Welcome to the November 2022 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: When it is in a person's best interests to end restraint which is necessary to keep them alive; and removing silos from capacity in substance and procedure.

(2) In the Practice and Procedure Report: A plethora of developments around transparency, reporting restrictions and closed hearings.

(3) In the Wider Context Report: Morahan in the Court of Appeal; Updated RCN guidance on sex and sexuality in care homes; and the relationship between clinical guidelines and negligence.

(4) In the Scotland Report: An imperative to reform mental health law; and the Hague Convention on the International Protection of Adults.

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

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HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

Protection of autonomy at the intersection of mental and physical health

Cambridge University Hospitals NHS Foundation Trust and Cambridgeshire and Peterborough NHS Foundation Trust v RD, Mrs RD and Mr RD [2022] EWCOP 47 (17 October 2022)(Lieven J)

Best interests – medical treatment

Summary

In *Cambridge University Hospitals NHS Foundation Trust and Cambridgeshire and Peterborough NHS Foundation Trust v RD, Mrs RD and Mr RD* [2022] EWCOP 47, Lieven J was concerned with a 26-year-old woman, RD, with diagnoses of Emotionally Unstable Personality Disorder, Post-Traumatic Stress Disorder and, at some points, psychosis. The case is particularly tragic because between the last hearing in the case and writing the judgment RD self-harmed and died. It raises the importance of protecting someone's autonomy to refuse life-saving treatment and the complex interplay between mental and physical health.

RD had spent significant periods of time in psychiatric units since the age of 15; and had been frequently detained under the Mental Health Act 1983 ("MHA 1983"). She was driven to hurt herself because of alleged adverse earlier experiences and she was highly resistant to treatment, particularly psychotropic medication. She had had many serious incidents of self-harm, which resulted in long periods of hospitalisation including periods in intensive care. In February 2022, she required tracheal reconstruction as a result of a significant injury she caused to her neck. When on leave from a psychiatric ward in June 2022, she cut her own throat and sustained a further significant neck injury with total transection of her trachea.

Following a brief discharge into a supported living placement, she returned to Addenbrooke's with another serious neck injury in July 2022 that meant she was likely to need a permanent tracheostomy with a possible laryngectomy. She was heavily sedated and ventilated in intensive care, after emergency surgery.

The clinical team discussed the treatment options with RD's parents (who were her health and welfare attorneys); and it was agreed that it was in her best interests to be subject to the least restrictive restraint should she take action which would pose a risk to her life; and a restraint plan was agreed. The clinicians had been particularly concerned that she would try to pull the tracheostomy out.

The applicant trusts sought best interest decisions approving a care plan in respect of treatment for her trachea injury. The plan included two alternative treatment plans.

The first question for the court was whether RD had capacity to make decisions in respect of treatment from her trachea injury, which was not easy to answer. There was evidence that her capacity was fluctuating – most of time she appeared to have capacity; but when she became distressed, she lost it. Lieven J accepted that the Court of Protection had jurisdiction on the basis that when she became distressed, she could no longer make the relevant decision.

The second question was, in the usual way, whether the treatment plan was in her best interests. The first plan was to apply in circumstances where RD indicated a desire to have medical support in order to prevent harm; and the second applied when RD indicated a desire for no treatment or intervention, which involved removal of the tracheostomy tube and palliative care. That desire could be expressed by RD removing the tracheostomy tube.

The Judge gave significant weight to the evidence from RD's parents, which included an explanation of RD's cycles of response whereby she would state that she wanted to live but then shortly thereafter significantly self-harm. It was therefore view that the time had come to let her make the choice.

Their evidence (along with that of one of the clinicians) was that RD's sense of autonomy was the most important thing for her; and that she is in charge of her own life and decisions. The continued use of restraint and replacing her tube if she removes it undermines her autonomy and further damages mental health.

In terms of RD's wishes and feelings, the Judge observed that they were *'complicated, fluctuating and highly ambivalent…RD will say that she wishes to live and then acts to destroy herself.'* [46] It was clear that this was a repeating pattern.

The court also took into account the evidence that RD could not be kept sedated for a prolonged period of time, given that she needed 3-6 months of consistent engagement in therapy before it was possible to remove the tube. The risks of ongoing sedation and ventilation included infection and physical deconditioning, which in turn would make it more difficult to move her off ventilation. Lieven J noted therefore that, without sedation, RD would instead require physical restraint otherwise she would remove the tube and die.

The Judge ultimately approved the treatment plans, including the alternative involving no restraint and palliative care, and decided that they were in RD's best interests. She acknowledged the complex intersection between RD's mental and physical health; and focused on RD's autonomy.

Comment

Whilst the court ultimately determined that (i) at times, RD lacked capacity to make the relevant decisions and (ii) when capacitous, RD expressed the wish to live, it undertook a careful survey of the authorities establishing that an adult with capacity can refuse treatment to save their lives, including those addressing the obligations inherent in Article 2.

Lieven J emphasised the importance of judicial scrutiny of any proposed treatment plan which gives effect to personal autonomy over the preservation of life; and therefore engages or is likely to engage Article 2. She observed that, *'it will be a very rare case where an adult who at times does not have capacity and who has expressed a will to live is allowed to die'* [47] given RD's expressed wishes on occasions and the sanctity of life. Ultimately, and notwithstanding those important factors, she decided to approve the treatment plans, given the evidence that '*what RD wants above all else is a sense of autonomy*.' [51]

Finally, it is also worth considering briefly how Lieven J addressed the issue of fluctuating capacity. She carefully laid out the relevant legal framework and case law, but as is often the case, she ultimately did not determine the issue, finding that when RD was distressed she lacked capacity to make the relevant

decision in her best interests. We do not have access to the final orders so it might be that the orders identify a specific threshold at which RD loses capacity, but these are not easy to set in concrete terms (see e.g. *Re DY* [2021] EWCOP 28).

Capacity: avoiding silos, and what should a supervisory body do when a DOLS assessor disagrees with a court-appointed expert?

Lancashire & South Cumbria NHS Foundation Trust & Lancashire County Council v AH [2022] EWCOP 45 (12 October 2022)(HHJ Burrows):

Capacity – medical treatment
Capacity – care

Summary

This case considered whether AH, who had diabetes and a diagnosis of a mild learning disability, had capacity to make decisions about residence, care, sharing information concerning her physical and mental health and care, and to conduct these proceedings.

AH was 46 years old and lived independently in the community. In late 2021, she was admitted to hospital suffering from acute confusion and high blood glucose. It had historically been difficult to ensure she managed her Type 1 diabetes care: AH has made it difficult for District Nurses to provide her insulin; [18] and AH's rigid thinking had led to difficulties with multiagency information sharing. [19] Issues of capacity were considered to be complex [20] and it was queried whether in addition to her established diagnoses, she may also have a personality disorder and autism.

The initial application by the statutory bodies was for AH to be admitted to a care home placement for assessment. A single expert report was obtained from Dr Camden-Smith, which concluded that AH had an:

> *38...inability to understand that the care package she wishes to be supplied to her in her flat is simply not possible. [AH] is further incapable of using and/or weighing the information that she does understand due to her extreme egocentricity and rigidity and refusal to take reality or other views into account. She clings determinedly to her wishes even when these are quite simply impossible.* ***This is due to a combination of her learning disability and personality traits (potentially autism as well) and has been a consistent factor throughout the years that she has been known to local solicitors and her care team****. Learning disability and autism are lifelong immutable conditions, whilst personality disorder can be amenable to therapy, but this has not been effective in [AH's] case. For these reasons it is my opinion that [AH] will not gain capacity in this area."*

Dr Camden-Smith also took the view that AH does not understand '*that she had emotional, psychological and mental health needs*' [39] and that AH lacks capacity to '*make decision about information sharing, restrictions that amount to a deprivation of liberty and to litigate in these proceedings*'. [41]

HHJ Burrows found that the approach taken by Dr Camden-Smith is a '*clear example of the expert moving away from treating capacity decisions in "silos", but rather considering how making decisions about different subjects interact with each other*'.[49] Her report '*considered the correct relevant*

information in her assessment, including crucially the reasonably foreseeable consequences of making the decision one way or another- as has most recently been made clear in A Local Authority v JB.' [50] The court accepted the evidence and made declarations accordingly.

HHJ Burrows identified the disconnect between the findings on capacity by the DOLS assessors and the expert evidence before the court. During the pendency of the case, AH had not been made subject to a standard authorisation (despite being a detained care home resident) due to conflicts between the DOLS assessors. The court had made a finding of lack of capacity for the purposes of s.48 and made orders accordingly. The proceedings could not be reconfigured under s.21A MCA and AH was not entitled to non-means tested Legal Aid [56]. HHJ Burrows expressed the view that *'where a court appointed expert reports on a case in which capacity is in dispute, and that expert concludes that capacity to make decisions as to residence and care are absent, that should be sufficient for the mental capacity requirement of Schedule A1 to be met without more.'*[57] This position, however, was recognised to be unenforceable [58].

HHJ Burrows explored what the supervisory body can do when an assessor concludes that P has capacity.

> *[60]…The assessors are, of course, independent of the supervisory body. That is necessary in order to make the process compliant with Article 5 of the ECHR. It would be unfortunate as well as very costly, if the supervisory body had to judicially review one of their assessors because that assessor reached a view that conflicted with a decision of the Court (see analogously, albeit within the context of the Mental Health Act where a Responsible Clinician challenged his own Hospital Managers in respect of the discharge of a patient: South Staffordshire and Shropshire Healthcare NHS Foundation Trust & Whitworth v The Hospital Managers of St Georges Hospital [2016] EWHC 1196 (Admin).)*
>
> *[61] It would be sensible, it seems to me, if the Local Authority as supervisory body agrees that P lacks capacity, that the **author of the report ought to carry out the assessment for the purposes of the DOLS, if that is possible**. Alternatively, I would expect any mental health or mental capacity assessor to have access to the report and any judgment such as this that has dealt with the issue of capacity.*

HHJ Burrows gave permission for the contents of Dr Camden-Smith's report and any judgment to be disclosed to any mental health or capacity assessor in respect of AH. Although not mentioned in the judgment, an option open to the supervisory body would have been to use that report as an equivalent assessment for the purposes of a standard authorisation.

PRACTICE AND PROCEDURE

Rules Committee to consider closed hearings

The Vice-President has established a subcommittee of the Rules Committee to consider closed hearings. Its members are Alex Ruck Keene KC (Hon) (Chair), Michael Mylonas KC, Joseph O'Brien KC and Fiona Paterson. Its terms of reference are as follows:

1. *The purpose of the Closed Hearings subcommittee of the Ad Hoc Rules Committee is to consider issues relating to so-called "closed hearings" and "closed material" and to prepare a report so as to enable the Vice-President to issue Practice Guidance as to the factors that must be taken into account when consideration is given exceptionally to:*

    a. *ordering a closed hearing (including listing such a hearing);*
    b. *ordering that a party (and/or their representative) is not to be told of the fact or outcome of a without notice application; or*
    c. *ordering that material is to be withheld from disclosure to a party (and/or their representative).*

2. *The report will also address the factors to be taken into account where either a closed hearing or the closure of material has taken place, during and at the conclusion of proceedings.*

3. *For purposes of the work of the subcommittee, its working definitions (subject to refinement in its report) are that:*

    a. *"closed hearings" are hearings from which (1) a party; and (2) (where the party is represented) the party's representative is excluded by order of the court;*

    b. *"closed material" is material which the court has determined should not be seen by the party (and/or their representative).*

4. *For the avoidance of doubt, and whilst the subcommittee will in its report seek to clear up linguistic confusion around the categories of hearing set out in the sub-paragraphs below, it understands that the intended purpose of the Practice Guidance is not to cover them as they raise distinctly different issues to those raised in respect of "closed hearings" and "closed material" as defined above:*

    a. *without notice applications brought by a party where no decision has been made by the court that any other party should be excluded from the determination of the application, or from knowing the fact or outcome of the application;*
    b. *hearings which take place without the knowledge of P, but with the knowledge of P's litigation friend;*
    c. *hearings at which all parties are present, but from which members of the public are excluded.*

Reporting restriction orders: when P's welfare is best served by publicity, and where to draw the line on the disclosure of personal information

Hinduja v Hinduja, Hinduja, Hinduja, A Private Hospital, Bloomberg LP and Hine [2022] EWCOP 36 (Hayden J) (23 August 2022)

Hinduja v Hinduja, Hinduja, Hinduja, A Private Hospital, Bloomberg LP and Hine [2022] EWCOP 37 (Hayden J) (23 August 2022)

Hinduja v Hinduja, Hinduja, Hinduja and Hine [2022] EWCA Civ 1492 (Peter Jackson LJ, Baker LJ, Warby LJ) (11 November 2022)

Reporting restrictions

Three judgements were reported on 11 November 2022 concerning a long-running case regarding Srichand Hinduja, the well-known and extremely successful businessman. The Court of Appeal considered a challenge to a decision in the Court of Protection to retrospectively lift a reporting restrictions order on proceedings heard in public. The Court of Appeal found that the core decision to lift the order was 'clearly sustainable', but varied the order made on a narrow basis in order to protect certain personal information about Mr Hinduja. The two first-instance judgments of Hayden J ([2022] EWCOP 36 and 37) were reported at the same time as the Court of Appeal decision.

Proceedings in the High Court

The proceedings related to Srichand Parmanand Hinduja (also referred to as 'SP' in the first-instance judgments), who has run the Hinduja Group along with his three brothers. The judgment notes his status as one of the richest people in the United Kingdom. Srichand Hinduja is now 86 years old and has a diagnosis of Lewy Body dementia; he is cared for in a private residential setting, which was the subject of the underlying Court of Protection proceedings. His two daughters and one of his brothers (Gopichand Hinduja) were also parties to the proceedings.

Difficulties within the family have given rise to court proceedings for several years, notably in *Hinduja v Hinduja* [2020] EWHC 1533 (Ch). The Court of Appeal noted that the judgment in the Chancery Division *'provides an amount of information about the family situation: Falk J also substantially dismissed an application by the brothers for restrictions to be placed on the normal access by third parties to court records and transcripts. As an exception, she required any application for certain documents to be made on notice to the parties so that they could be heard before disclosure occurred. One reason for this concerned the sensitivity of SP's personal position and his interests as a protected party.'* [7]

Court of Protection proceedings were lodged by Gopichand Hinduja in June 2020. There was an application in respect of a Property and Affairs Lasting Power of Attorney made by Srichand Hinduja in favour of his wife and daughters on disclaimer by his wife and an application was also made for orders relating to contact between Mr Hinduja and his three brothers, as it was contended that his daughters were restricting their contact with their brother. Concerns were also raised relating to Mr Hinduja's care at home, which was being overseen by one of his daughters, Vinoo. Following independent reports, a case manager was appointed to oversee Mr Hinduja's care. Orders were also made to permit Mr Hinduja's brothers to have contact with him (to the extent possible given the context of the pandemic). The first-instance judgment sets out that it was disclosed within the course of proceedings that his daughters, as LPA holders, had drawn on Mr Hinduja's funds to finance their own legal representation, and for their own private purposes. They subsequently disclaimed their status as LPA holders, and a professional deputy was appointed to manage Mr Hinduja's property and affairs.

These proceedings were almost all held in public subject to a standard transparency order, forbidding disclosure of the identities of Mr Hinduja and his family. The Official Solicitor, who represented Mr Hinduja, 'applied as long ago as September 2020 to vary the order to permit the identification of [Mr Hinduja] and the other parties while maintaining a restriction on the reporting of personal information concerning [Mr Hinduja's] health.' [Court of Appeal judgment at 10]

In March 2021, it was believed that Mr Hinduja was at the end of his life, and he was admitted to hospital. An application was made in March 2021 by Bloomberg LP and PA Media Group to allow them to name Mr Hinduja in reporting on the case, but in the anticipation that Mr Hinduja was nearing death, the RRO remained in place.

However, Mr Hinduja was not at the end of his life, and the judgment indicates that he remained in hospital far longer than was necessary due to disputes within the family, a situation which the court found manifestly contrary to his welfare. Both the court and Official Solicitor expressed their concern that Mr Hinduja's *'wealth effectively takes him to 'another world' outside the structures of the State's health and care systems. This may in many cases lead to a protected party receiving a very high level of care and attention. Here, it has made Srichand Hinduja's situation unclear, inaccessible, and at times impenetrable. That, in turn, has served to increase, rather than reduce, his vulnerability.'* [First instance judgment at 33]

A fresh application was made within proceedings in May 2022 by Gopichand Hinduja *'to allow information from the Court of Protection proceedings about SP's property and affairs to be disclosed into the Chancery proceedings and other proceedings. The motive for the application was said to be to counteract alleged misrepresentations by the daughters in those proceedings. The application was in similar terms to that issued by the Official Solicitor in 2020 and it did not seek a relaxation in relation to information about SP's welfare.'* [18]

The family reached an agreement relating to proceedings in the Chancery Division, allowing them to agree to vacate an eight-week trial due to take place in 2023. As a result, Gopichand Hinduja indicated that he did not wish to pursue his application to alter the reporting restrictions order. However, the application on behalf of the Official Solicitor remained live (though modified from her original position), and was heard in July 2022. At paragraph 20, the appellate judgment records that she argued that *'the only restriction should be on the reporting of SP's location and the identity of the institutions and clinicians presently caring for him. Further:'*

> *As to the health and welfare issues, the Official Solicitor recognises the concerns of the court that "policing" any ongoing reporting restriction in relation to the detail of SP's medical condition and incapacity may be difficult. And so, on careful reflection, she does not seek, at this stage, to argue for any order restricting reporting of such detail. She reserves the right to revisit this issue at a later hearing should it be required."*

The Official Solicitor's position hardened further in a responsive position statement of 13 July in which she asserted that SP had a "presumptive" right to a fully reportable hearing in open court:

> *"GP suggested that the Official Solicitor's position on behalf of SP was to waive his privacy rights, and that this position was not consistent with his best interests. And (implicitly) therefore that the Official Solicitor was taking a wrong position as his litigation friend in these proceedings. But as explained in the Position Statement of the Official Solicitor at [6] a party has a presumptive human right under Article*

6 to a fully reportable hearing in open court. This is the primary human right in play in a situation of this sort, and it sits alongside the common law right which is in similar terms. The position of the Official Solicitor on behalf of SP is, justifiably, to assert this important human right. And it is a mischaracterisation of her position on behalf of SP to characterise it as a waiver of his Article 8 rights. It may be that when a P does not oppose the making of an anonymity order in the COP this is an assertion of P's privacy rights. But that does not mean that a party who asserts the full open justice entitlement is waiving any Article 8 rights they may have. The Official Solicitor maintains the position she has taken on behalf of SP for the reasons already set out in submissions."

The application was opposed by Gopichand Hinduja, who argued that the RRO should remain in place to promote Srichand Hinduja's right to privacy:

> *11. Mr Rees QC, on behalf of Gopichand Hinduja, advances the opposite case. He contends that the reporting restrictions should remain in place. As a "fallback position" he suggests that it continues until Srichand Hinduja has died and should thereafter be reviewed. This, however, has not always been Gopichand Hinduja's position. As recently as 29th June 2022, Mr Rees was strenuously arguing for the discharge of the orders. It was expedient to do so at that time because Gopichand Hinduja considered that Vinoo Hinduja was taking active steps to ensure the counter-allegations that she was making about Gopichand Hinduja and his brothers were brought to wide public attention through the Chancery Division proceedings…*
>
> *14.Thus, the application made by Gopichand Hinduja, dated 27th May 2022 to lift the RRO, was also identical to that made by the Official Solicitor, now as long ago as 2020. As Mr Rees noted, wryly, in his June submissions, "[Vinoo Hinduja] raised no objection on that occasion and to raise such an objection now smacks of opportunism". Demonstrably, both Gopichand Hinduja and Vinoo Hinduja have changed their positions regarding the utility or ambit of the RRO. It is plain that the driver behind their shifting positions has been a calculation of their respective litigation interests. Insofar as it might be contended that these are connected with their evolving perceptions of Srichand Hinduja's best interests, I am bound to say, I find that connection to be tenuous…*
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> *17. It is necessary to identify the applications before the Court. Gopichand Hinduja now invites the court to retain the existing RRO; the Official Solicitor now invites the court to rescind the RRO almost entirely; Vinoo Hinduja now invites the court to discharge those features of the RRO which relate to Property and Affairs issues whilst retaining restrictions on reporting what I will for convenience call the health and welfare matters. In addition, I have written representations by Mr Brian Farmer, Press Association and Professor Celia Kitzinger, Open Justice Court of Protection Project. I also have the benefit of written and oral argument by Ms Clara Hamer, on behalf of Bloomberg News. Bloomberg is a New York based global news organisation, particularly noted for its financial journalism. Mr Jonathan Browning, a senior reporter for Bloomberg, has been at nearly every public hearing and has filed a supporting witness statement arguing for the lifting of the reporting restrictions. Mr Farmer and Professor Kitzinger also contend that the restrictions should be lifted.*

At first-instance, Hayden J considered that there was not a tension in this case between Mr Hinduja's Article 8 rights and the Article 10 rights of others, because *'on the factual stratum in this case, Article 10 itself serves effectively to promote Srichand Hinduja's Article 8 rights. Thus, what is usually a balancing exercise between rights which have an entirely different complexion, generates, it is argued, a confluence of interests pointing clearly to significant benefits for Srichand Hinduja in removing any reporting*

restrictions.' [27] The court noted the profound concerns of the Official Solicitor as to what had occurred in this case:

> *28. Central to the Official Solicitor's analysis is her view that the proceedings in the Court of Protection have become hijacked by the other parties' own dynamic agenda. The evolution of the parties' respective positions in relation to this application might be said conveniently to illustrate that point. Additionally, the extent to which investigation of Srichand Hinduja's health and welfare has been marginalised, during the course of the proceedings, troubles the Official Solicitor greatly, as it does me, as I have expressed on a number of occasions.*
>
> *29. Mr Millar submits that full reporting of these proceedings will "self-evidently deter continuation of those disagreements, whether inside or outside of any court room." The litigation history seems to indicate the force of this submission, at least "inside the court room". The proper scrutiny of the case by the press, it is argued, "will also deter the other parties from continued tactical behaviour that has little to do with [Srichand Hinduja]'s interests".*

Due to the family's high profile and the publicly available information from proceedings in the Chancery Division, it was extremely difficult for anonymised reporting to take place in respect of the Court of Protection proceedings without a high risk of jigsaw identification. [36] The court further found that there was no effective means of separating the RRO such that the property and affairs matters were in public, and the health and welfare matters were anonymised (as had originally been proposed by the Official Solicitor, and was essentially the position of his daughters before Hayden J). [37]

The court found:

> *52. As is clear from the above, I entirely accept the Official Solicitor's analysis that Srichand Hinduja's best interests have been consistently marginalised in consequence of the parties' shifting positions in the Chancery Division litigation. The chronology of their changing arguments in relation to this application to vary the reporting restrictions is powerful evidence of this.*
>
> *53. I consider Mr Browning's view that the COP proceedings "appear at times to have been used as leverage in the commercial litigation" is both justified and accurate. Public confidence in the fair and effective administration of the justice system goes to the heart of the right to freedom of expression protected by Article 10. Manifestly there is a powerful argument for this being placed in the public domain.*
>
> *54. The Official Solicitor's argument, to the effect that open reporting of these proceedings is more likely to provide a 'protective layer' to Srichand Hinduja's interest is, in my judgment entirely made out. At present Srichand Hinduja remains in hospital where he ought not to be. There is a conflict within the family concerning the financing of his care package. Suitable accommodation and appropriate care have not been identified. I do not consider that this would have occurred if these issues had been ventilated in public and reported.*
>
> *55. The unique circumstances created by the family's public profile and the ongoing Chancery Division proceedings have served to stultify any effective reporting. The risk of jigsaw identification or inadvertent breach of the RRO has effectively closed reporting down, notwithstanding that this court has been sitting in public throughout.*

> *56. The importance of maintaining probity and integrity in the appointment of attorneys under LPAs is central to the efficient operation of the property and affairs jurisdiction of the Court of Protection. Any departure from the high standards required plainly ought to be in the public domain, not least to maintain those high standards of practice.*
>
> *57. Whilst Srichand Hinduja was a man who preferred privacy, he also recognised the expediency of publicity when that was identified as necessary. Here, for the reasons above, publicity is expedient. Srichand Hinduja's Article 8 rights are not in opposition to the Article 10 rights of the press in this case but, in these unusual circumstances, the two are reconciled in the overall objective of promoting Srichand Hinduja's best interests.*
>
> *58. Whilst variation of the RRO, as contended for by the Official Solicitor, will permit some matters of a personal nature to be reported on, it is correct to say that a good number of those are already ventilated in the Chancery Division proceedings and thus in the public domain. Moreover, the sensitivity of the issues before this court, whilst important, should not be overstated. What now falls to be considered is a practical care plan i.e., identifying suitable property, arranging care and nursing support. Srichand Hinduja's diagnosis and condition are already in the public domain. They require no further exploration in this court.*
>
> *59. I have considered carefully the suggestion, advanced by Mr Rees as 'a fall back', that the variation of the RRO contended for by the Official Solicitor should be adjourned or postponed until after Srichand Hinduja has died. In different circumstances, historically, I yielded to that suggestion for the reasons I have set out. Rather than protecting Srichand Hinduja, as it was intended to, the reporting restrictions served to render him more vulnerable. It is clear that such a risk continues. Moreover, the concept of freedom of speech incorporates not only the right to comment but the choice as to when comment is made.*

Appeal

Gopichand Hinduja appealed this order, and the lifting of the RRO was stayed pending the appeal.

The Court of Appeal stressed that its holdings may be of limited application in other cases:

> *44. These proceedings are highly unrepresentative of the bulk of the work of the Court of Protection because of the unique public profile of SP and his family. We accept that the application of a standard RRO to this family has prevented any meaningful reporting of the proceedings and the family issues that lie behind them. In this respect SP's case is very much a case on its own facts and the judge took an exceptional course that has few if any implications for other cases.*

In relation to a challenge on the basis that Hayden J's order was in error because it relied on facts that had not been found in contested proceedings, the Court of Appeal made a notable finding that the court was not limited in its *'consideration to matters about which findings of facts have been'* and was *'entitled to make his assessment of the proceedings as a whole and to take a view of the parties' conduct.' It went on to observe that 'It is possible to envisage a case where it might be unfair for unresolved allegations to be published, but in this case it was the fact of the allegations and not their validity that mattered.'* [46]

The Court of Appeal further noted in obiter dicta that 'in a field that calls for the case-sensitive balancing of different kinds of rights, it may be unhelpful to label a particular right as 'presumptive'. [46]

In considering the substance of the challenge that Hayden J had erred in his conclusions by not reaching a 'halfway house' proposal in respect of the RRO, permitting identification, but limiting disclosure certain sensitive information relating to Mr Hinduja's health and welfare, the Court of Appeal found that:

> *47. The threshold for appellate interference with an evaluative conclusion of this kind is a high one, particularly in the field of case management. In our view the judge was fully entitled to take the view that he did of the inappropriateness of continued anonymisation of this family. Because of the close association between the family and its business empire, its fortunes matter to many other people. The way in which it has conducted itself in response to SP's predicament, including events concerning the LPA and disputes about care and welfare issues, are all matters of proper public interest. So too is the way in which the court acts in proceedings of this kind. It follows that, because anonymity is impossible, the RRO represents a heavy interference with the normal right of the media to report on proceedings held in public. It is apparent that the judge was acutely aware of this: paras. 38-45 and 55. In the particular circumstances, he also attached significant weight to what he saw as the salutary effect of publicity and little if any weight to SP's normal preference for privacy. In the latter regard, the judge's approach conforms to that taken in the Chancery proceedings by Falk J at para. 83…*
>
> *48…In relation to the Official Solicitor's initial proposal to separate property and affairs matters from health and welfare matters, he remarked that "this dual approach in a case in which the issues revolve around questions of capacity, treatment, care planning etc. present a very considerable challenge if the orders devised are to have any real prospect of enforceability": para. 6. When addressing Mr McKendrick's draft order at para. 46 and para. 3 of his supplementary reasons the judge reiterated that "the health, welfare, and property issues are so interconnected that however an injunction might be framed, it is almost certain to inhibit reporting, because of a perceived risk of eliding these two spheres of protection".*

However, the Court of Appeal considered that the order as drafted disclosed more information than was actually required in the public interest. At paragraph 50, it expressed *'sympathy with the judge, who was faced with a kaleidoscope of changing submissions' and noted that unusually, Mr Hinduja's litigation friend was not arguing for 'even a limited degree of privacy.'* The Court of Appeal found that *'[t]here is no conceivable public interest in those matters being made public, something that could understandably cause distress to SP's family. Publication of this material would in our view amount to a disproportionate breach of SP's rights under Art. 8 and it has not been asserted that there is any countervailing interest under Art. 10, or indeed under Art. 6.'* [50]

The Court of Appeal considered that in this case, it was *'possible to protect SP's intimate information without obstructing other reporting, and that, when understandably rejecting the 'half-way house' that was presented to him, the judge should have retained this narrow level of protection. The fact that some aspects of SP's diagnosis and condition are in the public domain and that the court was not expecting to explore them further (judgment para. 58) only takes the matter so far when the lifting of the RRO was to be retrospective and unconditional.'* [51] To that end, the argument advanced by Gopichand Hinduja that the court erred in failing to consider a more limited order which would have kept more information private was successful.

The Court of Appeal considered that there was no advantage in remitting the case, and substituted its own reporting restrictions order, which barred the disclosure of

10.4 any information about Srichand Parmanand Hinduja's clinical diagnosis or prognosis, healthcare and daily care unless the information is contained in any past or future published judgment given in the Court of Protection, the Chancery Division or another court in England and Wales.

10.5 Any information about SP's wife's clinical condition, healthcare, daily care and the time she spends with SP unless the information is contained in any past or future published judgment given in the Court of Protection, the Chancery Division or another court in England and Wales."

Comment

The Court of Appeal's caution that this case represented a truly unusual set of facts bears repeating: Srichand Hinduja and his family were already very well-known figures prior to this case, and many family members continued to be closely involved with the operation of major business interests. The family's great wealth and the proceedings in the Chancery Division (which themselves had already been the subject of a noted reported case which was not subject to reporting restrictions) also created a situation where the risk of jigsaw identification on any reporting of this case was essentially certain. Hayden J also made robust findings that the Chancery Division proceedings were looming large over the Court of Protection proceedings, and impacting on the parties' positions within them. Many other cases will not feature these elements and will need to be considered on their own facts.

However, the judgments do set out some points of interest, particularly:

1. Hayden J's careful analysis of Srichand Hinduja's views on his privacy, and particularly the finding that he was wiling to court media attention when it would be of benefit to him. We would consider that this factor may be of potential relevance in other cases (for example, the case of Tony Hickmott) where campaigns are launched to draw attention to a person's situation in hopes that this will change the conduct of a public body towards them.

2. The Court of Appeal's decision also emphasises the need to tailor a Reporting Restriction Order around the particular factors of public interest in the case, particularly where a person is being named. While transparency orders are typically made in standard terms, the Court of Appeal emphasised that there was 'no conceivable public interest' in the details of Srichand Hinduja's care and reporting on these points might lead to distress.

3. Finally, the *obiter dicta* of the Court of Appeal on the extent to which findings of fact are required in the context of making an RRO is of interest, and will doubtless be test further.

Covert medication and partially closed: when a party doesn't know what they don't know

Re A (Covert Medication: Closed Proceedings) [2022] EWCOP 44 (7 October 2022)(Poole J)

Best interests – medical treatment

Summary

This case concerned the personal welfare of A, a woman of 23 with a diagnoses of mild learning disability and Asperger's syndrome who was found to lack capacity to conduct this litigation or to make

decisions about her residence, care, contact with others, and her medical treatment for epilepsy, primary ovarian failure, and vitamin D deficiency. A had lived with her mother, B, until 2019, when she was removed to a placement following Court of Protection proceedings (heard by HHJ Moir). In those proceedings, an order was also made for indirect telephone contact between A and B. The background against which those orders were made was summarised by Mr Justice Poole at [2]:

> *A's primary ovarian failure had not been referred to or investigated by healthcare professionals and had remained untreated whilst she had been living with her mother. As a result A had not undergone puberty. She was aged 20 years 8 months at the time of the Judge's first judgment…. The advised treatment was by way of hormone medication which was straightforward, guaranteed to succeed, and would transform A from a child to a woman. Without treatment she would have an "extremely bleak" prognosis with significant risks to her physical and mental health*

Following A's move away from the family home in 2019, she had refused treatment by hormone medication. An application was therefore made, without notice to B, for an order to covertly medicate A. HHJ Moir granted the order (on the basis that A would be offered the treatment every day and only if she refused to take it would it be provided covertly). Covert medication was begun at the end of 2020, with regular court reviews and a programme to educate A about her health.

The matter was escalated to a Tier 3 Judge and came before Mr Justice Poole on 15 September 2022. His judgement was given in two parts.

(i) The first is the judgment that was delivered during closed proceedings to which A's family were not joined, authorising the continuation of the covert administration of hormone treatment to A.

(ii) The second part was the judgment given during the open proceedings, to which B was joined, and at which B was provided with the papers and judgment from the closed proceedings. This part of the judgment is concerned with the continuation of covert medication and the issue as to whether or not there should be a Reporting Restriction Order (RRO) in place.

Part 1 of the judgment

Having concluded that A remained incapacitous when it came to making decisions about her medical treatment and that the hormonal treatment remained in her best interests, the Court went on to consider the more difficult question as to whether the medication should continue to be given covertly to A. The Judge set out in some detail the very real risks that the programme of covert medication would be discovered by A (arising in the main from the significant changes in her appearance as a result of having gone through puberty) and the risk that this would cause A to lose all trust in professionals. The Court concluded that the

> *38…As A's body has visibly changed due to puberty, so the risks of discovery of the covert administration of medication, and the potentially harmful consequences of that discovery, have increased. On the other hand, the questions of cessation and what, if anything, A should be told about the changes to her body and the medication she has had, requires anxious consideration. The conclusion I have reached is that the long term continuation of covert medication is unsustainable but that its immediate cessation would not be in A's best interests. A's best interests are served by exploring the most effective way of transitioning from covert to open medication and/or ending covert medication in a way that is likely to cause the least harm to A.*

Other significant factors in the Court's judgment included:

(i) The fact that B had issued an application for A to be returned home to her care. Unsurprisingly a major plank of that application was that A had been removed from the family home but not been provided with the hormone treatment that it had been argued before HHJ Moir that she desperately needed. It would, as the Court concluded, be extremely difficult to hold that hearing without actively misleading B.

(ii) The fact that one of the reasons why the local authority was against increasing contact between A and B to include either video or face to face contact was to ensure that B was not alerted (by A's appearance) to the fact that A must have been given the hormone treatment covertly. In such circumstances Mr Justice Poole concluded that '*If B were to discover the use of covert medication inadvertently, then, given her past conduct and views, as set out in the Circuit Judge's judgments, B would be likely to find a way to inform A. That could have very harmful consequences for A as I have set out above.*' [42]

The Court therefore decided that B should be informed in an orderly way that A had undergone covert medication with injunctions being made preventing B from informing A of this. This was to be done at the start of the open proceedings on 20 September 2022 and a reporting restriction was to be put in place at the start of the open hearing, to be reviewed during the hearing.

Part 2 of the judgment

The Court informed B about the covert medication at the start of the open hearing and provided her with the bundle from the closed proceedings and the Court's judgment. The Court then went on to hear argument about the appropriate orders to make, concluding that covert medication should continue to be authorised, with an order that a plan should be drawn up to move to open medication 'with A's consent'. Orders to increase contact between A and B were also made.

The judgment concludes with consideration as to whether the RRO should be discharged. The relevant factors were on the one hand the need to protect A's Article 8 and potentially Article 2 rights (on the basis that if A were to find out that she had been covertly medicated she may stop eating and drinking – a risk Mr Justice Poole considered not to be fanciful) and on the other the need to protect Article 10 rights - about which the Judge said as follows:

> *80. In terms of Article 10, it seems to me that it is of considerable public interest that a case in the Court of Protection has involved closed proceedings, from which P's mother and family members were excluded and in which the use of covert medication for the purpose of inducing puberty has been authorised. These are exceptional circumstances. It is a matter of public interest that the court can and does authorise the use of covert medication in exceptional cases, but it adds another layer of exceptionality and public interest that family members were excluded from those decisions.*

In carrying out the balancing act, the Judge noted that the protections in place absent the RRO were the existence of the transparency order and the injunctions made to prevent B informing A that she had been covertly medicated. The Court held that it was unlikely that A, living the life she did with very limited contact from the outside world, would find out that she had been covertly medicated through a publication about her case. The RRO therefore added little protection for her and so it was discharged.

Comment

What is particularly interesting about this case, is the role the Open Justice Court of Protection Project (the Project) played in the decision to discharge the RRO. Having attended only the open hearings (for obvious reasons), their blogs of the proceedings that '*over a two year period of separation from her home and her mother - a separation that appeared to be for the primary purpose of administering endocrine treatment that A was not likely to receive at home - A had still not received endocrine treatment*' [8] was inaccurate. The Judge recorded the Project's submission that these proceedings had undermined their work. The fact that the Project's inaccurate record of the proceedings would stand uncorrected if the RRO were not discharged, was a factor in the Court's determination to discharge the RRO.

Also of note was the Judge's recognition of the important role the Project played in contributing to transparency and public understanding of the workings of the Court of Protection.

Reporting restrictions and deprivations of liberty of children: the risk of jigsaw identification

Re J (Deprivation of Liberty: Hospital) [2022] EWHC 2687 (Fam) (12 October 2022)(Poole J)

Article 5 ECHR – Children and young persons
Media – Anonymity

Summary

A 13-year-old girl ('J') with complex needs arising from ASD and ADHD was the subject of an interim care order. She was in hospital (but attending school) because the Local Authority was not able to find any accommodation for her. This was the eighth hearing where the High Court was being asked to authorise her continued confinement. The Judge outlined the challenges at [7]:

i) The number of available suitable placements for these children is far below the number needed; therefore

ii) Local Authorities with responsibility to accommodate and care for these children cannot find suitable places for them. To be clear, as this Applicant has done, Local Authorities search around the country for suitable accommodation, not just in their own areas. This is a national problem seemingly affecting all Local Authorities; therefore

iii) These children - children who are the most in need of support from skilled and experienced carers in safe and suitable placements - are accommodated in unsuitable places, such as holiday accommodation, homes that are not subject to any regulation, and sometimes, as in this case, even in hospitals where they do not belong.

iv) The care regimes designed to keep these children safe often involve depriving them of their liberty; therefore

v) The High Court is asked to authorise the deprivation of these children's liberty in unsuitable placements.

In July to August there were 237 applications to the recently established national DOL court for children. On this occasion, the Local Authority had identified a private landlord to provide a property it could rent, with care to be provided after staff were trained in the use of restraint. It would be an unregistered placement to be notified to Ofsted, with the risk that Ofsted might then serve cease and desist notices on the provider and property owner. She would be able her to continue her schooling, and all involved supported the proposed plan.

With reluctance, Poole J authorised the following present arrangements which gave rise to a deprivation of J's liberty at [22]:

i) J is not free to leave the hospital.

ii) J is subject to a maximum of 2:1 supervision at all times, save and except for when she has supervised access to the hospital grounds and/or the community as set out in detailed provisions, which shall be a maximum of 4:1 supervision. When J is in the hospital, she will have at least one carer with her inside her cubicle at all times.

iii) During term time, J is allowed to leave the hospital, with supervision, for eight hours to attend school. J is taken by carers to school in a taxi from the hospital and collected from school in a taxi with carers so she can be returned to the hospital.

iv) J is not allowed to access the hospital grounds after 20:00 each night.

v) If J were to attempt to leave the hospital outside of the specified times, she would be prevented from doing so. If she were to leave, she would be returned by emergency services.

vi) For her own safety, the safety of others and to prevent J from attempting to leave the hospital, J may be physically restrained (Ms Hurst for the Trust advised the court that in fact, at present, if J attempts to leave the hospital grounds then she is not prevented from doing so but is returned, with her compliance, by emergency services).

vii) The voluntary administration of oral sedative medication, subject to application of the principles for the use of restraint.

viii) Two members of the hospital security staff shall be available in the hospital grounds and attend as soon as possible once requested if required to provide support when J's behaviour escalates and intervention is required.

ix) J will not have access to a mobile phone or social media during her stay in hospital.

The court directed the use of the minimum degree of force or restraint required and emphasised that this authorisation was permissive, not directive. The more restrictive measures were reserved for when the risks were assessed as being higher. The proposed community arrangements in the new placement were also authorised, and it was stressed that she could not remain in hospital a day longer than was absolutely necessary.

In relation to reporting of the judgment, a journalist submitted that it was in the public interest for the Local Authority to be named. Poole J weighed up the competing rights under Articles 8 and 10 ECHR and concluded:

> *45. In the present case there is a strong public interest in knowing the identity of the applicant Local Authority. First, the applicant is a public body and is accountable. Scrutiny of public authorities requires it to be known which authority is doing what. Councillors within the Local Authority area*

should know what is being done in their name. Voters need to be able to hold their Council to account. Second, it is pertinent that the applicant is a large Local Authority covering a large population. Even with its resources it is struggling to find an alternative placement for this child. It is in the public interest to know the reality of the problems highlighted in this case.
46. The court has to be very mindful of the risk of identification of J. It would be contrary to her best interests for her to be identified as the subject of this case. What is the extent of that risk? Manchester is a large city with a population of over half a million and several hospitals within the Greater Manchester area serving the population of the city of Manchester and beyond. The risk of identification is therefore much lower than it would be if the Local Authority covered a smaller population. To reduce the risk of identification via knowledge of location, I can order that there shall be no information that would identify or be likely to identify the hospitals where J has and is living, the staff working there, or the location of her family home, or the location of the hospitals within Greater Manchester. My RRO of 4 October prohibited identification of the Trust that is responsible for the hospital where J is. No objection is taken to that reporting restriction.
47. In my judgement, the public interest in knowing the identity of the Applicant Local Authority comfortably outweighs the risk of identification of J by the Applicant Local Authority being identified. That risk is extremely small. As to the suggestion that J herself would be harmed or distressed by knowing that the Council was being identified, I reject that. I don't believe that she would consider that identification of the Council would jeopardise her anonymity. That is speculation. It is also very speculative to suggest that potential providers would be put off offering services because the Council was named. I do not believe that that is a realistic suggestion.

Comment

With depressing familiarity, the latest case yet again underlines the scandalous lack of provision for children with complex needs. Had the Local Authority not been able to propose an alternative at this eighth hearing, the Judge would have been unlikely to have granted the authorisation (para 27). The judgment notes the very limited role of the court where only one option is available but emphasises that this does not render it a mere rubber stamp because there remain decisions to be made about the necessity and proportionality of the restrictions. The same is true of the Court of Protection. Unlike to the Court of Protection, however, the High Court has been far more willing not to authorise deprivations of liberty where it cannot in all good conscience be said that the arrangements are in the person's best interests. The balancing exercise regarding the identification of the Local Authority and the risk of jigsaw identification also serves as a useful reminder for how to approach similar issues in the Court of Protection.

Vulnerable litigants, capacity and the new Civil PD1A

AXX v Zajac (Vulnerable parties - Article 6 ECHR - PD1A - case management - split trial - disability - brain injury - personal injury - psychosis - PTSD - mental health - Equal Treatment Bench Book - adjustments) [2022] EWHC 2463 (KB) (5 October 2022)(Senior Master Dr Victoria McCloud)

Other proceedings – Civil

Summary

The judgment of Master McCloud in *AXX v Zajac* is the first reported judgment concerning the provisions of CPR PD1A, concerning vulnerable litigants. It is a model in two ways. Firstly, it contains a plain language summary at the outset for the benefit of the Claimant. Second, it is a model of how to approach difficult issues engaging vulnerability and capacity. Master McCloud, indeed, expressly sought to "provide something of a worked example (good, bad, or merely respectably amateur is for others to judge but I call to mind a character in *Les Miserables* to the effect that "*I am not totally useless. I can be used as a bad example*."). We commend reading the judgment for the detail of the worked example, and for an explanation of how – on the facts of the case – ordering a split trial so as to maximise the chance that the Claimant would engage with the experts represented a step to enable him to put his evidence before the court for purposes of PD1A.1(5)(c). Of wider relevance were two sets of observations. The first was in the context of a refusal to order an automatic stay in the event if the Claimant did not engage with the Defendant's experts. Master McCloud observed that:

> *32. I took the view that since mental capacity is context specific, and in this instance the court does not have evidence that the Claimant (whilst lacking capacity to conduct litigation) is unable to understand (with any suitable assistance) the need to speak to the experts, and that he has at least apparently consented before to examination by his own experts (by participating in examination), and that there is evidence that he is able to cope day to day with life tasks such as shopping and feeding himself, I could reasonably make the above order. However, I considered that since there is a possibility that he will continue to refuse to see the Defendant's experts it would be proportionate in that event to bring the issue back to court so that a more formal decision can be made as to whether the Claimant does or does not have capacity to consent to medical examination, and hence whether his refusal is on an 'understanding', as opposed to a 'non-capacitous', basis. Sanctions such as a stay or debarring order could only fairly be imposed on an informed basis in the light of such an assessment and of course weighing up fairness to both sides.*

Master McCloud also made some wider observations about the approach to the new Practice Direction:

> *33. I shall make some observations on the approach to PD1A taken here. The vulnerability provisions essentially spell out in the form of a "structured reasoning tool" the process which the court should go through and the factors to consider in every case so as to ascertain whether a person is vulnerable, how it may affect their role and position in the claim, and what steps to take to assist that person to participate. It does not replace the existing provisions in cases where a party actually lacks capacity to conduct litigation, but it can and should inform the court as to steps to take where a witness is vulnerable – which could for example include situations where a party can be enabled to have capacity to do certain other things such as attend a hearing and cooperate with experts in a medical examination.*
>
> *34. It will be apparent that the approach I have taken sees the new provisions as a part of the wider duty of the Court to ensure hearings, and the management of cases, are fair and to have regard to and apply equalities duties and the principles of Article 6 of the Convention. Whilst I have taken a 'structured' approach to applying the listed criteria and categories of vulnerability, this is on the footing that the Practice Direction is a useful reasoning tool but is neither an exhaustive set of provisions nor intended to be construed narrowly as if a statute. Hence my reading of the provision as to enabling a person to put his evidence before the court is a purposive one and not a narrow one.*

> *35. It is I think generally known that an innovation introduced by myself many years ago suitable for some cases is the 'disability adaptations appointment' appropriate to complex cases with disabilities which need to be accommodated, by which, away from the argument and heat of a contentious hearing, the parties can attend before the court on what amounts to a 'mention' to discuss in a non-judgmental way how to plan a trial and what adaptations need to be made. In my judgment where especially vulnerable litigants are involved, consideration of disability adaptations may become relevant to the application of the vulnerability guidance in PD1A and the two are complementary.*

Comment

There is an important, but difficult, interaction between the concepts of capacity and vulnerability. This often arises in the context of the question as to whether it is necessary to engage the inherent jurisdiction of the High Court as opposed to the Court of Protection. The decision in *AXX* suggests how this interaction may start to be worked out in a context where there are now formal provisions within the CPR addressing both capacity and vulnerability. It also suggests – properly – that responding properly to vulnerability in the context of litigation is a matter which takes time, professional curiosity, and a willingness to think creatively.

THE WIDER CONTEXT

Hague Convention on the International Protection of Adults

Readers may be interested to note Adrian Ward's report (the second article in this month's Scottish Mental Capacity Report) of the recent Special Commission on the 2000 Hague Convention on the International Protection of Adults.

Supporting migrants lacking mental capacity in relation to immigration matters

Migrants Organise has co-published guidance with the NRPF Network, 'Supporting Migrants Lacking Mental Capacity in Relation to Immigration Matters.' The guidance is available here, and an event around the publication will likely be held in early 2023. Migrants Organise summarises the guidance as follows:

> *This guidance is aimed largely at statutory social and mental health services who are working with migrants with issues with their mental capacity to engage with the immigration process. Providing support around immigration can often be a crucial element of a person's holistic support plan to improve their welfare and wellbeing. This however can be extremely difficult to achieve if the person in question has difficulties with their mental capacity in relation to immigration matters.*
>
> *In this guidance, we have provided a framework on how to assess mental capacity in relation to immigration matters, including the different decisions that a person needs to make in order to resolve their immigration issues. We also covered the steps that can be taken by statutory services if a person does lack the mental capacity to make immigration decisions.*
>
> *This guidance will also be relevant to immigration practitioners, and anyone else who is working with vulnerable migrants and asylum seekers with mental health issues.*

Oliver McGowan Mandatory Training on Learning Disability and Autism is launched

Health Education England has announced that:

> *The Oliver McGowan Mandatory Training on Learning Disability and Autism to assist health and care staff caring and supporting people with a learning disability and autistic people has been launched following a long campaign.*
>
> *The training is named after Oliver McGowan, who died in 2016 after being given antipsychotic medication, despite warning that they were unsuitable for him, highlighting a lack of understanding of the needs of people with a learning disability or autistic people. Oliver's mother Paula successfully launched a campaign to make training on caring for people with a learning disability and autistic people mandatory for all health and care staff.*

This innovative training has been developed from the beginning with expertise from people with a learning disability and autistic people as well as their families and carers.

The first part of the Oliver McGowan Mandatory Training is now ready to be accessed following a two-year trial which involved 8,300 health and care staff across England.

Participants found there has been an increase in their knowledge, skills and communication with autistic people and people with a learning disability after completing the training.

The Oliver McGowan Mandatory Training will provide staff with the right information to make reasonable adjustments as well as challenging their preconceptions of autism and learning disabilities.

Greater knowledge of learning disability and autism will ensure that care and support can be better tailored to suit people's needs and is expected to lead to better interactions and outcomes and fewer incidents of inequality and avoidable deaths for people with a learning disability and autistic people when they need to receive care.

The Health and Care Act 2022 introduced a requirement that regulated CQC registered service providers must ensure their staff receive training on learning disability and autism that is appropriate to their role.

The Oliver McGowan Mandatory Training, which has been developed in partnership with Health Education England, Department for Health and Social Care, Skills for Care and NHS England, is ready for staff across the health and care sector to access today.

The Oliver McGowan Mandatory Training comes in two tiers and is designed so staff receive the right level of mandatory training.

The first part, the elearning package, is required for both Tier 1 and Tier 2 of the Oliver McGowan Mandatory Training and is now live.

Tier 1 has been designed for staff who need general awareness of the support autistic people or people with a learning disability may need, while tier two is for people who may need to provide care and support for autistic people or people with a learning disability.

All staff will complete the one hour and 30-minute elearning package, which includes learning from autistic people and people with a learning disability, their carers, family members and subject matter experts.

Those completing Tier 1 will then be required to take part in a 60-minute online interactive session, while those completing Tier 2 will be required to attend a one-day face-to-face training session co-delivered by trainers who have a lived experience with learning disability and autism.

These sessions are expected to be available from early 2023 and have been designed to offer people with a learning disability and autistic people employment opportunities as part of the delivery team.'

CQC Report: Experiences of being in hospital for people with a learning disability and autistic people

The CQC has published a report (which also arose out of the multi-agency review into the death of Oliver McGowan), 'Who I am matters: Experiences of being in hospital for people with a learning disability and autistic people.' Who I am Matters is also available in an easy read format.

The Key Messages of the report are summarised as follows:

People have a right to expect:

- *access to the care they need, when they need it and that appropriate reasonable adjustments are made to meet people's individual needs. This starts from the first point of contact with a hospital. This is not just good practice – it is a legal requirement.*
- *staff communicate with them in a way that meets their needs and involves them in decisions about their care*
- *they are fully involved in their care and treatment*
- *the care and treatment they receive meets all their needs, including making reasonable adjustments where necessary and taking into account any equality characteristics such as age, race and sexual orientation*
- *their experiences of care are not dependent on whether or not they have access to specialist teams and practitioners.*

However:

- *People told us they found it difficult to access care because reasonable adjustments weren't always made. Providers need to make sure they are making appropriate reasonable adjustments to meet people's individual needs.*
- *There is no 'one-size-fits-all' solution for communication. Providers need to make sure that staff have the tools and skills to enable them to communicate effectively to meet people's individual needs.*
- *People are not being fully involved in their care and treatment. In many cases, this is because there is not enough listening, communication and involvement. Providers need to make sure that staff have enough time and skills to listen to people and their families so they understand and can meet people's individual needs.*
- *Equality characteristics, such as age, race and sexual orientation, risked being overshadowed by a person's learning disability or autism because staff lacked knowledge and understanding about inequalities. Providers need to ensure that staff have appropriate training and knowledge so they can meet all of a person's individual needs.*

- *Specialist practitioners and teams cannot hold sole responsibility for improving people's experiences of care. Providers must make sure that all staff have up-to-date training and the right skills to care for people with a learning disability and autistic people***.**

Resource for activities for people with dementia

The Daily Sparkle service may be of interest to some readers; it produces materials to support activities for people with dementia in care homes or in the community. It produces a 'reminiscence newspaper', as well as a variety of activities programmes, using a subscription service model. It is available for both professional care providers and individuals supporting those with dementia.

Worcestershire s.117 Mental Health Act ordinary residence case will go to the Supreme Court

The *Worcestershire* s.117 Ordinary Residence case (reported on in relation to the first instance in the May 2021 Wider Context Report, and in the Court of Appeal in the February 2022 Wider Context Report) is to be heard by Supreme Court. DHSC has announced that a date has not yet been set, but *'Ordinary residence disputes raising similar issues to those in the Worcestershire case will continue to be stayed until we have a final decision by the Supreme Court.'*

Morahan in the Court of Appeal: The limits of Article 2 procedural obligation

R(Morahan) v His Majesty's Assistant Coroner for West London [2022] EWCA Civ 1410 (28 October 2022) (Lord Chief Justice, Nicola Davies LJ, Baker LJ)

Summary

The Court of Appeal has again rejected attempts to expand the reach of *Rabone* and arguments that Article 2 ECHR was engaged in the death of a voluntary mental health patient who died while on leave, not by suicide, but by an involuntary overdose.

Tanya Morahan died in July 2018 as a result of a cocaine and morphine overdose. An inquest into her death heard that she had been progressing well while a voluntary patient at a unit operated by Central and North West London NHS Foundation Trust.

The court considered the relevant Article 2 case law noting:

1. the Article 2 procedural obligation (to conduct an investigation) arises parasitically where there has been a breach of the substantive or "operational" duty on the state to protect life [9].
2. some categories of death will trigger a procedural obligation automatically, the paradigm example being a violent death in custody, either by the hands of another or by suicide [10].
3. outside of the category of systemic breach of the Article 2 obligation, the automatic procedural (ie investigative) obligation will not arise [10].

The judgment of Green J in *R (Letts v Lord Chancellor* [2015] 1 WLR 4497 which appears to establish a free-standing category or procedural obligation arising in the absence of substantive or operational breach was doubted. [11]

The Court of Appeal considered the evolution of the case law and its analysis of the ambit of the article 2 operational duty from *Savage v. South Essex Partnership NHS Foundation Trust* [2009] 1 AC 681 (death by suicide of a psychiatric patient involuntarily detained under the Mental Health Act 1983) to *Rabone v. Pennine Care NHS Trust* [2012] 2 AC 72 (death by suicide of a informal psychiatric patient while absent from hospital during a period of negligently granted leave) to the Strasbourg case of *Fernandez de Oliveira v. Portugal* (2019) 69 EHRR 8 (death by suicide of a voluntary psychiatric patient who was left unattended in hospital, left his bed and jumped in front of a moving train).

It repeated as it has done previously (see *Maguire* – discussed further below) the relevance of the *indicia* identified by Lord Dyson in *Rabone* which demonstrate the existence of an operational duty. In addition to the necessary but not sufficient condition of a "real and immediate risk to life", these are: (a) assumption of responsibility by the state for the individual's safety; (b) vulnerability of the deceased; (c) the level of risk in question: whether or not it is an "exceptional" risk.

The court noted that at the time of her death, Tanya Morahan had been assessed as having capacity to consent to her treatment and admission; that her admission was voluntary and that she was making good use of unescorted leave such that ultimately her detention under s.3 MHA 1983 was rescinded and she remained at the rehabilitation unit as a voluntary patient. On one period of absence from the unit, it was observed, Ms Morahan got drunk but returned as promised, unharmed. On the next period of absence on 3 July 2018, however, she did not return: after an absence of ten days police visited her property and found she had died of an unintentional drug overdose. Further investigation suggested her tolerance would have been reduced due to a long period of abstinence, further, that she was more likely to have died closer to the time she was last seen alive (3 July 2018) than the time her body was discovered (9 July). [37]

The Coroner held that no substantive obligation was owed: while Ms Morahan was vulnerable, there was no real and immediate risk of death of which the Trust or police were or ought to have been aware. The Divisional Court upheld this decision on the basis that there was no real and immediate risk of death from such a cause (accidental death by recreational drug use) of which the Trust was or ought to have been aware; further, that even if there had been such a duty, there was no arguable breach such as to give rise to a parasitic procedural obligation.

The Appellant appealed on three grounds [40]:

1. *First, the Divisional Court erred in its conclusion that Ms Morahan's death did not occur in circumstances in which the article 2 operational duty was arguably owed by the Trust.*
2. *Secondly, the Divisional Court erred in not concluding that an automatic duty to hold an article 2 compliant inquest (a Middleton inquest) arose on the facts.*
3. *Thirdly, the Divisional Court erred in concluding that there was no arguable breach of any article 2 substantive duty.*

All three grounds were dismissed.

On the first ground, the Court of Appeal upheld the conclusion of the Divisional Court that no operational duty was owed. It held that there was no real and immediate risk of death of which the Trust ought to have been aware, Tanya Morahan having no history of accidental drug overdose and no previous comparable incidents on previous episodes of unescorted leave: the relevance of a previous positive

drug test following a period of leave was dismissed [41-2]. The court repeated with approval the dictum of Popplewell LJ at [124] of the Divisional Court judgment: *'the risk must be real, avoiding the benefit of hindsight, and be a risk of death, not merely of harm even serious harm. There was nothing to suggest that permitting Tanya to continue her rehabilitation into the community after her absence on 30 June/1 July gave rise to a real and immediate risk of death by overdose.'* Evidence of "high risk" of serious harm through drug use was similarly rejected as not meeting the "specific" meaning of "real and immediate risk" [44].

On the second ground, Court held there was no authority to support the argument that an operational duty is owed to *all* voluntary psychiatric patients – noting *"the risk of death in this sad case is accidental death from the recreational use of drugs of a voluntary patient who was genuinely at liberty to come and go. It is far removed from the circumstances in Rabone where the very purpose of being in hospital was to protect against the risk of suicide"* [46]. It considered the extension required to include Tanya Morahan's death within the current criteria would be "*an invitation to march ahead of Strasbourg in this area"* [48] which the court was bound to decline.

Finally, as to the possibility of an arguable breach of any Article 2 substantive duty the court dismissed this ground with just one line: *'This ground of appeal does not arise given our conclusions on the existence of an article 2 operational duty.'* [50]

Comment

This will be a disappointing judgment for families, no doubt, many of whom struggle to conduct inquests without the benefit of legal aid and legal advice in the absence of an article 2 ruling. It was, perhaps, unsurprising in the context of a quite difficult set of facts: while the domestic courts may be prepared to accept an extension of state assumption of responsibility to include a voluntary patient (*Rabone)*, it is, arguably, a further extension of the current case law to include a duty to protect such a patient against all and any risks.

The Supreme Court will be considering the matter again in a few days, the case of *R (Maguire) v. Blackpool and Fylde Senior Coroner* [2021] QB 409 (CA) being heard on 22 and 23 November 2022 at which the potential engagement of the substantive and subsequent procedural Article 2 obligations will be analysed in the context of a woman lacking capacity to make decisions regarding her treatment and care and deprived of her liberty pursuant to a standard authorisation.

Updated RCN guidance on Older People in Care Homes: Sex, Sexuality and Intimate Relationships

The Royal College of Nursing has updated its guidance 'Older People in Care Homes: Sex, Sexuality and Intimate Relationships' which can be found here: https://www.rcn.org.uk/Professional-Development/publications/older-people-in-care-homes-uk-pub-010-111 It is the third edition of this guidance, and was co-authored by none other than our very own Victoria Butler-Cole KC. The aim of the guidance is to help those working with older people living in care homes to work effectively with issues around sexuality and sexual relationships. It not only raises awareness of these issues, but sets out the legal and professional frameworks within which nursing and caring practice takes place and gives pointers for developing policies that address sexuality and sexual health needs in care homes. It also has suggestions on how to broach issues concerning sexuality, intimate relationships and sex and provides guidance on dealing with situations where expression of sexuality is seen as a concern, containing a very helpful step by step framework for assessment where in such circumstances. Lastly

it has some very useful worked through case examples (some of which no doubt readers will recognise from their practices) which sets out the approach adopted and the actions taken.

The relationship between clinical guidelines and negligence

O'Brien v Guy's & St Thomas' NHS Trust [2022] EWHC 2735 (KB) (31 October 2022)(HHJ Tindal, sitting as a High Court Judge)

We briefly mention the personal injury case of *O'Brien v Guy's & St Thomas' NHS Trust* [2022] EWHC 2735 (KB) for its consideration of the correlation between negligence and acting contrary to national and/or in-house clinical guidelines. The central issue was whether a doctor was negligent in administering a certain dosage of antibiotic whilst a patient was in ICU. After helpfully reviewing the authorities, HHJ Tindal summarised the legal principles at paragraph 88:

(1) *Even 'national' clinical guidelines are not a substitute for clinical judgement in an individual case. This is made clear by NICE and many of its actual clinical guidelines, by the GMC and by Courts e.g. Montgomery, Sanderson and Hewes.*

(2) *It follows even 'national' clinical guidelines are not a substitute for expert evidence about that impugned clinical judgement (Loveday). However, they may inform expert evidence, e.g. as additional evidence of a Bolam-compliant body of practice at a particular time, even if the guideline comes later (Jones, Dowson).*

(3) *Departure from a national guideline is not necessarily prima facie evidence of negligence, but is likely to call for some explanation: with the nature and detail required depending on the circumstances, including the strength of the guideline's 'steer' (Price). So, departure from an 'unsatisfactory' (e.g. incomplete, flawed or contradictory) guideline may not require so detailed an explanation (Sanderson).*

(4) *Compliance with a national guideline may be prima facie inconsistent with negligence if the guideline constitutes a Bolam-complaint body of opinion or practice (Bland). It may not do so if 'unsatisfactory' (in a similar sense), but it may still 'militate against negligence' depending on the circumstances (Cumbria). However, these points do not apply to 'in-house' guidelines, as a defendant cannot in principle (or probably in practice) set their own Bolam standard of care.*

(5) *What ultimately matters is whether the conduct fell within a Bolam-compliant practice in the usual way (Hewes, Cumbria, Price). Just as guidelines are no substitute for clinical judgement and expert evidence, they are no substitute (nor a shortcut) for the Bolam/Bolitho approach. However, as clinical guidelines are relevant, practitioners and experts should consider whether any national clinical guidelines were applicable - and if any 'in-house' guidelines should be disclosed.*

Decision-making styles and stresses - the case of autism: in conversation with David Mason

In this 'in conversation with,' Alex talks to PhD student David Mason about the research that the King's College London ReSpect Lab is undertaking with autistic people into decision-making styles and stresses, and how this research can assist in thinking better about mental capacity assessments in the context of autism.

How to read a Court of Protection judgment - shedinar

Prompted by a number of situations recently in which I have been concerned that professionals may not always know how to read a Court of Protection judgment and whether, and how, it applies to a similar-sounding situation in front of them (especially reading coverage of this case), Alex has recorded a short (15) minute shedinar on the subject.

Wittgenstein, clinical dilemmas, and Voluntarily Stopping Eating and Drinking

"Whereof one cannot speak, thereof one must be silent." Whilst the philosopher Ludwig Wittgenstein was thinking of rather different matters to clinical dilemmas, it is sometimes difficult to escape the impression that his rather cryptic statement is one that has resonance in such situations. I am thinking, in part, of situations where one or other person involved simply feels they cannot speak: for instance, a clinician who feels that they cannot start a difficult conversation with a patient about CPR, or a person who is afraid to challenge a consensus developing around a best interests decision because they do not feel they have the standing within a hierarchy. These are hugely problematic situations, the causes of which require unpicking and addressing, but at one level identifying the right thing to do is not all that difficult; it is a question of supporting/nudging/more the individuals concerned to do it.

More broadly and more deeply, I am also thinking of situations where (often for – ironically – unspoken reasons) it is felt to be too difficult to issue guidance about dilemmas. I was, for instance, troubled to find when joining a Royal College of Physicians working group to develop updated guidance about supporting people who have eating and drinking difficulties that there appeared to be no guidance from any professional body about how to proceed where the professionals involved felt that the person's choice was too risky. The updated guidance does address the situation, seeking to set out a framework to calibrate the rights at play without appearing to give licence to excess risk aversion (see pages 25-6 of here). But the process of developing that part of the guidance reinforced my initial sense that the previous silence of the guidance (not just from the RCP, but more broadly) may well have reflected in significant part the fact that to speak of the dilemma required addressing uncomfortable questions about the limits of autonomy. Speaking of such matters is not easy, not least because there may not be complete consensus societally about those limits. But not speaking of them, and not providing any framework within which to have a transparent discussion is, I would suggest, a recipe for immense difficulty on the ground.

In similar vein, we might also think of the consistent refusal to issue national guidance about triage decisions during the first waves of the pandemic. It is difficult to escape the impression that this was in large part down to the fact that acknowledging that there may be points where it would not be possible to treat everyone requiring hospital admission for COVID-19 would be inconsistent with the national myth that the NHS is always be able to cope. The COVID-19 inquiry well help us understand the consequences for patients, but from working with clinicians during those waves, it is clear that the failure to issue such guidance placed them in exceptionally invidious positions (some of which are addressed in this paper from August 2020). A huge irony of this is that, as a deliberative democracy exercise I was involved in between the first and second waves made clear, 'ordinary' members of the public were entirely capable of understanding why triage might be necessary, and able to engage in sophisticated discussions about the relevant factors, and particular concerns to take into account.

Why am I talking about this now? In part, it is because it is a phenomenon about which I am increasingly troubled. In part, though, it is because of the publication by Compassion in Dying on 2 November 2022

of a call for guidance about voluntarily stopping eating and drinking (VSED). This is an almost paradigmatically Wittgensteinian (if that's a word) situation: an area which gives rise to hugely strong feelings, is legally challenging (even if the challenge sometimes is less the letter of the law and more about application of the law), and engages very deep ethical issues. But all of these are factors which should lead to open discussions to seek both to generate consensus about the right approach, and to provide clear guidance for both individuals who might choose to stop eating and drinking, and for those responding to such decisions. I therefore both welcome the publication of the report, and very much hope that it does spark a move towards the creation of such guidance.

Alex Ruck Keene KC (Hon)

What place has 'capacity' in the criminal law relating to sex post JB?

A paper that Alex has written with Allegra Enefer has been published in the International Journal of Law and Psychiatry. As they put it in the abstract:

> *The term 'capacity' has come to assume a variety of meanings in the law of England and Wales, and the failure of statutes and judges to specify its meaning and application across the civil and criminal law leads to problems. Nowhere is this perhaps clearer than in the law relating to sexual capacity. This paper begins with an overview of two streams of law on sexual capacity in the civil and criminal law. The first stream traces through the criminal law provisions of the Sexual Offences Act 2003, the work by the Law Commission which led to its enactment, and the ways in which its provisions have been applied by the courts in practice; and the second examines the Mental Capacity Act 2005 ('MCA 2005') and its parallel application by the civil courts. We illustrate how the case of* A Local Authority v JB *[2021] UKSC 52 brought these problems to the fore, as the Supreme Court was at last confronted with the differences between the definition and use of the term 'capacity' by the civil and criminal law on sexual capacity. We suggest that the decision made by the Supreme Court in JB has left open terrain which ought to be used to reframe, or perhaps even replace, the concept of 'capacity' within the criminal law on sexual capacity.*

The full article is here. For more about the JB case, see here.

Alex Ruck Keene KC (Hon)

Book Review: *Compulsory Mental Health Interventions and the CRPD; and The Right to be Protected from Committing Suicide*

Compulsory Mental Health Interventions and the CRPD (Anna Nilsson, Hart, 2021 hardback/paperback/eBook, c.£75/£33; and The Right to be Protected from Committing Suicide (Jonathan Herring, Hart, 2022, hardback/eBook, c.£76/£62).

[*A version of this book review will be forthcoming in due course in the International Journal of Mental Health and Capacity Law, so this serves as a sneak preview – the most recent issue of the journal can be found here*]

Although not designed to be read together, these two works complement each other in interesting ways in addressing obligations upon the State in the context of crisis.

The first, by Anna Nilsson, Postdoctoral Fellow at the Faculty of Law, Lund University, is based in large part upon her doctoral thesis, and is the more ambitious in scope. Motivated, as she describes, by a conflict between two competing positions within the current debate over the future of coercive psychiatry, the book seeks to articulate a framework for permissible compulsory care using the model of proportionality developed by Robert Alexy. For those unfamiliar with his work, it is a reconstruction and theorisation of the German Federal Constitutional Court. It can, perhaps rather crudely, be seen as a refined version of the principles by which the European Court of Human Rights tests whether interference with qualified ECHR rights are justified (i.e. asking whether the interference is in pursuit of a legitimate aim, is necessary in a democratic society, and is proportionate; Alexy adds a second stage, as to whether the policy or practice is suitable in the sense of contributing to the legitimate aim). It also, in a way distinctly unfamiliar to common lawyers, involves the use of formulae to assist in the balancing exercise required at each state.[1]

Before she applies Alexy's framework to compulsory care, Nilsson opens with a crisp chapter on the approach to mental health care under the CRPD, serving as a helpful tour d'horizon of the debates, and identifying that the treaty text is silent on the key question, as it neither prohibits nor explicitly permits compulsory mental health care. In this chapter, she focuses, in particular, on the importance, but also the ambiguity, inherent in the concept of 'on an equal basis with others' which attaches to the central CRPD rights in play. She notes that the CRPD Committee has recognised that some state policies may give rise to differential treatment but be justified, so as not to give rise to unlawful discrimination but has "devoted little attention to the question of what standard such justifications must meet" (p.37). A central plank of her argument is that the standard is (or perhaps more accurately should be) that adopted by other UN bodies, namely that:

"*not every differentiation of treatment will constitute discrimination, if the criteria for such differentiation are reasonable and objective and if the aim is to achieve a purpose which is legitimate under the* [relevant convention]."[2]

Nilsson is not the first person to have made the argument that the standard UN approach is applicable to the CRPD,[3] but her argument is the most sustained and nuanced, using Alexy's approach to help tease out each of the aspects of the objective and reasonable standard, and hence to provide a

[1] For a common law critique of attempts to use a cruder version of such formula – the balance sheet – in determining best interests for purposes of the Mental Capacity Act 2005, see Kong, C., Coggon, J., Dunn, M., & Ruck Keene, A. (2020). An aide memoire for a balancing act? Critiquing the 'balance sheet' approach to best interests decision-making. Medical Law Review, 28(4), 753-780. In fairness, Nilsson recognises the potential objection to Alexy's work as attempting to compare the incommensurable (page 102).

[2] UN Human Rights Committee General Comment on Non-Discrimination (1989/1994) at paragraph 13.

[3] For instance, it was developed by reference to the Mental Capacity Act 2005 by the Essex Autonomy Project team led by Wayne Martin. See Martin, W., Michalowski, S., Jütten, T., & Burch, M. (2014). Achieving CRPD Compliance: Is the Mental Capacity Act of England and Wales compatible with the UN Convention on the Rights of Persons with Disability? If not, what next?.

framework to evaluate domestic systems of compulsory mental health care. As she makes clear (see page 159) and applying this framework, she considers that the CRPD does permit some form of compulsory care for purposes of protecting the health and life of the person concern, in the circumstances where an individual is in need of medical care and a free and informed treatment decision cannot be obtained, even though they have access to decision-making support. However, to be consistent, any rule that does apply in domestic law in this regard must apply regardless of whether the situation involves a person with a psychosocial condition. With specific regard to suicide, she proposes that it is possible to produce a consistent argument justifying the use of compulsion for purposes of suicide prevention for people with certain psychosocial conditions, as there is no other group of people at similar risk of ending their lives by their own hands. However, and as Nilsson does throughout the book, she emphasises that any such justification rests crucially on evidence – in this case about the rates of suicide amongst different groups. And, more broadly, the more evidence that there is that voluntary alternatives are as effective as compulsory means in preventing serious deterioration in health or suicide, the harder it will be to justify compulsory care.
As interesting as Nilsson's argument is, and as helpful as it is in identifying a nuanced way through the debates, it does have two problems. The first is a simple matter of rhetoric. Recourse to Alexy's abstruse formulae to justify what, in the eyes of a significant minority, is seen as medical torture, does feel close to analysing angels dancing on the head of a pin. It is, at minimum, unlikely to persuade those who are not, at some level, already persuaded – even in inchoate fashion – to the idea that there are some circumstances where intervention is legitimate.

The second is perhaps a matter of timing. Whilst Nilsson does make reference to the UNCRPD Committee's General Comment 5 on Equality and Non-Discrimination, published in 2018,[4] she does so only in relatively short compass, perhaps (I speculate here) because it post-dated the bulk of her doctoral work. It is unfortunate she does not engage with it in more detail, because this General Comment adds to a body of evidence suggesting that it is not clear that the UNCRPD Committee does, in fact, subscribe to the same approach as other UN bodies when it comes to differential treatment.[5] If

[4] CRPD/C/GC/6.
[5] For a detailed analysis of this argument, see Gurbai, S. (2020). Beyond the Pragmatic Definition? the right to non-discrimination of persons with disabilities in the context of coercive interventions. Health and Human Rights, 22(1), 279. General Comment 6 only refers to the concept of objective and reasonable criteria in relation to the situation where reasonable accommodation is denied (see paragraph 27). At paragraph 17, the CRPD Committee identifies that the definition of discrimination within the CRPD "is based on legal definitions of discrimination in international human rights treaties, such as article 1 of the International Convention on the Elimination of All Forms of Racial Discrimination and article 1 of the Convention on the Elimination of All Forms of Discrimination against Women. It goes beyond those definitions in two aspects: first, it includes 'denial of reasonable accommodation' as a form of disability-based discrimination; second, the phrase 'on an equal basis with others' is a new component. In its articles 1 and 3, the Convention on the Elimination of All Forms of Discrimination against Women contains a similar but more limited phrase: 'on a basis of equality of men and women'. The phrase 'on an equal basis with others' is not only limited to the definition of disability-based discrimination but also permeates the whole Convention on the Rights of Persons with Disabilities. On the one hand, it means that persons with disabilities will not be granted more or fewer rights or benefits than the general population. On the other hand, it requires that States parties take concrete specific measures to achieve de facto equality for persons with disabilities to ensure that they can in fact enjoy all human rights and fundamental freedoms."

this is so, then there is, even on the sometimes rarefied plane of debates in this context, a more fundamental problem to her analysis: namely that the UNCRPD Committee may simply not accept that there could ever be any justification for differential treatment in the context of mental health crisis. Whether the UNCRPD Committee are right in this (both as a matter of interpretation of the Convention, and in a broader, ethical, sense) is a different question, but it would have been interesting to see Nilsson tackling this issue head-on.

These two issues perhaps rather detract from the book's use for those seeking to win arguments. However, they do not stop the book being a very useful tool for those who might be seeking to design principled and evidence-based mental health care regimes, because it provides a helpful set of measures against which to stress test both legislation[6] and policies.

In his latest book, Jonathan Herring, DW Wolf-Clarendon Fellow in Law at Exeter College and Professor of Law at the Faculty of Law, University of Oxford, takes on a narrower, but intensely problematic, aspect of the terrain covered by Nilsson: namely State obligations towards suicidal[7] people. Herring explains in his introduction how he was motivated to write the book by his 'astonishment' at how many of his students thought that the appropriate response for a doctor faced with a patient expressing a wish to die was to facilitate suicide, and how the right to die had come to dominate in discussions about suicide and end-of-life questions. His book is a characteristically thoughtful and elegant development of the legal and ethical case for treating those with suicidal thoughts, and the taking of reasonable steps to prevent them attempting suicide. Each chapter takes the form, in effect, of a mini-essay. Some are very helpful convenient summaries, such as the opening chapters on definitional issues, the empirical evidence for the causes of suicide,[8] and of the arguments for societal responsibility for suicide. Other chapters seek to advance an argument, in particular the chapter on human rights and suicide, which involves a close reading of the case-law of the European Court of Human Rights to develop a thesis that the state's obligations to secure the right to life under Article 2 in the presence of suicide risk extend beyond the paradigmatic position of psychiatric patients. And the last chapter, about euthanasia and suicide, helpfully locates the debates around assisted dying/euthanasia within the wider (often too often lost) context of the 'right' approach to suicide.

As a self-confessed capacity nerd, I turned with particular interest to the sections on capacity in chapters 5 (ethics and suicide) and 7 (the current law on suicide). In crude paraphrase, Herring considers the test for capacity contained within the Mental Capacity Act 2005 does not serve the interests of the suicidal well. I do not dispute this; indeed, there are further avenues Herring could have explored here, including the Strasbourg jurisprudence relating to life-sustaining treatment refusal in the presence of doubts about mental capacity.[9] Another could have been the phenomenon of capacity

[6] In this regard, it can also be seen as a useful adjunct to the tools developed by David Goddard in his recent, stimulating, book on "Making Laws that Work: How Laws Fail and How We Can Do Better" (Hart, 2022).

[7] I am very conscious of the linguistic issues here. I am using this term broadly to encompass those with suicidal thoughts, and those who may have taken action upon those thoughts.

[8] Albeit with a strongly Western-centred focus; more broadly, it would be fascinating to read a book by an author from the Global South on the same theme.

[9] In *Arskaya v Ukraine* [2013] ECHR 1235, for instance, the ECtHR found that there had been a breach of Article 2 ECHR where a person, S, repeatedly refused to life-saving treatment in circumstances where "S. showing symptoms of a mental disorder, the doctors took those refusals at face value without putting in question S.'s capacity to take rational decisions concerning his treatment. Notably, if S. had agreed to undergo the treatment, the outcome might have been different […]. the Court considers that the question of the validity of S.'s refusals to accept vitally important treatment should have been

being used against those expressing suicidal ideas that has attracted increasing attention over recent years.[10] In this regard, and as discussed in works highlighting that phenomenon, it is deeply problematic that professionals (often, but not exclusively liaison psychiatrists) appear often to be asking themselves whether a person has capacity to take their own life without actually (a) having a clear idea as to precisely what the components of that decision might be;[11] and (b) the relevance or otherwise of the question. As I have discussed elsewhere,[12] in many situations, it is completely irrelevant as to whether or not a person has capacity to take their own life: if the provisions of the Mental Health Act 1983 are likely to be in play, the question is the risk that they are at, not whether or not the risk they are at is (in effect) capacitously caused.

Whilst I found myself nodding in agreement with the majority of the book (and frequently emailing myself materials contained in the footnotes), two issues did niggle. The first is that I felt Herring did skate perhaps too rapidly over the question of whether and when compulsion to prevent suicide was justified. He addresses, in relatively brief compass, the recent Strasbourg jurisprudence[13] identifying the tension between the right to liberty and bodily integrity on the one hand, and the right to life on the other. However, for my part, I would have welcomed a more granular investigation of this issue, not least because it would have been useful to have a discussion of the extent to which there is (or can be) a conflation in the public policy mind between detention and securing the right to life.[14] That would also have allowed him to tease out another potential argument against zero-suicide policies (addressed in chapter 8), which he only addresses in very glancing terms: namely that it can lead to 'excessive' steps taken to avoid suicide – and especially excessive compulsory steps, which are not only not always effective in preventing suicide, but also can cause harm in and of themselves,[15] Indeed, this is precisely an area where it would have been interesting to see Herring apply the sort of analysis applied by Nilsson in her book to the question of when compulsion can be justified in the interests of securing the right to life.

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properly answered at the right time, namely before the medical staff refrained from pursuing the proposed treatment in relying on the patient's decision. From the standpoint of Article 2 of the Convention a clear stance on this issue was necessary at that time in order to remove the risk that the patient had made his decision without a full understanding of what was involved."

[10] See, inter alia, Beale, C. (2022). Magical thinking and moral injury: exclusion culture in psychiatry. BJPsych bulletin, 46(1), 16-19; Aves, W. (2022). If you are not a patient they like, then you have capacity". DOI:10.13140/RG.2.2.34386.84163.

[11] Noting in this regard the Supreme Court decision in *A Local Authority v JB* [2021] UKSC 52, in which the Supreme Court emphasised both the relevance of foreseeable consequences as part of the information to be processed, and also (at paragraph 74) that

[t]he importance of P's ability under section 3(1)(a) MCA to understand information relevant to a decision is also specifically affected by whether there could be "serious grave consequences" flowing from the decision. Paragraph 4.19 of the Mental Capacity Act 2005 Code of Practice provides:

"If a decision could have serious or grave consequences, it is even more important that a person understands the information relevant to that decision."

[12] See my blogpost: https://www.mentalcapacitylawandpolicy.org.uk/capacity-and-suicide/

[13] In particular *Fernandes de Olivera* (2019) 69 EHRR 8.

[14] This came through very strongly in the *Rabone & Anor v Pennine Care NHS Foundation* [2012] UKSC 2, the tenor of which could on one view be read as being to the effect that 'keeping the person in hospital means keeping alive; letting the person out of the hospital means letting them die.'

[15] Albeit that, by definition, if the harm is to a person who is still alive, there may be an argument to be had as to whether such harm is a price worth paying to keep another alive.

The second issue is one which, I have to say, I found very surprising, given Herring's usual sensitivity to language. I did wonder when I saw the reference to "committing suicide" in the title whether Herring was going to give an explanation in the introduction as to why he used this term. Suicide has not been a criminal offence in England & Wales since 1961; given the extensive literature on why the term should not be used,[16] it was curious not to see an explanation as to why it was used. It is quite possible that it was, in effect, a sub-editorial decision on the part of the publisher as to the choice of title – if so, it was a revealing one about quite how far we still have to travel.
Nonetheless, despite these issues, I will definitely be putting this book on my reading list for my Law at the End of Life course at King's College London as a stimulating, important, and nuanced contribution to an area which can sometimes all too easily be portrayed in unhelpfully crude terms.

[Full disclosure, I was provided with an inspection copy of these books by the publishers. I am always happy to review books in the field of mental capacity and mental health law (broadly defined).]

Alex Ruck Keene KC (Hon)

[16] See, for instance, Nielsen, E., Padmanathan, P., & Knipe, D. (2016). Commit* to change? A call to end the publication of the phrase 'commit* suicide'. Wellcome open research, 1.

SCOTLAND

Scott Report: prompt implementation required to avoid continuing illegality

The case of *X v Mental Health Tribunal for Scotland* [2022] CSOH 78, 2022 SLT 1234, decided by Lord Harrower on 19th October 2022, would warrant extensive coverage and discussion in a journal focusing upon mental health law. At a time when needs for reform of both mental health and incapacity law have been drawn together, commencing with the remit for the work of the Scottish Mental Health Law Review ("SMHLR") and now fulfilled with the Final Report of the Review, it is relevant to note that this case highlights another aspect of those combined areas of legislation requiring prompt action by the legislature to remedy illegality. Hitherto, this Report has referred several times to the illegalities resulting from the breach of the obligation to make appropriate provision to regulate deprivations of liberty in terms of Article 5 of the European Convention on Human Rights. In this case, the court identified unlawfulness resulting from what the court has held to be unjustified discrimination contrary to Article 14 of that Convention. The discrimination is between so-called "forensic patients" subject to compulsory orders under the Mental Health (Care and Treatment) (Scotland) Act 2003, and so-called "civil patients" subject to compulsory treatment orders under that Act. Broadly, those can be viewed as parallel regimes with different starting-points. The court has held that there is discrimination against forensic patients because for them the Mental Health Tribunal for Scotland ("MHTS") cannot specify "recorded matters", which it can do for "civil patients".

The SMHLR Report recommends extending to forensic patients the power to specify recorded matters. The Report was issued after the hearing of this case, while it was at avizandum. Lord Harrower noted its terms and has referred to them in his judgment.

Several eminent Scottish practitioners are well versed in both mental health law and adult incapacity law. For those who are primarily adult incapacity practitioners, seeking to extend their understanding of similarities and differences between the regimes for forensic patients and civil patients in the matter of making compulsion orders and compulsory treatment orders, respectively, and the role of recorded matters, they could not do better than read Lord Harrower's judgment. Potentially more importantly for adult incapacity practitioners, it helpfully maps the journey towards reaching a conclusion that Article 14 has, or has not, been breached.

Behind the particular issues in this case, though not mentioned by Lord Harrower, is the uneasy relationship between criminal law and mental health law. In this case, X had a previous criminal record, but had been acquitted in terms of section 51(a) of the 2003 Act. He was found to be not guilty of the offence with which he had been charged. His life from the time of such acquittal onwards has however been governed by the provisions of criminal law applicable to "forensic" patients, not those who might happen to meet the same criteria for compulsory intervention in their lives classified as "civil" patients. On specifics, although I have stepped back from full analysis of the decision for the reasons that I have given, I would draw attention to the following points.

At [22] of his judgment, Lord Harrower expressed the view that: "*… both parties tended to under-estimate the legal consequences that might follow from the fact that a Tribunal had specified one or more recorded matters*"; and at [23]: "*… whatever limitations there may be to the Tribunal's power to specify treatment, care and services for the patient, I am not prepared to hold that the power is so ineffective that it would be of no advantage to the forensic patient were it available to the Tribunal*". Later, he emphasised [26]

that: "*The power to specify recorded matters provides a focal point for a more intensive scrutiny by the Tribunal, both procedurally and substantively, of the care team's assessment of needs and their formulation of a care plan*"; and at [27] "*… while there may well be legal consequences following upon a failure to implement a care plan [as Lord Harrower had already noted in his judgment], the 2003 Act provides a distinct, additional remedy, in the case of a failure to provide the specified recorded matters*". Finally, though couched solely by reference to a particular provision of the relevant Code of Practice, this judgment exemplifies the point that it is for lawyers to check the law as expressed in statute, without necessarily accepting interpretations contained in Codes of Practice. At [27], prior to the passage quoted above, he opined: "*Nor do I accept that the power to specify recorded matters is limited, as the Code of Practice appears to suggest, to specifying "essential" treatment, care and services. The legislation is perfectly clear: it extends to any treatment, care [or] service the Tribunal considers 'appropriate'*".

Reverting to the primary point identified here, it is disappointing that at time of publication we still wait for Scottish Government to tell us what it itself will now do regarding implementation of the SMHLR Report, particularly as regards matters identified as urgent.

Adrian D Ward

Special Commission meeting on Hague 35

Scotland has a particular interest in Hague Convention 35 of 2000 on the International Protection of Adults, and thus in the proceedings of a Special Commission that reviewed the practical operation of Hague 35 on 9th – 11th November 2022. Hague 35 governs cross-border issues and relationships in adult incapacity matters with the other countries in respect of which Hague 35 is in force. Scotland was the first country in respect of which Hague 35 was ratified. The others for whom it is currently in force are Austria, Belgium, Cyprus, Czech Republic, Estonia, Finland, France, Germany, Greece, Latvia, Monaco, Portugal and Switzerland. It was signed by Malta during the Special Commission, and has also been signed by Ireland, Italy, Luxembourg, Netherlands and Poland, but is not yet in force for any of those countries. Scotland remains the only jurisdiction in the UK for which it is in force, though it is understood that the UK Ministry of Justice hopes to remedy that in respect of England & Wales, and perhaps in respect of Northern Ireland, next year.

The Special Commission was attended by many more members of HCCH than those who have yet ratified, and by observers from several intergovernmental and non-governmental organisations, including European Law Institute (which I represented). As such international matters are reserved to the UK Parliament, the UK delegation was led by the UK Ministry of Justice. It is perhaps rather unfortunate that on the important subject of judicial cooperation cross-border, the UK spokesperson narrated extensive discussions with judiciary in the Court of Protection of England & Wales, leading to statements of "our position", without explicit mention that this did not apply to Scotland. The meeting was a hybrid meeting. A representative of Scottish Government was personally present as part of the UK delegation, but did not speak.

The Special Commission meeting had full status as a diplomatic session of HCCH, but did not produce any definitive outcomes, as its purpose was preliminary to a meeting of the HCCH Council on General Affairs and Policy in March 2023. Final output from that meeting likely to be of significant assistance to Scottish practitioners will be a practical handbook on the working of Hague 35, and a country profile.

Advanced drafts of these, and of an implementation checklist, were considered at the Special Commission, and will be finalised in the light of the conclusions and recommendations of the Special Commission.

There was extensive discussion of the status under Hague 35 of "instructions given and wishes made by the adult". Those words form the definition of advance directives under Council of Europe Recommendation (2009)11 on principles concerning continuing powers of attorney and advance directives for incapacity. That was adopted as the definition of "advance choices" in the report of the Joint Working Group of the Law Society of Scotland on (a) advance choices, and (b) medical decision-making in intensive care situations. A proposed project to draft Europe-wide model laws on advance choices (advance directives) is expected to be considered by the ELI Council shortly, for adoption as an ELI project. We shall update readers on the outcome.

Previous discussions had included assertions that advance directives are powers of representation. Discussions then eventually led, by the time of the Special Commission, to acceptance that they can only be categorised as powers of representation when they take the form of directions to an attorney or other representative, and not when they are separate free-standing instruments in accordance with the definition and provisions of Recommendation (2009)11. The position adopted, however, is that they are within the scope of Hague 35 (because in terms of Articles 1 and 4 they are not expressly excluded, though this leaves as the only provisions actually applicable to them the provisions of Chapter V of the Convention on cooperation).

At time of writing the official conclusions and recommendations of the Special Commission, and the Minutes of the Meeting, are not yet available. We shall provide the link to them once they are. In the meantime, it is understood that they will express the view that the absence of a specific conflict rule to cover advance directives does not appear to create practical difficulties, and that there is currently no need or interest (on the part of member states) in adding a provision regarding them. It would appear that advance directives will need to follow the trajectory of powers of attorney, which has been a relatively rapid one with effective provision in growing number of European states, and a substantial rise in uptake since they have become available (the latter being demonstrated in more countries than the notable example of Scotland), and for the inevitable consequences of the lack of clear provision for them in the Hague regime, before problems "at the coal face" come to the attention of Ministries of Justice and their equivalents across Europe. This is being taken as supporting the need for the proposed ELI project, which will not itself be a private international law project, but is aimed at achieving similarity of provision across Europe, enhancing recognition (in the practical sense of the term) and thus operability.

That point links to an issue on powers of attorney raised by STEP (Society of Trust and Estate Practitioners) and CNEU (the Council of Notaries in the European Union), with the support of Switzerland, France and IAFL (the International Academy of Family Lawyers), which drew attention to the fact that at the level of operability the difficulties cross-border with powers of attorney are such that it is common practice, where a person has known connections with more than one country, to recommend creating powers of attorney in each country, indicating that to that extent Hague 35 is not in practice achieving its purpose. The STEP intervention analysed the cause as being an unduly broad interpretation of Article 15(3) of Hague 35, which covers manner of exercise of powers of representation (governed by the law of the state in which they are exercised), and failure to distinguish that from matters of existence, extent, modification and extinction of powers of representation which

under Article 15(1) are governed by the law of the state of the adult's habitual residence at the time of creation (or of another state specified by the adult within the limitations in Article 15(2)).

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Conferences and Seminars

Forthcoming Training Courses

Neil Allen will be running the following series of training courses:

30 November 2022	BIA/DoLS Update Training
13 January 2023	Court of Protection training
26 January 2023	MCA/MHA Interface for AMHPs
2 February 2023 (AM or PM)	Necessity and Proportionality training
16 March 2023	AMHP Legal Update
23 March 2023	Court of Protection training

To book for an organisation or individual, further details are available here or you can email Neil. Local authorities or other organisations can book places by emailing neil@lpslaw.co.uk. Individuals can book online To book for an organisation or individual, further details are available here or you can email Neil. Full details of available online courses are available at www.lpslaw.co.uk/courses/.

'Mediation of Medical Treatment Disputes: A Therapeutic Justice Model': 29 November 2022, 9:30-12:30

The research seeks to investigate whether and, if so, the extent to which, mediation can and should be viewed as a form of therapeutic justice in medical treatment disputes.

The event will start with perspectives from leading practitioners in the field who will draw on their own experience of medical treatment disputes concerning adults and children to consider how mediation can be used in these ethically challenging cases. This will be followed by presentations from the core research team to outline the aims of the research, the empirical methods and the ways that you can get involved with the project.

The launch event will be held online by zoom on the morning of 29 November 2022. Further information about the event is available and you can register to attend here.

Is Mental Capacity Law Law? 23 November 2022, 13:00-14:30

Prof John Coggon is presenting his paper on "Is Mental Capacity Law Law?" in Oxford; those interested can listen remotely and details are available here. From the event page:

There is an in-built principled tension within the statute, which at once aims to promote a value-neutral, skeletal framework for decision-makers, whilst also importing value commitments; both through values-commitments inherent to the Act and—crucially—by the creation of vacuums that must be filled by values that are neither introduced by law nor from the person for and about whom a decision is being made. This invites critical questions about assumptions that underpin the normative validity of the statute: both in its claims to assuring legal *authority, and to the essence of judicial decision-making under the Act.*

Advertising conferences and training events

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

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

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