Institute of International and Comparative Law on 11 February on Hague 35 and cross-border matters. More details will be available soon on the BIICL website.

Fatal Accidents Inquiries and Psychiatric Patients

The next seminar in the Centre for Mental Health and Incapacity Law series will be on Fatal Accidents Inquiries and Psychiatric Patients, to be held on 27 January 2016, the speakers being Jill and Dr John Crichton. More details can be found here.

Editors
Alex Ruck Keene
Victoria Butler-Cole
Neil Allen
Annabel Lee
Anna Bicarregui
Simon Edwards (P&A)

Guest contributor
Beverley Taylor

Scottish contributors
Adrian Ward
Jill Stavert

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 Mind in return for postings for English and Welsh events. For Scottish events, we are inviting donations to Alzheimer Scotland Action on Dementia.

Chambers Details

We are taking a break over the New Year, so our next Newsletter will be out in early February. Please email us with any judgments or other news items which you think should be included. If you do not wish to receive this Newsletter in the future please contact marketing@39essex.com.

David Barnes
Chief Executive and Director of Clerking
david.barnes@39essex.com

Alastair Davidson
Senior Clerk
alastair.davidson@39essex.com

Sheraton Doyle
Practice Manager
sheraton.doyle@39essex.com

Peter Campbell
Practice Manager
peter.campbell@39essex.com

London 81 Chancery Lane, London, WC1A 1DD
Tel: +44 (0)20 7832 1111
Fax: +44 (0)20 7353 3978

Manchester 82 King Street, Manchester M2 4WQ
Tel: +44 (0)161 870 0333
Fax: +44 (0)20 7353 3978

Singapore Maxwell Chambers, 32 Maxwell Road, #02-16,
Singapore 069115
Tel: +(65) 6634 1336

For all our services: visit www.39essex.com

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Editors

Alex Ruck Keene
Victoria Butler-Cole
Neil Allen
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Simon Edwards (P&A)

Scottish contributors

Adrian Ward
Jill Stavert

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INTERNATIONAL TRADE
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Editors and Contributors

Alex Ruck Keene: alex.ruckkeene@39essex.com

Alex is recommended as a 'star junior' in Chambers & Partners 2016 for his Court of Protection work. He has been in cases involving the MCA 2005 at all levels up to and including the Supreme Court. He also writes extensively about mental capacity law and policy, is an Honorary Research Lecturer at the University of Manchester, and the creator of the website www.mentalcapacitylawandpolicy.org.uk. **To view full CV click here.**

Victoria Butler-Cole: vb@39essex.com

Victoria regularly appears in the Court of Protection, instructed by the Official Solicitor, family members, and statutory bodies, in welfare, financial and medical cases. Together with Alex, she co-edits the Court of Protection Law Reports for Jordans. She is a contributing editor to Clayton and Tomlinson 'The Law of Human Rights', a contributor to 'Assessment of Mental Capacity' (Law Society/BMA 2009), and a contributor to Heywood and Massey Court of Protection Practice (Sweet and Maxwell). **To view full CV click here.**

Neil Allen: neil.allen@39essex.com

Neil has particular interests in human rights, mental health and incapacity law and mainly practises in the Court of Protection. Also a lecturer at Manchester University, he teaches students in these fields, trains health, social care and legal professionals, and regularly publishes in academic books and journals. Neil is the Deputy Director of the University's Legal Advice Centre and a Trustee for a mental health charity. **To view full CV click here.**

Annabel Lee: annabel.lee@39essex.com

Annabel appears frequently in the Court of Protection. Recently, she appeared in a High Court medical treatment case representing the family of a young man in a coma with a rare brain condition. She has also been instructed by local authorities, care homes and individuals in COP proceedings concerning a range of personal welfare and financial matters. Annabel also practices in the related field of human rights. **To view full CV click here.**

Anna Bicarregui: anna.bicarregui@39essex.com

Anna regularly appears in the Court of Protection in cases concerning welfare issues and property and financial affairs. She acts on behalf of local authorities, family members and the Official Solicitor. Anna also provides training in COP related matters. Anna also practices in the fields of education and employment where she has particular expertise in discrimination/human rights issues. **To view full CV click here.**

Simon Edwards: simon.edwards@39essex.com

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

Adrian Ward adw@tcyoung.co.uk

Adrian is a practising Scottish solicitor, a consultant at T C Young LLP, who has specialised in and developed adult incapacity law in Scotland over more than three decades. Described in a court judgment as: "*the acknowledged master of this subject, and the person who has done more than any other practitioner in Scotland to advance this area of law,*" he is author of *Adult Incapacity*, *Adults with Incapacity Legislation* and several other books on the subject. **To view full CV click here.**

Jill Stavert: J.Stavert@napier.ac.uk

Professor Jill Stavert is Reader in Law within the School of Accounting, Financial Services and Law at Edinburgh Napier University and Director of its Centre for Mental Health and Incapacity Law Rights and Policy. Jill is also a member of the Law Society for Scotland's Mental Health and Disability Sub-Committee, Alzheimer Scotland's Human Rights and Public Policy Committee, the South East Scotland Research Ethics Committee 1, and the Scottish Human Rights Commission Research Advisory Group. She has undertaken work for the Mental Welfare Commission for Scotland (including its 2015 updated guidance on Deprivation of Liberty). **To view full CV click here**.