Essex CHAMBERS

MENTAL CAPACITY REPORT: COMPENDIUM

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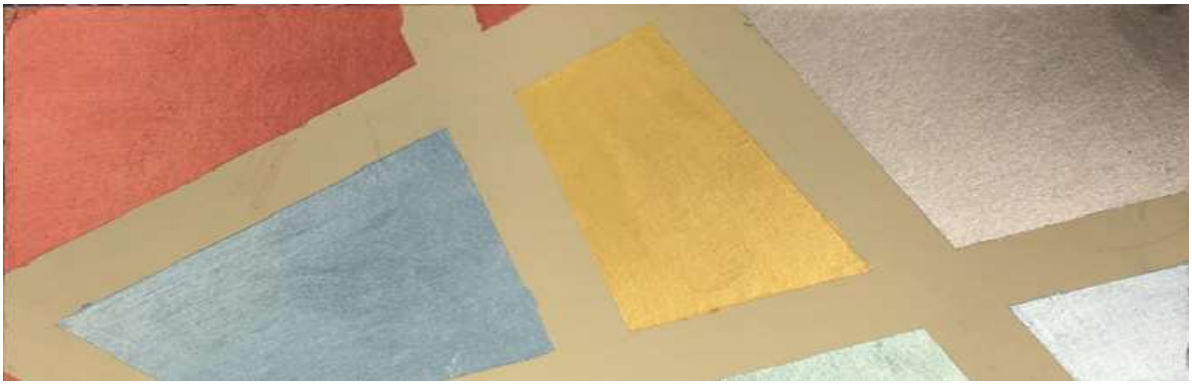

Welcome to the July 2020 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: LPS delayed to April 2022; alcohol dependence and other capacity conundrums; stem cell donation and altruism, and when to come to court in medical treatment cases;

(2) In the Property and Affairs Report: updated OPG guidance on making LPAs under light-touch lockdown and a face-off between potential professional deputies;

(3) In the Practice and Procedure Report: a basic guide to the CoP; litigation capacity and litigation friends and observations about intermediaries and lay advocates;

(4) In the Wider Context Report: capacity and the Mental Health Tribunal, a change of approach to s.117 aftercare and lessons learned from a close encounter with triage;

(5) In the Scotland Report: the Scott Review summary of responses to its initial survey and a response from the Chair to the critique in our last issue.

You can find our past issues, our case summaries, and more on our dedicated sub-site here, where you can also find updated versions of both our capacity and best interests guides. We have taken a deliberate decision not to cover all the host of COVID-19 related matters that might have a tangential impact upon mental capacity in the Report, not least because the picture continues to change relatively rapidly. Chambers has created a dedicated COVID-19 page with resources, seminars, and more, here; Alex maintains a resources page for MCA and COVID-19 here.

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The picture at the top, "*Colourful*," is by Geoffrey Files, a young man with autism. 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

LPS delayed to April 2022

The Government announced on 16 July 2020 that LPS would not be coming into force on 1 October 2020, but instead in April 2022.

It has been clear for some time that 1 October was not just ambitious but impossible, so this clarification is very welcome. In a written statement, the Care Minister, Helen Whately, told Parliament that, whilst the intention had been to bring them into force on 1 October 2020:

> *It is now clear that successful implementation is not possible by this October. We now aim for full implementation of LPS by April 2022. Some provisions, covering new roles and training, will come into force ahead of that date. I will continue to update the sector and stakeholders on timings.*
>
> *The Government will undertake a public consultation on the draft regulations and Code of Practice for LPS. That will run for 12 weeks, allowing sufficient time for those that are affected, including those with learning disabilities, to engage properly.*
>
> *The sector will need time following the publication of the final Code to prepare for implementation. We will give the sector sufficient time to prepare for the new system to ensure successful implementation. I am considering a period of approximately six months for this.*
>
> *After we have considered responses to the consultation, the updated Code and regulations will need to be laid in Parliament to allow for proper scrutiny. This needs to happen well in advance of the target implementation date, first to allow for that scrutiny and second because some of the regulations need to come into force earlier.*
>
> *Health and social care has been at the frontline of the nation's response to COVID-19, with social care providers looking after many of the most vulnerable in society. We have received representations from public and private bodies from across the sector over the last few months, outlining the pressures they face if they were to implement by October 2020.*
>
> *My overall objective remains to ensure implementation of an effective system in particular for those whose lives will be most affected by this legislation.*

> *The forthcoming draft Code of Practice and regulations will also offer more detailed information about how LPS will operate in practice. I will provide a further update on the progress of implementation in due course. I hope that the additional time announced today provides reassurance to the sector.*

This announcement is very timely: as the CQC has identified in its third "Covid Insight" published on 15 July 2020:

> *… our inspectors have seen that, with providers increasingly looking towards the introduction of the Liberty Protection Safeguards (LPS), providers' focus on DoLS has waned and training in some areas has stagnated. Poor understanding of DoLS has remained a fundamental issue. This together with the delays and uncertainty over the progress of LPS may mean there is an increasing risk of people being deprived of their liberty without the proper authorisation.*

It will be very important to make clear that, with nearly 2 years left until LPS comes fully into force, training on DoLS must continue; when the revised timeline promised by the Care Minister is published, thought will need to be given as to how that training can start to move towards LPS implementation. Similarly, DoLS (and also community DoL applications) must continue to be deployed where necessary, and insofar as possible.

It is also important to flag that it is already possible for work required by DoLS and (equally, if not more importantly), community Deprivation of Liberty applications to be done in such a way as to build towards LPS implementation. By way of example, a community DoL application (on a COPDOL11 form) already contains, in essence, all of the materials that would be required for consideration of the position under LPS.

Alcohol dependence and the Court of Protection

London Borough of Tower Hamlets v PB [2020] EWCOP 34 (Hayden J)

Mental capacity – assessing capacity

Summary

This decision deals with the thorny question of capacity in the context of alcohol dependence. The central issue was whether PB, a 52 year old man with a history of serious alcohol misuse, had capacity to make decisions about his care and residence.

The facts

PB suffered from alcohol-related brain damage and had been diagnosed with a dissocial personality disorder. In addition, he had diagnoses of chronic obstructive pulmonary disease, hepatitis C and HIV. He had become homeless and was then accommodated by the local authority in a supported living

placement with a care package designed to prevent him from accessing alcohol (for example, PB was not allowed to leave the placement without an escort). The resulting deprivation of liberty was authorised, but PB objected to it. Specifically, PB asserted that he wished to stay at the placement but to be able to drink alcohol in moderation. However, a trial period of PB being allowed to drink broke down when PB returned drunk on various occasions and was abusive to staff.

The evidence

Expert evidence from a consultant psychiatrist initially found that PB had capacity to make decisions about his residence and care. In short, this conclusion was reached on the basis that, although PB seriously underestimated his ability to keep his alcohol dependence under control (recognised to be a common tendency of those suffering from substance abuse), he was able to explain coherently why he thought drinking in moderation would be possible (with the support of a stable placement and not being around other alcoholics) and, crucially, PB understood and accepted the risks to his health and well-being that would result from continued heavy drinking. This included an appreciation of the fact that he could die.

However, the expert subsequently changed his view, finding that in fact PB lacked capacity to make decisions about his care and residence. The rationale for this was that in weighing up information, PB was unable to appreciate that he did not have control over this drinking.

The court's approach

Hayden J rejected the expert's approach, and instead returned to first principles in his assessment of capacity. In so doing, he restated the provisions in s.1 and s.3 of the MCA 2005 and reviewed the case law on capacity. In light of this, Hayden J explained: "*at the core of the Act is a central distinction between the inability to make a decision and the making of a decision which, objectively, would be regarded by others as unwise*" (paragraph 5). Further:

> *14. Even where an individual fails to give appropriate weight to features of a decision that professionals might consider to be determinative, this will not in itself justify a conclusion that P lacks capacity. Smoking, for example is demonstrably injurious to health and potentially a risk to life. Objectively, these facts would logically indicate that nobody should smoke. Nonetheless, many still do. In Kings College NHS Foundation Trust v C and V [2015] EWCOP 80 at [38] MacDonald J stated:*
>
> > *"It is important to note that s 3(1)(c) is engaged where a person is unable to use and weigh the relevant information as part of the process of making the decision. What is required is that the person is able to employ the relevant information in the decision-making process and determine what weight to give it relative to other information required to make the decision. Where a court is satisfied that a person is able to use and weigh the relevant information, the weight to be attached to that information in the decision-making process is a matter for the decision maker. Thus, where a person is able to use and weigh the relevant information but chooses to give that information no weight when reaching the decision in question, the element of the functional test comprised by s 3(1)(c) will not be satisfied. Within this context, a person cannot be considered to be unable to use*

> *and weigh information simply on the basis that he or she has applied his or her own values or outlook to that information in making the decision in question and chosen to attach no weight to that information in the decision making process."*

Hayden J went on to explain that the relevant question for determination here was not, in fact, whether PB had the capacity to make decisions upon alcohol. Rather, it was, as the local authority proposed, "*whether PB has the capacity to decide on where he should live and the care to be provided from him. That assessment requirements consideration of many of the factors identified by Theis J in LBX v K, L and M* […] *It also requires an evaluation of whether PB understands the impact on his residence of care arrangements of his continuing to drink, potentially to excess*" (paragraph 41). Hayden J went on to answer this question in the affirmative, noting PB's various statements in which he recognised the likely risks and consequences of continued heavy drinking (including the risk of death). Hayden J noted that:

> *42. Whilst I agree entirely with the Local Authority's structured approach to the test to be applied, I do not agree with its conclusion on the evidence. On the contrary, PB's analyses his dependency on alcohol in a way which is both articulate and rational. He is also clear as to the dire consequences of his drinking to excess. He makes the association between the consequences of drinking to excess and the impact on his care arrangement. He reconciles the two in his own mind by his conclusion that he should stay where he is but moderate his drinking to reasonable limits. There is within his plan an inherent recognition that drinking to excess and the sustainability of the placement are irreconcilable. There is much evidence from PB's history that he is unlikely to be able to achieve this, but the potential gulf between his aspiration to moderation and the likely reality, does not negate the thought processes underpinning his reasoning. In any event I do not consider that there is evidence here which is sufficiently choate to rebut the presumption of capacity. The plan that PB identifies may not be sustainable long term but that does not permit an inference that he is unable to foresee the consequences of drinking to excess on the sustainability of the placement.*

Hayden J declined to provide general guidance applicable to all substance abuse cases on the basis that each case must be carefully considered on its facts. He also declined to give guidance on the second issue that DJ Eldergill had identified, namely, *"[w]hether or in what circumstances the Mental Capacity Act 2005 (MCA) should be used coercively to prevent people who are alcohol dependent from gaining access to alcohol*." However, he noted that he was:

> *50.* […] *uncomfortable with the terminology used in the order.* […] *Coercion has pejorative implications, it implies persuasion by use of force or threats. As such it has no place in the Court of Protection and jars entirely with the applicable principles of the MCA. Moreover, the question only arises when the issue of capacity has been determined. If P has capacity then manifestly the Act does not apply. If P lacks capacity, facilitating compliance with a regime to which he is opposed will always involve the lightest possible touch, the minimal level of restraint or restriction and for the shortest period of time.*

Hayden J concluded at paragraph 51 with a statement of general principles, including the useful reminder that, "[w]*hatever factual similarities may arise in the case law, the Court will always be concerned to evaluate the particular decision faced by the individual (P) in every case. The framework of the Mental*

Capacity Act 2005 establishes a uniquely fact sensitive jurisdiction," and that "[t]*he criteria by which capacity is evaluated on any particular issue should not be confined within artificial or conceptual silos but applied in a way which is sensitive to the particular circumstances of the case and the individual involved, see London Borough of Tower Hamlets v NB (consent to sex) [2019] EWCOP 27. The professional instinct to achieve that which is objectively in P's best interests should never influence the formulation of the criteria on which capacity is assessed*."

Comment

On the facts of the case before Hayden J, it appears that the conclusion that PB had capacity to make decisions about his residence and care arrangements would have no actual impact, because, as Hayden J noted, he was "*perfectly happy to remain where he was*," and it appears that, albeit rather by default than by design, he was able to leave the placement and drink. Oddly, therefore, it might be said PB's case was rather easier than the majority of cases in which alcohol dependence is in play, where the consequence of a conclusion that, notwithstanding the impact of that dependence, the person retains the capacity to make decisions about their residence and care arrangements is that the relevant public bodies feel that they are required to watch a vulnerable individual self-destruct, seemingly powerless to protect them from themselves.

Although Hayden J declined to give general guidance, the approach that he took to the question of alcohol dependence highlights two key points.

The first is that questions of capacity do not arise in isolation: in most situations the question of whether or not a person has capacity to make decisions about drinking is not, in and of itself, likely to be of critical importance. Rather, it is the impact of their potential drinking upon their capacity to make other relevant decisions (here, as often about matters relating to residence and care) that is going to be of significance. In other words, the proper approach will be to consider whether P is able to understand, retain, use and weigh relevant information for purposes of another decision, the consequences of their alcohol dependence (for instance breakdown of the placement, homelessness or even death) being part of that relevant information.

In some cases, it may be that (1) P cannot understand, retain, use or weigh those risks; and (2) the reason why they cannot do so is because of the impact of sustained alcohol and/or drug abuse. In such a case, it can logically be said that that P's alcohol dependence means that they do not have capacity to make decisions about their residence and care arrangements. In other cases, this being one, if P can understand those risks (and there is no other relevant information that they cannot process) then they will not lack capacity to make decisions about their residence and care arrangements. This is the case even where P is unrealistic about their ability to limit or moderate their substance abuse, so long as that lack of realism does not equate to inability to process the risks of that abuse. While the latter may be illustrative of unwise decision-making, it does not lead to the conclusion that P actually lacks the ability to make the relevant decision.

Capacity conundrums

In two decisions of interest, not least because in both the person was found to have capacity to decide to use the internet and social media, the Court of Protection has continued to use the tailor-made guidance/list of relevant information approach endorsed by the Court of Appeal in *Re B*. Both cases illustrate the fine line between a capacitous unwise decision and a lack of capacity.

In *A Local Authority v AB and SB* [2020] EWCOP 32, a 30-year-old woman with moderate intellectual disability spent most of the week living with her mother, AB, and the weekends with her partner. A number of expert reports were prepared, focusing on SB's decisional capacity regarding many matters. It was not in dispute that she had capacity in relation to sex and the withholding of information and lacked capacity to conduct the proceedings. But in relation to residence, care, internet/social media, contraception and financial affairs, her mother – described as clearly a concerned and committed parent – contended that her daughter lacked capacity whilst the local authority and Official Solicitor agreed with the expert evidence that she had capacity.

Her mother recalled her daughter's vulnerability, including the 3-4 times SB left with known offenders and became pregnant by them on 7 occasions, the times she went missing and had to be tracked down by her mother. And how SB was largely funding her partner's flat whilst he uses his money to gamble and buy illicit substances, with limited understanding of money. However, the court agreed with the expert evidence, observing "*An evaluation of capacity does not and must not require or allow the court or others to substitute its own values and priorities with those that belong to a patient*" (para 37). This emphasises that where someone is able to understand, retain, use and weigh relevant information, the amount of weight or importance to attach to salient details is a matter for them, not others. As the judge noted, "*The weight to attach to that information is a matter for SB. The consequences that have in the past arisen as a result of the weight that she has attached to this information are in my view a quintessential example of an unwise decision*" (paragraph 57).

The other case of *A Local Authority v RS* [2020] EWCOP 29 concerned a man in his mid-20s with autism and mild learning disability. As a child he was exposed to domestic and alcohol abuse, bereavement, and inappropriate sexual activity and now lived in a supported placement. His fetish was paraphilic infantilism, or ABDL (adult baby / diaper lover), involving adults role-playing a regression to an infant-like state, including the wearing of nappies. The concern was that pursuing this interest in the exploration of his sexuality led him to engage in risky behaviour, including meeting males found on the internet. The judge was asked to determine RS's ability to decide on residence, care, contact, and internet/social media use. MacDonald J concluded that RS had capacity for all four matters.

The judgment navigates the tightrope between unwise decisions and incapacitated views:

> *42. … As I have noted, risky behaviour is not inevitably evidence of a failure to understand the risk being taken or evidence of an inability to weigh that risk when deciding whether to act despite it. The repetition of risky behaviour can also indicate that a person has understood the risk, weighed it and*

decided to take it anyway notwithstanding the dangers.

The social work evidence of past occasions of objectively risky or unwise decisions failed to address *why* they demonstrated incapacity as distinct from other possible reasons for unwise/risky behaviour. Moreover, "*The fact that a decision to make contact with a man to satisfy fetish urge may be considered risky is not of itself evidence of a lack of capacity to take that decision*" (paragraph 49). There were also issues as to the causative nexus, particularly whether RS's decision-making were influenced by a mental impairment "*as opposed to from his psychological makeup, his sexual proclivities and desire and the fact he is a young man with a level of impulsivity commonly seen at his age, which factors cause him to make unwise but capacitous decisions*". The expert evidence developed under cross-examination:

> *52. Dr Lawson clearly articulated in cross examination the factors that led him to this revised conclusion. First, that it is important not to use, as the local authority had sought to use, repetitive risky behaviour to justify an assessment of lack of capacity. If RS's risky behaviour stemmed from his learning disability and autism it would be seen in all areas but it is not. Second, further consideration had to be given to the significant issues of RS's maturity and his actual age and he gave these more weight in coming to a balanced view as to why he makes unwise decisions. Third, and within this context, caution was required against making the mistake of attributing RS's impulsive decision making to his learning disability and autism where elements of RS's history and development may explain that conduct, which falls within the ordinary recklessness demonstrated by young people. Fourth, the sexual element is a powerful drive and RS's mild learning disability and autism are not the driving force behind his fetish and ABDL behaviour. Fifth, on the totality of the evidence Dr Lawson could not consider RS to have an abnormal level of impulsivity. Sixth, whilst the possibility cannot be excluded that RS's impulsive and reckless decision making is linked to his learning disability and autism, his decision making could also represent a normal level of impulsivity and recklessness for a young person of his age.*

With regard to the use of the internet and social media in particular, the judge noted that "*the behaviour of RS in meeting up with strangers after only limited contact with them online, which the local authority seeks to characterise as* ***so*** *fundamentally irrational that it must demonstrate that RS lacks capacity, is now also the basis of some widely used social media applications*" (paragraph 54). In conclusion, therefore, it was declared that RS had capacity to decide the four matters and no changes to his support were anticipated. Nor was he deprived of his liberty, so no authorisation was required.

Stem cell donation, altruism and the Court of Protection

A NHS Foundation Trust v MC [2020] EWCOP 33 (Cohen J)

Best interests – medical treatment

Cohen J has confirmed that it can be in the best interests of a person to donate stem cells, applying the test set down in s.4 MCA 2005. The case concerned a young woman, MC, who had turned 18, and the potential donee was her mother, who had chronic leukaemia. The precise basis upon which it was said that MC lacked capacity to consent to the harvesting and use of the stem cells does not appear

from the judgment, the focus being upon whether it was in her best interests to do so.

The decision does not, perhaps, come as a surprise given that it had been understood long before the MCA was enacted that altruistic donation could be in the (common law) best interests of an individual: see *Re Y (Mental Patient: bone marrow donation)* [1997] Fam 110. It is, however, helpful to have the confirmation of the position by reference to the MCA itself. It is also of no little interest that Cohen J was careful to identify the risks to the woman, MC, as well as the benefits to her, which he identified as follows:

> *15. Without the transplant MC's mother's prospects are poor and deteriorating. Whilst there is no certainty of the outcome of the procedure it elevates a poor chance of survival to a 43-45% survival rate at 5 years, and that is obviously a potentially highly significant benefit. MC lives at home with a loving family and there are clear benefits, emotional, social and psychological, to MC of her mother's life being extended.*
>
> *16. Next I must give weight to the fact that although MC has not understood the details, she understands that her mother is not well and that she may have ability to extend her mother's life and perhaps enable her to recover. MC wants to do that – it has been her repeated wish expressed to the doctors and to the Official Solicitor that she wants to give what help she can.*
>
> *17. I also give some weight, although lesser weight, to the fact that MC may be seen by others positively by acting altruistically.*
>
> *18. I agree with both Counsel that it is overwhelmingly in MC's best interest to participate in the proposed programme and donate her stem cells for the benefit of her mother. It is in MC's best interests as much her mother's.*

Cohen J identified that (perhaps surprisingly) this was the first time that an application for the extraction of bone marrow or stem cell donation by someone lacking capacity had come before the Court of Protection and the first time the Human Tissue Authority ('HTA') had been involved in a case of this nature.[1] The HTA has a statutory responsibility to assess all donations of bone marrow or peripheral blood stem cells from adults who lack capacity to consent and children who lack competence to consent.[2] Potential donors that lack capacity or competence must be referred to an Accredited Assessor (AA), who submits a report to the HTA following interviews with the donor, the person/s acting on the donor's behalf and the recipient. Cohen J expressed some views about the

[1] The exact nature of its involvement is not clear, because they were not a party and it does not appear that it made any submissions to the court.

[2] By virtue of the Human Tissue Act 2004 and the Human Tissue Act 2004 (Persons who Lack Capacity to Consent and Transplants) Regulations 2006 ('the Regulations'). The restrictions on and requirements for living organ donation and transplantation are set out in sections 33 and 34 of the Human Tissue Act and sections 9-14 of the Regulations. They require that donations of bone marrow and peripheral blood stem cells from children (anyone under the age of 18) who are not competent to give consent, or from adults lacking capacity, must be approved by the HTA. The Regulations include the requirement that the HTA is satisfied that consent for removal of the material has been given, or the removal is otherwise lawful (for example sanctioned by the Court).

process undertaken by the HTA, noting at paragraph 22 that "*there should be a considered risk and benefit analysis by the accredited assessor.* […] *However, it could only be beneficial if a considered deliberation of the factors set out within s.4 of the Mental Capacity Act 2005 was performed in each case where the HTA is faced with an issue of capacity of the donee*."

One other point of interest is that Cohen J appeared to take it as self-evident that the decision to consent had to be taken by the court as there was neither an LPA nor a deputy who had the power to consent on MC's behalf (see paragraph 19). This appears to have been reflecting the approach taken by the HTA itself, on the basis that the Human Tissue Act makes no provision for appropriate consent for the removal of material from a living adult who lacks capacity to consent for himself or herself, such that, where there is no ADRT refusing consent or LPA or deputy to consent, the HTA considers that Court of Protection must make the decision on behalf of the person.[3] Interestingly, however, the HTA's approach is founded upon the statement in the Code of Practice to the MCA that, where an adult lacks the capacity to consent to the removal of bone marrow, the case must be referred to a court for a declaration that the removal would be lawful. The HTA "believes that the same approach should be adopted for donation of PBSCs. Donation may then only proceed if court approval has been obtained and, following court approval, the case is referred to, and approved by, an HTA panel." However, as the Supreme Court identified in *NHS Trust v Y* [2018] UKSC 46 (in the context of life-sustaining treatment), the Code of Practice cannot, itself, establish a legal obligation to bring a case to court – it would, perhaps, be helpful in the next case which comes before the Court of Protection in this area for the court to spell out precisely why there is such an obligation in this context.

Medical treatment cases – when to come to court

In two recent medical treatment cases, Hayden J has taken the opportunity to reinforce the message about when applications should be brought.

The case of *Hull University Teaching Hospitals NHS Trust v KD* [2020] EWCOP 35 concerned a 57-year-old woman with paranoid schizophrenia who smoked around 60 cigarettes a day and whose collapsed right lung required 15-20 minutes of keyhole surgery to which she objected but without which she would die. Because of active persecutory delusions and anxiety, Hayden J determined that KD lacked capacity to decide whether to have the proposed treatment and that the procedure and aftercare was in her best interests. Moreover, his Lordship agreed with the Trust's decision that the case required an application to be brought to court, consistent with the Serious Medical Treatment Guidance [2020] EWCOP 2: it is not quite clear whether this was solely because the treatment would be against KD's wishes, or whether it was because the steps taken to enable surgery and recovery would go beyond restraint to a deprivation of liberty requiring judicial authorisation.

In *University Hospital Coventry and Warwickshire NHS Trust v K and Mrs W* [2020] EWCOP 31, a woman in

[3] See paragraph 36 of the HTA's Code of Practice G: Donation of allogeneic bone marrow and peripheral blood stem cells for transplantation.

her mid-30s had recently been diagnosed with cancer. Without radiotherapy and chemotherapy, she would likely die a painful death within a year. The treatment offered a 30-40% prospect of survival for more than 5 years, after which she would have a normal life expectancy. However, the treatment would render her infertile as it would expedite the menopause. K had been enthusiastically cooperative with treatment so far, but there was much worse treatment to come.

The reasons behind the application were threefold:

1. It was highly intrusive treatment over a considerable period of time;
2. It would cause infertility;
3. There was a distinct possibility K might withdraw her cooperation when the treatment became more distressing.

The pre-emptive, rather than reactive, nature of the application was commended by the court. On the evidence, Hayden J concluded that K lacked capacity to consent to treatment because she was unable to retain the relevant words and concepts to evaluate them so as to be able to use or weigh them. In terms of best interests, 10 radiotherapy sessions and 2 sessions of chemotherapy were proposed, during which it may be necessary to address her anxiety with sedative medication. If she were to refuse to attend hospital for treatment, he agreed that it would not be in her best interests to compel her to travel there. Indeed, he agreed with the clinicians that to restrain would be more likely to exacerbate her withdrawal than encourage her cooperation.

Short note: incapacity and the limits of persuasion[4]

In *Avon and Wiltshire Mental Health Partnership v WA & Anor* [2020] EWCOP 37, Hayden J had to consider the capacity of a young Palestinian man to make decisions about his nutrition and hydration and, if he lacked capacity, what would be in his best interests. The factual matrix of the case is exceptionally complex, sensitive, and tragic which we do not set out here. The decision as to his capacity was, as was clear both from the evidence and the judgment, as borderline as it is possible to get. Ultimately, however, Hayden J concluded that the young man, WA, lacked capacity to make decisions about his nutrition and hydration, but that it was not in his best interests for forced naso-gastric feeding to be carried out without his agreement. It was, he considered:

> *102.* […] *fraught with unmanageable and significant risk. Ultimately, it cannot be reconciled, in my judgement, with the protection of WA's autonomy. I consider that every effort should be made, with the parents at the centre of the process, to persuade, cajole and encourage WA to accept nutrition and hydration. Attempts to deploy these techniques should be permitted with far greater persistence than would be considered appropriate in the case of a capacitous adult. I have no doubt that the attempts of persuasion will be delivered in the kindly and sensitive way that is most likely to persuade WA. I make no apologies for repeating that I consider WA has a great deal to offer the world as well*

[4] Note, Katie having been involved in this case, she has not contributed to this note.

> *as much to receive from it. No effort should be spared in encouraging him to choose life. This said, I have come to the clear view that when WA says no to CANH his refusal should be respected.*

On the face of it, it might be thought difficult to square this conclusion with the prior conclusion that WA lacked capacity to make decisions as to his nutrition and hydration. Put another way, why should his refusal be respected if it is incapacitous? The answer can perhaps best be understood by locating it in the specific context within which the treating team found themselves in which, as Hayden J indicated, the consequence of the judgment was two-fold:

1. The team were to be 'armed' with the confidence to seek to persuade WA in a way that they would feel uncomfortable doing with a person whose decision-making was unimpaired;
2. The treating team could, at the same time, be confident that if, despite this persuasion, WA did not actively assent ('consent' here would appear to be a slightly difficult word to use) to receiving nutrition and hydration, they would be acting lawfully if they did not then seek to impose such treatment against his will.

The judgment also contains the following points of wider importance.

WA who, unusually, but not uniquely, was found to have litigation capacity even though his subject matter capacity was in doubt, took part in the proceedings remotely. Hayden J observed that:

> *60. It is an interesting feature of remote hearings that they have served, in a number of cases, actively to promote the participation of P in the court process. I have visited WA (remotely) in his hospital bed, with his parents in attendance, on two occasions. Firstly, at the directions hearing and again when he gave his evidence. It was possible to set up an arrangement where I could see him but the Advocates and everybody else present in the court could only hear him. He has listened to every word of evidence with keen attention and self-evidently been able to provide full instructions to his legal team, in whom he plainly and rightly has great confidence. There are wider lessons to be learnt from this for the future.*

Hayden J was astute to identify that, in the particular circumstances of WA's case, "passive submission" had clearly to be distinguished from consent:

> *95. In some circumstances a plan predicated on compliance without actual agreement may be entirely legitimate. I think, for example, of transfusion cases where Jehovah's witnesses will often indicate that they will submit to an order of the Court in the face of their religious beliefs. Ms Sutton has collated the various phrases that have been used to try to capture the essence of the Treatment Plan which is intended to communicate with clarity what is expected of those charged with providing treatment. She identifies: "gentle persuasion"; "tacitly compliant"; "passive acceptance"; "tacit cooperation" and "acquiescence". Set out in this way they illustrate the complexity of the challenge to the treating clinicians and nurses, particularly to having regard to WA's background. Moreover, looked at collectively, the phrases reveal themselves to be that which they are i.e. euphemisms for force feeding. A plan which stated specifically that WA will be force fed unless he actively resists would, I suspect, cause most people to recoil from it. It does not become any less disagreeable when dressed*

in softer language.

Conversely, Hayden J identified that there might be circumstances in which non-verbal consent could be manifested:

> *97. I have observed before, most notably in M v N (by her litigation friend, the OS), Bury Clinical Commissioning Group [2015] EWCOP 9 that feelings and even strong feelings can often be expressed non-verbally. In fact, I noted in that judgment that feelings can sometimes be communicated, in contra distinction to what is actually said. DT told me in her evidence that there can be times when she considers that WA demonstrates to her both that he understands a proposed treatment and that he does not actively resist it. I took this to mean that this was absent expressed agreement. The reassuring and kindly presence and encouragement of his parents, particularly DT has, I am sure, resulted in WA receiving treatment in which there has been real and nonverbally expressed consent. It is this that the plan has tried to capture.*

Finally, and in terms of the presumption of capacity, Hayden J observed that:

> *Ms Scott,* [on behalf of WA] *submitted that in circumstances where the evidence was so finely balanced as to be on a "knife edge", it could not easily be said properly to have rebutted the presumption of capacity enshrined within the framework of the MCA. Though that submission is superficially attractive, Ms Scott agreed, in the course of exchanges, that it did not absolve the court from its duty rigorously to analyse the evidence. The presumption of capacity serves to place the burden of proving incapacity squarely on the shoulders of the applicants. The burden of proof remains the balance of probabilities, nothing more northing less (see Re: B [2008] UKHL 35). In some cases, the evidence will tip the balance significantly in one direction. In other cases, such as this, the balance will be more delicately poised, though still identifiably weighted to one side.*

DoLS under COVID-19

In the CQC's 3rd "Covid Insight" published on 15 July 2020, it notes that, since the start of lockdown, it has seen notifications from adult social care services drop by almost a third (31%), and in hospitals by almost two-thirds (65%).

The decrease has varied across the regions. In adult social care, London saw the largest percentage change with a 37% drop, followed by a 35% reduction in the East of England. For hospitals, the South East saw the largest percentage reduction of 82%, followed by 71% in London.

We will wait with some considerable interest, and no little anxiety, to see whether this trend is reversed as the impact of lockdown lessens.

Deprivation of liberty and 16/17 year olds – practice guidance

Research in Practice has made freely available practice guidance written by Alex and Camilla Parker to help professionals identify when a deprivation of liberty may be occurring in the context of a 16 or 17-year-old, in particular in light of the Supreme Court decision in *Re D* in 2019, and to provide key

pointers as to what should happen at that stage. The guidance can be found here.

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PROPERTY AND AFFAIRS

"Use an LPA service"

From 17 July, the OPG is offering a new service. Once an LPA is registered, attorneys and donors will be sent an activation key. They can create an account online at Use a lasting power of attorney and use the activation key to add LPAs to their account. A donor or attorney can then make an access code which they can give to organisations to view an online summary of an LPA. For more details, see this blog here. We understand that the intention is that this service is going to be rolled out in the future in relation to LPAs registered before 17 July 2020.

Short note: discontinuing as a deputy

In *Cumbria County Council v A* [2020] EWCOP 38, Hayden J considered the position in relation to the situation where a local authority wishes to cease being a property and affairs deputy, and have a professional deputy appointed. In almost all cases, this will come at greater cost to the person – in the test cases before Hayden J, it appears from the identified comparator that the cost would be more than twice as much.

Hayden J made clear that where a deputy wishes to discontinue in the role, an application must be made to the court. Critically, the application will not be granted automatically:

> *30.* […] *The decision is one for the court, acting within the parameters of reasonable discretion. Frequently, the reasons for the application will be obvious e.g. retirement or ill health. On other occasions the basis for the application will be less straightforward and the court will have to evaluate the strength of it through the prism of P's welfare interests. Those factors identified in the passages above i.e. the complexity of P's estate; conflicts of interests; P's own wishes and feelings; the value of the estate etc, may be relevant considerations in any particular case. There can be no presumption of the outcome of the application, nor any fettering of the court's discretion. The guide will always be P's best interests, including his financial interests.*

There had been a suggestion before the court that it could examine whether the approach taken by Cumbria County Council in identifying groups of people where it no longer wished to act as deputy complied with s.149 Equality Act 2010 (i.e. the Public Sector Equality Duty). However, Hayden J made clear that the Court of Protection could not undertake such a review:

> *31.* […] *it is manifestly the case that this court is not able, within its statutory remit, to grant any public law remedy. This should not be taken as inferring that the court is required to disregard any failure by a public body to protect from discrimination, merely that it has no power to remedy it.*

Hayden J emphasised that:

> *33.* […]*The Mental Capacity Act 2005 and the jurisprudence of the Court of Protection reflect precisely the same philosophy as that underpinning the Equality Act. The central ethos of both legal*

frameworks is entirely consonant. The MCA aims, ultimately, to promote equality for the incapacitous to the same degree as their capacitous coevals. It imposes an obligation actively to promote capacitous decision taking and it erects a presumption of capacity in order most effectively to promote personal autonomy.

34. When the court comes to consider an application by a deputy to be discharged from the role it will, as I have analysed above, arrive at its decision by focusing on the impact on P of either granting or refusing the application. When approaching its task, the court will consider whether the application is consistent with the objectives of the MCA i.e. whether or not the application is motivated to promote P's best interests in accordance with the principles that I have identified. If the application appears to be driven by arbitrary or discriminatory criteria devised, for example to save costs, then the court (if it identifies them) will take them in to account to whatever degree is appropriate when coming to its decision. This will not be in consequence of a public law style review of compliance with Equality legislation, but rather the application of the principles of the MCA. The issue here is not one of jurisdiction (see ***N v A CCG*** *[2017] UKSC 22), but of how the application should be approached within the framework of the Mental Capacity Act 2005. It is unnecessary to say more on the point.*

LPA guidance update

On 7 July 2020, the OPG updated its Guidance on making LPAs in the context of Coronavirus to reflect the changes to lockdown.

The most obvious issues are signing, witnessing and the certificate provider's conversation with the donor.

As these are critical, they are set out in full here:

Signing and witnessing the LPA

You should follow government guidance on social distancing to ensure that you satisfy requirements when signing and witnessing an LPA. Do not:

- *use digital signatures - the document must be printed out and signed by hand with a black pen*
- *send people photocopies or scans of the LPA to sign - everyone must sign the same, original document*
- *ask people to send you a scan or photocopy of the page they've signed - we cannot register an LPA that includes scans or copied pages*

Witnessing the donor and attorneys' signatures

Someone must watch the donor signing the LPA, then sign it themselves to say they've witnessed the signature. Each attorney and replacement attorney's signature must also be witnessed, as long as that person:

- *is aged 18 or over*
- *has mental capacity*
- *is not an attorney or replacement attorney on the LPA*
- *Rules on witnessing*

The witness must:

- *be shown the blank signature and date box before they're signed*
- *have a clear view of the person signing the LPA, so they can see the signature being made*
- *be shown the completed signature and date box immediately afterwards*
- *Signatures must be witnessed in person.*

If the donor cannot sign the LPA

If the donor is not able to use a pen and cannot sign the LPA, someone else can sign on their behalf.

The donor and 2 other people must be there in person to witness the signature being made. The 2 witnesses must also sign the LPA.

You must follow all the rules on witnessing in accordance with the government social distancing guidance.

Make sure the LPA is signed in the right order

It's very important that the LPA is signed in the right order. If it's not, we cannot register it. The donor may have to make a new LPA, get it signed again, and pay another application fee.

The certificate provider and donor conversation

The certificate provider must talk to the donor about the LPA to make sure the donor understands it and is not being pressured to make it.

We recommend this conversation happens face to face, but you must consider the government social distancing guidance. If this must be over phone or a video call, the certificate provider should make sure the call is private.

Short note – the professional deputy as friend?

In *Re OT* [2020] EWCOP 25, the court had to decide who to appoint as deputy to manage the property and affairs of an 81 year old woman, OT. The rival contenders were:

1. KKL, a trust corporation working closely with (both in terms of being the subsidiary of and working from the same office with) a charity called JNF Charitable Trust ("JNF UK"). OT had, when capacitous, approached KKL and chose them over many years to write and rewrite her Will.

2. Ms Lynsey Harrison, a partner in Clarion Solicitors, a professional deputy approached by OT's social worker SAH under an approved scheme used by Leeds City Council for referrals required on behalf of vulnerable people for legal advice or deputyship.

Ms Harrison objected to KKL being appointed on three main bases:

> *The first is its lack of independence from JNF UK and the potential for a conflict of interest to arise between OT's interests and the interests of JNF UK as the main and residuary beneficiary of OT's latest will. The second is KKL's lack of experience as a deputy and the third is KKL's geographical distance and their apparent conflict with others with whom the deputy would need to work in OT's best interests pursuant to section 4(7) of the Act.*

KKL objected to Ms Harrison being appointed in part because of their assertion that they should be higher in the ranking order, and in part because of an asserted conflict of interest associated with her ability to charge a fee for her work as a professional deputy and to pay solicitors costs to her own firm for legal services. DJ Geddes made observations of perhaps wider import to other situations where a local authority approaches a professional deputy in similar circumstances, rejecting the following specific allegations:

> *a. That the arrangement under which Leeds City Council refers vulnerable people to a small pool of approved solicitors is somehow "cosy" or improper. There is nothing wrong with such a system in my judgment and no evidence to substantiate the hint that it is somehow against OT's interests.*
>
> *b. That the inclusion within the application and draft order of the words "to authorise the deputy to pay Clarion Solicitors Limited the costs of this application and if this amount sought exceeds the fixed costs allowed the deputy is authorised to agree their costs and pay them from the funds belonging to OT. In default of agreement or if the deputy or solicitor would prefer the costs to be assessed and to be carried out on the standard basis" is a "cosy arrangement regarding costs that is buried in the small print in her application". Appreciating some licence for advocacy given that this is taken from Counsel's skeleton argument this is nevertheless (literally) factually wrong (this element of the order is printed in exactly the same uppercase print as the other orders sought in the application) and reflects standard wording within the templates produced by the Court of Protection. It is perhaps right to say, however, that where the deputy is a partner in the solicitors' firm whose fees stand to be agreed it might be wise for them to agree either to stay within the fixed regime or to have an assessment or, if appropriate, for the court to restrict the licence to agree costs in a similar way.*
>
> *c. That it is somehow surprising that Ms Harrison is not being funded by Leeds City Council to make this application or to oppose the application of KKL. This is not surprising at all. It certainly does not raise "serious questions" as asserted by Mr Arkush in his skeleton argument. The role of Leeds Social Care was limited to making the referral through Lawdesk. They are not the client of Ms Harrison, nor is OT. There is a risk to Clarion Solicitors of taking such referrals in that if their application were rejected they might be left to bear their own costs of bringing the application which they do so purportedly in OT's interests. Of course, in this limited sense they have an interest in either the success of the application or at least in not being criticised for bringing the application to the point of*

> *disapplication of the general rule about costs contained in rule 19.2 of the Court of Protection Rules 2017 namely that "Where the proceedings concern P's property and affairs the general rule is that the costs of the proceedings… shall be paid by P or charged to P's estate".*

As regards where KKL sat in the pecking order, DJ Geddes noted that the fact that she had approached them and trusted them to write and rewrite,

> *52.* [.,,] *shows both that she trusted the company to act in her interests and is likely evidence that she identified with JNF UK's aims and objectives. This is relevant to her values, and to her wishes for the purpose of section 4 of the Act but the evidence simply does not allow me to accept the submission that they should be treated - in particular where there is clearly potential for a conflict of interest as I have found - as if they are family or close friends of OT.*
>
> *53. In my judgment they may well fit into the description of professional adviser. The difficulty with preferring KKL to Ms Harrison on this basis is their lack of independence from JNF UK. A solicitor or accountant who knows their client well from years of managing their personal affairs is clearly an appropriate deputy but would be expected to maintain independence. It would be unthinkable and a clear breach of their code of conduct to facilitate the writing of a Will or to act as deputy or executor of a Will under which they stood to gain.*

Ultimately, having conducted a detailed examination of the factors for and against the appointment of KKL, DJ Geddes found that;

> *59. In my judgement the magnetic features have to be the need to investigate whether KKL's conduct of OT's affairs to date has been in breach of the Fundraisers Code and the clear potential for a future conflict as a result of JNF UK being the sole beneficiary of OT's estate. Nothing in Mr Arkush's submissions addressed those points to my satisfaction. The undertaking offered was certainly not enough to reassure me that OT's interests could be adequately protected if KKL were appointed as OT's deputy. On the other hand by requiring an assessment of Ms Harrison's costs if they exceed the fixed rate regime I can mitigate or even eliminate any concern arising from her relations with Clarion solicitors in respect of this application.*

PRACTICE AND PROCEDURE

Basic guide to the Court of Protection

A team comprising Tor, Sarah Castle (the Official Solicitor), Jakki Cowley (an IMCA), and Alex have produced a basic guide to the Court of Protection for lay people who may be going to court, or may be attending court. The guide, building on earlier guide by Tor, is accompanied by a glossary of the terms that are regularly used. Jakki has also written a more personal guide called "You're going to a welfare hearing at the Court of Protection – what does this mean for you?." These documents are not official documents, but we hope that they may be of help in ensuring that those who attend court know what it does, and how it does it. All of the documents can be found here, along with an easy read guide focusing (in particular) upon participation written by Dr Jaime Lindsey of the University of Essex.

Alongside these documents, it also helpful to flag the guide to remote hearings produced by the Transparency Project. It is designed for those attending family proceedings, but has practical information which may be equally useful to those attending hearings before the Court of Protection.

The COP Mediation scheme in practice

The Court of Protection mediation scheme in practice

Even though COVID-19 may be making everyone rethink how conventional proceedings unfold in the Court of Protection, it does – or should not – detract from the importance of mediation. On the Court of Protection Handbook website can be found a *guest post* by Alex Troup of St John's Chambers, Bristol, outlining his experience as a mediator under the *Court of Protection Mediation Scheme* which is currently up and running on an informal pilot basis.

Litigation capacity and litigation friends – news from the civil courts

Hinduja v Hinduja & Ors [2020] EWHC 1533 (Ch) (High Court (Chancery Division) (Falk J))

Litigation friend – family members

Summary

In a judgment relating to the business affairs of the Hinduja family, the Chancery Division has undertaken an important analysis of when, precisely, medical evidence is required to support the proposition that a party in civil proceedings requires a litigation friend, as well as the circumstances under which it can properly be said that a person should not be a litigation friend.[5]

The proceedings were brought under Part 8 of the Civil Procedure Rules to determine the validity and effect of two letters. Through an oversight, however, the Claimant's advisers did not file a certificate

[5] The case also concerned consideration of restricting access to court documents, not considered here.

of suitability from the Claimant's daughter at the time, as required by CPR r. 21.5. Such a certificate was filed, and Falk J had to consider whether and how to regularise the position. For technical reasons which are immaterial here, she took the view that the better course was to make a fresh order to appoint his daughter, Vinoo, as litigation friend under CPR r.21.6. There were two preconditions to the exercise of that power: (1) that the Claimant, SP, was a protected party and (2) whether Vinoo met the conditions set down in CPR r.21.4(3) to be a litigation friend. Were she to make such an order, Falk J would then make an order regularising the position under CPR 21.3(4) (and the Defendants, whilst challenging the two pre-conditions noted above, did not challenge the making of such an order if they were met).

Was SP a protected party?

The core submission of the Defendants was that the court did not have sufficient evidence to conclude that SP lacks capacity to conduct the proceedings. It was submitted that the information contained in the certificate of suitability did not properly address the tests in the MCA 2005, and no medical evidence was provided. Relying upon *Masterman-Lister v Brutton* [2003] 1 WLR 1511, the Defendant submitted that SP's Article 6 ECHR rights were engaged, and the court should require medical evidence to be provided.

Especially in cases before the civil courts, it has been a working assumption that medical evidence was required. However, as Falk J noted:

> *There is no requirement in the* [Civil Procedure Rules] *to provide medical evidence. The absence of any such requirement was commented on by Chadwick LJ in Masterman-Lister at [66]. There is no reference to medical evidence in CPR 21.6. The only reference to medical evidence is in paragraph 2.2 of PD 21, which applies where CPR 21.5(3) is being relied on. That requires the grounds of belief of lack of capacity to be stated and, "if" that belief is based on medical opinion, for "any relevant document" to be attached. So the Practice Direction provides that medical evidence of lack of capacity must be attached only if (a) it is the basis of the belief, and (b) exists in documentary form. It does not require a document to be created for the purpose.*

Falk J considered that references by the Court of Appeal in *Masterman-Lister* and the later case of *Folks v Faizey* [2006] EWCA Civ 1381 to medical evidence being needed in almost every case were not:

> *39.* [….] *intending to lay down any rigid principle under which medical evidence is required unless the circumstances are exceptional. The question will always depend on what the circumstances are. For example, Folks v Faizey was a personal injury claim where the claimant had suffered a severe head injury in a road traffic accident. The issue of capacity arose during the proceedings, the Court of Protection was involved (which would have required at least some medical evidence in any event), and there was a real dispute between medical experts about whether the claimant had capacity. The need for medical evidence was obvious. Similarly in Masterman-Lister, which like Folks v Faizey related to serious injuries following a road traffic accident, there was a real issue about capacity.*

Falk J also considered that the suggestion in *Baker Tilly v Makar* [2013] COPLR 245 that medical

evidence would ordinarily be required was, again, related to the factual context. Baker Tilly was, she considered, an "*extraordinary case where a judge had concluded that a litigant lacked capacity based on her behaviour in the course of the proceedings. That is not something that the court is ordinarily in a position to do.*" By contrast, in this case:

> *41.* […] *the certificate was provided by a close family member. Vinoo lives with her parents and cares for them daily. There can be no one who is in a better position to comment on whether her father has capacity to conduct the litigation. The certificate of suitability confirms that her father is no longer able to give instructions to lawyers and has asked her to do so. The fact that he may have capacity to ask her to act in the litigation does not mean that he has capacity to conduct proceedings. As explained in Masterman-Lister at [74] and [75], questions of capacity are issue specific.*

Falk J also considered that:

> *44. The wording of the certificate amounts to confirmation that SP is not able to make decisions for himself in relation to the proceedings because of an impairment. The confirmation is specific to the proceedings and in my view sufficiently addresses the test in s 2(1) of the 2005 Act.*
>
> *45. I also do not accept Mr Rees' suggestion that the evidence must expressly address each of the tests in s 3 of the 2005 Act, that is SP's ability to understand, retain and use or weigh information, or to communicate decisions (tests which I note are, in any event, expressed in the alternative: a person lacks capacity if any one of them is not met). The certificate confirms that SP is not able to give instructions to lawyers. In the context of a clear statement that SP lacks capacity to conduct the proceedings due to disease, I think that addresses the statutory test.*

In the context of the case itself, Falk J noted that there was no evidence that actually contradicted the evidence that SP lacked capacity to conduct the proceedings. Nor did she consider it necessary, or in accordance with the overriding objective, to require medical evidence to be produced.

Suitability of litigation friend

In order to appoint Vinoo as SP's litigation friend, Falk J had to be satisfied that (a) Vinoo could fairly and competently conduct proceedings on SP's behalf, and (b) she had no interest adverse to that of SP. (There was no dispute that Vinoo had provided the required undertaking to pay costs). The Defendant's case was that the tests in CPR 21.4(3)(a) and (b) are not met. The Defendants maintain that Vinoo has her own separate financial interest in pursuing the proceedings, and that she would not be in a position to form an independent and objective judgment about the merits of the claim and SP's best interests. The correct course, the Defendants submitted, would be to appoint an independent professional or the Official Solicitor.

Falk J undertook a detailed analysis of the case-law, in particular the decision in *R (Raqeeb) v Barts NHS Trust* [2019] EWHC 2976 (Admin), in which MacDonald J had stressed the need for the litigation friend to approach the litigation with objectivity. Falk J suggested, however, that:

> *59.* […] *some caution is required in relation to MacDonald J's comments about objectivity. It should also not be assumed that a relative with a financial interest is necessarily debarred from acting as a litigation friend.*
>
> *60. The comments made about objectivity were obviously made in the context of the facts of that case. The key tests to apply are those set out in the rules. In conducting litigation fairly and competently on behalf of a protected party, it is obvious that a litigation friend must acquaint him or herself with the nature of the case and, under proper legal advice, make decisions in the protected party's best interests. Being "objective" in this context cannot mean independent or impartial vis-à-vis both parties to normal adversarial civil litigation. The litigation friend is acting on behalf of the protected party. Any objectivity required must relate to the litigation friend's ability to act in the protected party's best interests, and in doing so listen to and assess legal advice, and properly weigh up relevant factors in making decisions on the protected party's behalf.*

Falk J continued:

> *61. The requirement not to have an adverse interest is closely linked to the requirement that the litigation friend can fairly and competently conduct the proceedings. Any adverse interest would obviously risk compromising the litigation friend's ability to act fairly in the protected party's best interests, or at least risk giving the appearance of doing so. For example, in Nottinghamshire County Council v Bottomley [2010] EWCA Civ 756 a litigation friend who was subject to a conflict of interest as between the local authority who employed her and the child she was representing was removed. Stanley Burnton LJ made the point at [19] that a litigation friend must be able to exercise some independent judgment on the advice received, and it would be unfair to expect the litigation friend to choose a form of settlement most unfavourable to her employer. He also said that the principle that justice must be seen to be done requires the litigation friend not to be seen as having a conflict.*
>
> *63. Whether the existence of a financial interest on the part of the litigation friend should debar them from acting will depend on the nature of the interest, and whether it is in fact adverse or whether it otherwise prevents the litigation friend conducting the proceedings fairly and competently on the protected party's behalf. A person is not prevented from being a litigation friend simply because they have a personal interest in the proceedings. It would, for example, be relevant if any personal interest that the litigation friend had meant that he or she could not approach the litigation in a balanced way, in the sense of not being able to weigh up legal advice and decide what should be done in the protected party's best interests. But it would be highly unlikely that a litigation friend would be unable to do so simply because he or she has an interest in the proceedings, in circumstances where that interest is aligned with that of the protected party.*

Finally, Falk J agreed with the observations of Laurence Rabinowitz QC sitting as a Deputy High Court Judge in *Davila v Davila* [2016] 4 WLUK 347, that the fact that the litigation friend has his own independent interest or reasons for wishing the litigation to be pursued ought not, in general, to be a sufficient reason for impeaching the appointment, because such an interest would generally run in the same direction as the protected party rather than being adverse to his interests. She also agreed with his observation that the reference to being able fairly and competently to conduct the proceedings was aimed at ensuring that the litigation friend has the skill, ability and experience to be able properly to

conduct litigation of the sort in question, but that in general the court should not be required to conduct an enquiry extending far beyond that, considering unproven allegations not directly related to the matters giving rise to the litigation.

On the facts of the case before her, Falk J concluded that there were no good grounds to indicate that Vinoo could not fairly and competently conduct proceedings on SP's behalf. As against the Defendants, she observed:

> *66. SP's litigation friend will not, and indeed cannot, be impartial: he or she is conducting adversarial proceedings on behalf of the protected party. What is required is that the litigation friend acts in the protected party's best interests.*

Falk J also took into account that SP had chosen Vinoo as one of his attorneys under lasting powers of attorney for both his property and financial affairs, and health and welfare, under powers of attorney made in June 2015. As such, Falk J observed, "*she has a duty to act in his best interests. The fact that she was appointed to these roles by SP is also a strong indication that he trusted her to act in his best interests, and indeed to do so in all aspects of his life. Obviously this does not automatically qualify Vinoo to act as a litigation friend, but it is of some relevance*" (paragraph 67).

Interestingly, Falk J found that the fact that (depending upon how proceedings unfolded), Vinoo might be required in due course to give evidence "*cannot sensibly prevent her from acting as a litigation friend. As already indicated, there is no requirement for independence and there is no basis to suggest that acting as a witness means that she cannot fairly conduct proceedings on her father's behalf, or that she has an adverse interest*" (paragraph 79).

One other point of particular note was that:

> *85.* […] *it is the court that will ultimately decide the effect of the [key] letter, making its decision on the facts and law in the normal way. In the same way that in Raqeeb XX's religious views were not relevant to the substantive issues before the court, Vinoo's motivations will not be relevant to the decision that the court makes, and the court will in any event want to hear both sides of the argument (Raqeeb at [36] and [41]). Furthermore, the question of SP's own subjective views or wishes (whether in July 2014 or subsequently), and the extent (if at all) to which that question is relevant, will be matters to be determined by the trial judge on the evidence.*

Comment

Falk J's careful analysis of whether, and why, medical evidence is required before a court can conclude that a party is a protected party is important. Perhaps reflecting the traditional deference shown by civil courts to medical expertise in the context of capacity (a deference not shared by the Court of Protection with its much greater familiarity with the concept), it seems usually to have been understood that medical evidence was required. However, as Falk J makes clear, the CPR (and, for that matter, the FPR and the Court of Protection Rules) have no requirement for medical evidence. It

will – and should – be a matter for the judge to determine in the circumstances of the case before them whether there is a need for medical evidence to enable them to determine whether an individual is a protected party.

Similarly, Falk J's analysis of the obligations upon a litigation friend (and hence the determination of suitability to be a litigation friend) is nuanced and careful. Caution may, though, be required in translating them across to the avowedly inquisitorial jurisdiction of the Court of Protection, where, traditionally, the litigation friend for P does seem to be treated as under a duty dispassionately to examine where P's best interests lie, no matter how those issues are framed by the other parties (see, for instance, the reference by Charles J in *Re UF* [2013] EWHC 4289 (COP) to the need for the litigation friend to be able to take "*a balanced and even-handed approach to the relevant issues*," endorsed by Baker J in *B v D* [2016] EWCOP 67). Whether, of course, (1) a litigation friend is in fact under a duty to act in MCA best interests; and (2) whether (even if they are) that requires them to act as gate-keeper to determine what arguments to advance on behalf of P, are different questions, addressed here.

Intermediaries and lay advocates

Two cases decided recently have considered these support mechanisms. In *S (Vulnerable Parent: Intermediary)* [2020] EWCA Civ 763, the Court of Appeal made some important observations about the role of intermediaries in 'hybrid' hearings and also emphasised the particular difficulty faced by at last some of those with learning disabilities in participating in proceedings by video. As Peter Jackson LJ noted:

> *27. A particular issue may arise where a witness with a learning disability is being questioned by an advocate who is not physically present. Even assuming that the technology works in an optimal way, the process removes many of the visual cues that are so valuable to individuals with a cognitive impairment. On 22 April 2020, the Equality and Human Rights Commission published an interim report into video hearings in the criminal justice system and their impact on effective participation by defendants who have a cognitive impairment or a mental illness. Such defendants may have difficulty retaining information, have a short attention span, be reluctant to speak up and have extreme anxiety:*
>
> > *"We found that video hearings can significantly impede communication and understanding for disabled people with certain impairments, such as a learning disability, autism spectrum disorders and mental health conditions."*
>
> *One of the report's recommendations to government is to consider the use of registered intermediaries to provide remote communications support to such defendants in video hearings.*
>
> *28. There is of course no direct read-across between a defendant in prison and a party or witness attending court as part of a hybrid hearing. I mention the EHRC interim report only to underpin the fact that the use of remote technology has additional implications for parties and witnesses with a learning disability. Being questioned by someone whose face appears on a screen is not the same as face-to-face conversation and the demands of following a hearing in more than one medium inevitably adds to any existing difficulties in understanding what is being said.*

In *C (Lay Advocates) (No.2)* [2020] EWHC 1762 (Fam), Keehan J usefully clarified the role of a lay advocate, and also funding responsibilities. In terms of the role, he clarified the position at paragraph 11 thus:

> *i) a lay advocate does not provide legal services;*
>
> *ii) a lay advocate is not a McKenzie Friend;*
>
> *iii) a lay advocate is not an intermediary (albeit an individual may be qualified to act as an intermediary and as a lay advocate);*
>
> *iv) the term 'lay advocate', for the purposes of this judgment, means a person who is qualified and/or has experience of assisting and supporting a party in proceedings who has an intellectual impairment or learning difficulties which compromises their ability to process and comprehend information given to them. The function of the lay advocate is to ensure that the party does understand the information provided and is able to respond to the same and thereby, is enabled to participate effectively in the proceedings. This assistance and support will be required both in court during the proceedings and out of court for the purposes of taking instructions and preparing the party's case for the court proceedings.*

The Secretary of State for Justice, who appeared before Keehan J, agreed on behalf of HMCTS and the LAA that:

> *i) payment for lay advocates at hearings is a matter for HMCTS; and*
>
> *ii) payment for lay advocates to assist with communication between the client and their solicitor out of court is, in cases benefitting from legal representation funded by civil legal aid, a matter for the LAA subject to the LAA being satisfied that it is a justifiable and reasonable disbursement in the course of the legal representation provided.*

THE WIDER CONTEXT

Social distancing, testing and COVID-19

We have updated our guide to social distancing and those with impaired decision-making capacity. Alex has also done a shedinar with the National Mental Capacity Forum on testing for those with impaired decision-making capacity.

"Abandoned, forgotten and ignored"

Inclusion London has published a hard-hitting interim report on the impact of Coronavirus on disabled people, drawing upon survey evidence, and, as the introduction outlines, painting

> *a stark picture. From the outset, we have been discriminated against, forgotten, and in some cases abandoned as policymakers have ignored our needs. Or, at best considered them as an afterthought.*

SCIE best interests guidance for COVID-19

SCIE has published a helpful guidance document "Best interests decisions: A COVID-19 quick guide" covering some of the most common scenarios encountered at present, such as testing, social distancing, self-isolating and hospital discharge.

4th LeDER report

The latest annual report from the Learning Disabilities Mortality Review (LeDeR) programme has now been published, showing deaths in the calendar year 2019. It shows that treatable causes of death accounted for 403 per 100,000 deaths in people with learning disabilities, compared to just 83 per 100,000 deaths in the general population. The report indicates that the majority of people with learning disabilities continue to die before reaching the age of 65. In the general population, 85 per cent of deaths happen at or after the age of 65, but in sharp contrast this is the case for just 37 per cent of people with learning disabilities. As with previous years, the recommendations include recommendations relating to seeking to increase understanding of, and adherence to, the Mental Capacity Act.

LGO taking complaints again

The Local Government and Social Care Ombudsman has now resumed all existing casework and from 29 June has been taking on new complaints through its website. As the website notes:

> *Over the coming weeks, it is likely the Ombudsman will receive complaints about events which have happened during the crisis. The law still requires people to have complained to their local council or care provider before they bring their complaint to the Ombudsman.*

Short note – the lockdown regulations in the courts

We briefly mention the judicial review challenge to the legality of the Health Protection (Coronavirus, Restrictions) (England) Regulations 2020[6] in *Dolan et al v Secretary of State for Health and Social Care et al* [2020] EWHC 1786 (Admin). Amongst the wide-ranging arguments were that the Regulations were outside the powers conferred by Parliament, and that the restrictions breached Articles 5 and 8 ECHR. After setting the pandemic scene, Mr Justice Lewis dismissed each of the arguments. The Regulations were lawfully made under the Public Health (Control of Diseases) Act 1984. The challenge to the initial version of the restrictions on movement were historically academic, so focusing on the amended regulation 6 which prohibited people from staying overnight elsewhere, it was held that this did not constitute a deprivation of liberty:

> *71 … Persons will be in their own home overnight. They will be with their families or others living with them as part of their household. They will have access to all the usual means of contact with the outside world. The prohibition is on staying overnight at a place other than their home (although that will, in practice necessitate them staying in their own home overnight). They are able to leave their home during the daytime to work or to meet others (subject to the requirements of regulation 7 on gatherings). Furthermore, regulation 6 is limited in time and has to be reviewed regularly and the restriction must be removed as soon as it is no longer necessary to combat the threat posed. The facts fall far short of anything that could realistically be said to amount to a deprivation of liberty within the existing case law.*

In relation to Article 8 interferences, these were necessary and proportionate to the legitimate aim of protecting health:

> *78. Any interference is proportionate. The restrictions are limited. Persons remain free to live with family members or friends forming part of their household. They may communicate with other and family members by means of communication such as telephones and, if available, internet facilities. They may physically meet family and friends outdoors (subject to the restrictions on numbers in regulation 7). Given the limited nature of the restrictions, the gravity of the threat posed by the transmission of coronavirus, the fact that the Regulations last for a limited period and have to be reviewed regularly during that period, and restrictions must be terminated as soon as no longer necessary to meet the public health threat, there is no prospect of the current regulations, at the current time, being found to be a disproportionate interference with the rights conferred by Article 8 of the Convention.*

This is unlikely to be the last case to challenge aspects of the measures taken by the government, both in terms of the law and policy.

Lessons learned from a close encounter with triage

[6] Now repealed – Alex has summarised the current Regulations in England from the perspective of those working with people with impaired decision-making capacity here.

Readers may find of some interest this paper, a narrative reflection from the viewpoint of a COVID-19 Ethics Working Group (of which Alex was a member) in a large London hospital in the middle of the COVID-19 pandemic. Its ethical claim is that a lack of detail in national decision-support guidelines, together with a lack of good quality and visible information sharing between clinical decision-makers in hospitals and communities, led to fear-driven anticipatory triage with serious consequences for patients and NHS staff. The paper offers some recommendations for minimising these consequences ahead of a potential second wave.

Capacity to apply to the MHT revisited

SM v Livewell Southwest CIC (Mental health [2020] UKUT 191 (AAC) (Upper Tribunal (AAC) (Nicol J, UTJ Ward and Tribunal Judge Johnston, DCP))

Mental capacity – assessing capacity

Summary[7]

In an unusual split decision in the Upper Tribunal (Administrative Appeals Chamber), the question of the capacity that a patient requires to bring an application to the Mental Health Tribunal (strictly the First-Tier Tribunal (HESC) was reconsidered. In particular, the question was whether the decision in *VS v St Andrew's Healthcare* [2018] UKUT 250; remained good law. That decision set the test as a two part-one: does the applicant understand that she is detained; and does she understand that the Tribunal has power to discharge her?

The majority (Nicol J and UTJ Ward) held that the decision did remain good law, their reasons for so doing being set out at paragraph 77.

a. *We repeat that the present legislative structure does not include an automatic referral to the Tribunal to test the legality of the patient's detention. In MH v UK the Strasbourg Court rejected the proposition that such an automatic referral was required by Article 5(4) of the ECHR.*

b. *Instead the system chosen by our legislature depends in the first place on there being an 'application' to the Tribunal.*

c. *It is the case, as we have said, that there is no express requirement for the person who makes such an application to have capacity. However, we draw no conclusion from this. It is entirely unsurprising that that sort of matter should have been left to implication.*

d. *The making of an application has consequences. Only one application under s.66(1)(a) can be made. Under s.66(1)(b) only one application can be made every 6 months. We consider it sensible and appropriate that there should be some test of capacity for an 'application' to have those consequences.*

[7] Note, Neil having been involved in the case, he has not contributed to this summary.

e. *The test of capacity in VS is deliberately couched at a low level. That is consistent with what Lady Hale in H (at [4]) described as the 'very limited capacity required to make an application'. As Judge Jacobs said, it would not be appropriate for the test as to capacity to initiate an application to be the same as the test of capacity to conduct the application. That would be too demanding. It would also, as Judge Jacobs also said, (though rather more diplomatically) make a nonsense of the power to appoint a representative for a patient who became incapacitated after starting the application.*

f. *It may be thought that those who have been subjected to detention under the MHA 1983 will be more likely, because of their mental ill health to lack capacity. That may be, but plainly there is not an automatic equation between the two.*

g. *Measures have been taken to assist patients who are detained so that they do have sufficient understanding of what is involved to make an application. (As Judge Dumont observed in granting permission to appeal, the government's response to the judgment in MH v UK drew attention to the provisions for IMHAs in the Mental Health Act 2007). Notably these include the mandatory explanation of rights under MHA 1983 s.132 and the assistance which can be (and was in the present case) offered by an IMHA.*

h. *However, Parliament has stopped short of giving an IMHA the power to make an application to the Tribunal on behalf of an incapacitated patient. That omission must have been deliberate. The difficulty faced by an incapacitated patient was apparent from the MH litigation (which had reached the House of Lords, if not the Strasbourg Court, by the time the Mental Health Bill 2007 was before Parliament) and the 2007 Act did specifically address the issue of incapacitated patients in other respects (see, for instance MHA 1983 s.130B(4) and s.130C(4A)). We note that Modernising the Mental Health Act: increasing choice, reducing compulsion: the Final Report of the independent review of the Mental Health Act 1983 (2018) p.124 recommended giving IMHAs such a power, but so far that legislative change has not yet been made.*

i. *In the present case there was the added complication of the Appellant's pregnancy. In our view the F-tT gave perfectly rational reasons why it decided against adjourning the hearing to see whether it could hear evidence from Mr Houghton, the Appellant's IMHA.*

j. *We agree with Mr Allen that the legislation does distinguish between 'wishes' (which may, for instance, include a wish to leave the hospital) and decisions. We also agree that the relevant decision in the present case was the decision to make an application to the Tribunal. We cannot see how the test for capacity to make that decision could be less than Judge Jacobs analysed in VS.*

k. *In our view the test for capacity to make an application under s.66(1)(a) (where the issue will be whether the patient could be detained under MHA 1983 s.2) must be the same as the test for capacity under s.66(1)(b) (where the issue will be whether the patient could be detained for treatment under MHA 1983 s.3). After all, in both paragraphs the legislation refers to 'an application' and, in accordance with the usual canons of statutory interpretation, one would expect Parliament to have intended that the same word had the same meaning in the two*

paragraphs.

l. There are alternative ways by which the Tribunal can have jurisdiction to determine the legality of detention. Notably, there is the Secretary of State's power to make a reference under MHA 1983 s.67. In the present case no one raised that possibility with the Secretary of State. We will return to that topic when we turn to Judge Dumont's third indent.

m. The legislative scheme with which we are concerned has significant differences to that which governs situations where it is thought necessary to deprive someone of their liberty. Both situations may involve people with mental ill health, but the legislative structures differ. Thus, there is scope for the legality of detention to be reviewed by the Court of Protection. Such a review may be triggered by the person concerned, but it may also be initiated by the 'Relevant Person's Representative' -see Mental Capacity Act 2005 Schedule 1A paragraph 102(3)(b). We respectfully do not consider that the second of the two limbs of para.86(1) of RD can bear the weight Judge Johnston seeks to place on it; it is discussing what the position is where the patient does not have capacity, rather than indicating when she should be taken to have it, and is a reflection of the existence of the role of Relevant Person's Representative with its attendant responsibilities. Because of these differences, we have not found the analogy with the situation in the Court of Protection to be particularly helpful.

Deputy Chamber President Sarah Johnston (i.e. the judicial head of the Mental Health Tribunal in England) was in the minority, holding that *VS* sets the bar too high in requiring an understanding that the FtT has power to discharge the patient. She observed in so doing that:

120 It is hard to countenance that the law would operate to deny the opportunity for a hearing to a patient with a mental disorder who is waiting outside the Tribunal and is ready to participate. Justice would not be served.

121. In my view striking out an application on the formal basis that the patient does not understand the Tribunal is a body who can discharge the applicant is not in keeping with the application of the overriding objective. There would be a duty to strike out an application if it was not properly made, for example, if the patient had already made an application in the specified period, or if it was an application made for detention under the wrong section. Even in the latter case it is the Tribunal's practice to ask for an amended application to be made to facilitate access to justice. It would not justify the striking out of M's application were it not for the test in VS. If the test is "I want to be free to leave" and the only avenue for this is an application to the Tribunal, striking out the case is not in accordance with the overriding objective.

At paragraph 86, the UT also set out a useful summary of the procedure that should be followed

a. Wherever possible the applicant and her representatives should be alerted that her capacity to make the application may be an issue. […]

b. If the Tribunal considers that the applicant's capacity has fluctuated and, while she did not have capacity at the time of the application, she does have capacity at the time of the hearing, the

Tribunal should consider inviting the applicant to make a fresh application, abridging any of the procedural obligations and proceeding to consider the substance of the application. […]

c. *Otherwise, the F-tT was correct that what matters is whether the applicant had capacity at the time the application was made. Making a decision as to that issue may be difficult, but it is no different from the task that courts and tribunals are regularly called to make about events in the past.*

In terms of referrals to the Secretary of State, the mechanism by which patients who lack capacity to apply can nonetheless have their situation considered, the UT noted at paragraph 88:

a. *The Code says that hospital managers should raise this possibility with the Secretary of State if, among other reasons, the patient lacks capacity to do so herself.*

b. *However, the Code also says that anyone can make such a suggestion to the Secretary of State. The IMHA who will have seen the patient and had the opportunity to assess their wishes would be well suited to make the suggestion to the Secretary of State, if the IMHA considered that the patient wished to leave but lacked capacity to make an application to the Tribunal.*

c. *A third possibility would be the Tribunal itself. In a case, such as the present, where the Tribunal had found (a) that the patient lacked capacity, but (b) wished to leave the hospital, it would have been very sensible for the Tribunal to have done so.*

d. *Indeed, in other cases (uncomplicated by the patient's pregnancy and imminent confinement in this case) a combination of these factors may well lead the Tribunal to consider whether, before striking out the application, it would be sensible to adjourn for a short period to see if the Secretary of State wished to make a reference so that the Tribunal could consider as expeditiously as possible whether the statutory conditions for detention were made out*

Comment

It is perhaps striking that the judicial head of the Mental Health Tribunal took a different, and more expansive, view of Article 5(4) than did the majority. It is perhaps also to be hoped that in due course some of the issues that arose here will fall away if, as the Review of the Mental Health Act proposed, IMHAs could be empowered (in a similar fashion to RPRs under DoLS) to bring applications on behalf of patients who lack capacity, rather than having to go the round-the-houses route of bringing about a referral to the Secretary of State and then, in turn, to the Tribunal.

Vulnerable parties and witnesses in Employment Tribunal proceedings

Drawing heavily upon the recent work of the Civil Justice Council in this area, the President of the Employment Tribunal for England & Wales has issued guidance designed to:

focus the attention of all Employment Tribunal judges and members, parties, witnesses and

representatives upon the issue of vulnerability, however that issue might arise or appear. There is no universal definition of vulnerability for this purpose, but a good test of vulnerability might be whether the person is likely to suffer fear or distress in giving evidence because of their own circumstances or those relating to the case.

Change of approach to ordinary residence for s.117 after-care

On 24 June 2020, the Department of Health and Social Care set out its position when determining ordinary residence under s.117(3) of the Mental Health Act 1983. Although the 'note' is to be read alongside its statutory guidance, the two are entirely incompatible and the latter has yet to be amended to reflect the change of position. According to the guidance at para 19.68, there is no deeming provision for s.117. So a person's ordinary residence for MHA purposes is determined using the *Shah* test. As a result, the responsible after-care bodies can change if the person's ordinary residence changes. However, para 19.68 no longer represents the Department's position and will be updated once the case of *R (Worcestershire County Council) v Secretary of State for Health and Social Care and Swindon Borough Council (*ie Ordinary Residence 7: 2020 determination) has been decided.

In the *Worcestershire* case, the patient was ordinarily resident in Council B before being first detained under the MHA. Following discharge, she was placed by Council B into Council A and subsequently re-detained under a s.117 qualifying provision. Under the statutory guidance, Council B would then be responsible for her after-care provision. However, the Secretary of State instead determined that such responsibility should stay with Council B for the following reasons:

1. The Supreme Court decision in *R (Cornwall CC) v SSH* [2016] AC 137 should apply and so "for fiscal and administrative purposes" Council B should be responsible.

2. Alternatively, "immediately before being detained" in s.117(3)(a) should be interpreted as "immediately before being *first* detained". And, at that time, she was ordinarily resident in Council B.

3. Alternatively, Council B's s.117 duties did not lapse when she was detained for a second period.

Pending the resolution of the judicial review proceedings, there is significant legal uncertainty. Disputing local authorities will need to ensure that without prejudice agreements are reached to avoid prejudice to patients. And no doubt a rush of referrals seeking Secretary of State determinations will now come which, pending *Worcestershire*, will be stayed unless there are exceptional circumstances. Interestingly, s.117 was an historical mistake made by the Conservative government when it accepted Labour's opposition amendment to what ultimately became the MHA 1983, assuming (wrongly) that it merely duplicated the general NHS duties. One cannot help but wonder whether a second mistake of similar gravity has been made in the wording of the Care Act 2014 which amended s.117. Given the significance of the issue, it could be some time before the *Worcestershire* case is finally resolved and clarity restored. If only the case could also look at which CCG is responsible for s.117 as that is even more uncertain!

RESEARCH CORNER

We highlight here recent research articles of interest to practitioners. If you want your article highlighted in a future edition, do please let us know – the only criterion is that it must be open access, both because many readers will not have access to material hidden behind paywalls, and on principle.

This month, we highlight the (slightly belated) second 2019 issue of the International Journal of Mental Health and Capacity Law, edited by our Scottish contributor Jill Stavert, and featuring, amongst others, a timely article by Lucy Series "On Detaining 300,000 People: the Liberty Protection Safeguards."

SCOTLAND

Scott Review – summary of responses issued

The first main phase of the work of the Scottish Mental Health Law Review ("the Scott Review") was to seek views and experiences about mental health law in Scotland. The consultation period lasted from January to the end of May 2020. Remarkably, despite the great volume of responses received, the Review Team published their "Summary of Responses to the Phase 1 Consultation" on 1st July 2020, barely a month after the extended consultation period ended. 264 responses were received, a number of them "composite" responses from large organisations. In addition, the Review Team took account of evidence gathered at meetings with nine organisations. Even without the constraints of lockdown, to have converted all of that input into 43 pages of coherent narrative, done to a high standard, is a significant achievement upon which the Review Team is to be congratulated. The document is available here.

Already widely welcomed is the unequivocal clarification provided in the first two pages in response to the significant concerns, on which we reported in the June Report, that both the Interim Report of the Review issued in May 2020 and the ensuing Newsletter issued on 12th June appeared to signal a substantial narrowing of the work of the Review Team to concentrate on mental health law, largely to the exclusion of adults with incapacity and adult support and protection law. The introduction to the Summary of Responses could not be clearer. The exclusive focus upon mental health law is to be restricted to the first phase now completed. Sensibly, next will follow an equivalent examination of how the Adult Support and Protection (Scotland) Act 2007 works alongside adult incapacity and mental health legislation. There is an explicit assurance to those who contributed to the 2018 Consultation on the Adults with Incapacity (Scotland) Act 2000 that their responses, and the conclusion and recommendations made following that Consultation and subsequently, will be used by the Review.

A few issues that have caused concern still await clarification. It would be helpful to have equally explicit reassurances that areas of law that properly belong within the three Acts but are at present located in other legislation, or which are not addressed at all, will be fully covered by the Review. Put simply, one seeks reassurance that the Review will address the three areas of relevant law, not just three existing Acts. Clearly, the greatest concerns about non-compliance with basic human rights requirements attach to these "extraneous" topics. Examples are the problematic shortcut past many of the protections of the 2000 Act provided by section 13ZA of the Social Work (Scotland) Act 1968; and the ongoing scandal of the almost complete absence of adequate protections in the existing system of appointees receiving social security benefits – not even subject to the principles of adult incapacity law or the general provision of monitoring and control in the 2000 Act. Some of the most serious gaps include three topics originally proposed for inclusion in the 2000 Act, but omitted: provision to remove all the uncertainties around advance directives (emphasised during the current crisis, and by the greater clarity of the law in England & Wales); inadequate provision and safeguards

for medical and other decision-making in intensive care settings, including decisions about withholding or withdrawing life-preserving treatment (the deficiencies of current provision also being highlighted both by the current crisis and comparison with the greater certainty, and also the clearer protection for professionals acting properly in emergency situations, provided in England & Wales); and the lack of mandatory requirements for a specialised judiciary (the need for which is emphasised by existing contrasts between sheriff courts, largely dependent upon resources available to each).

Readers of the Summary of Responses should be clear that this is a well-structured account of what the Review Team heard, bringing several relevant themes out clearly; but it is not a programme of work for the Team ahead. As the document puts it: "It is important to note that this report is an analysis of responses received from individuals and organisations, highlighting the themes of significance for them. It reflects their priorities which will help to inform ours." Nevertheless, anyone with relevant experience who reads the Summary will quickly recognise the authenticity with which it reflects experience "on the ground", and emerging themes which to a large extent may be found to be broadly common to all areas of law within the remit of the Review. There are however some matters where differing experiences point to a need for comparison between the relevant Acts. For example, concerns about the language of the 2003 Act emerged as soon as the Bill was published, with recognition even at that stage that the "jigsaw puzzle" approach to drafting in that Act, compared to the relative clarity of the 2000 Act, was not appropriate to legislation likely to be referred to on a daily basis by professionals and others who are not lawyers. However, though one might conclude that in some matters one of the relevant Acts is somewhat better than another, all require improvement to approach "best" rather than "better". The latest Summary of Responses reports concerns that the principles "need teeth", already recognised in places such as the Three Jurisdictions Report that benign statements of principle require to be developed into attributable and enforceable duties.

The Summary of Responses contains a great deal, not mentioned here, of interest and value. This Report does not attempt the almost impossible task of providing a summary of a summary!

At the end of my item "Scott Review – Interim Report" in the June Report, I mentioned that John Scott QC, Chair of the Scottish Mental Health Law Review, had kindly permitted me to make public the personal Critique of the Interim Report which I had submitted to him. A link was provided. I am delighted that John has now provided a response to the Critique and has permitted us to publish it. His response also takes account of some of the points in this article, which he saw in draft. His response appears immediately below, with our thanks to him for contributing in this way.

Adrian D Ward

The Scott Review – response to Adrian Ward's critique

[*As presaged above, we are very pleased to be able to set out here John Scott QC's response*]

Adrian Ward has engaged positively, indeed enthusiastically, with the review from the outset. He has

continued this helpful engagement with a paper containing his views on the work of the review to date, including what we have published in our Interim Report in May and the recent report containing analysis of the 264 responses received to our Call for Evidence as well as other evidence received. I am grateful to Adrian for the opportunity to offer some thoughts on his paper.

Our Interim Report acknowledged that our focus so far, including in our Call for Evidence, has been primarily on the Mental Health (Care and Treatment) (Scotland) Act 2003. Adrian has identified some of the reasons for this in his analysis. In our report, we also referred to other important work, concluded and ongoing, in relation to Adults with Incapacity and Adult Support and Protection legislation, as well as the Independent Review of Learning Disability and Autism in the Mental Health Act ("*the Rome Review*").

Ours is the overarching review which is intended to pull together all the strands of this other work, to meet our principal aim - to improve the rights and protections of persons who may be subject to the existing provisions of mental health, incapacity or adult support and protection legislation as a consequence of having a mental disorder, and remove barriers to those caring for their health and welfare.

In relation to the work of the Rome Review, we await the response of the Scottish Government which, in turn, will inform our work in relation to learning disability and autism. In particular, a significant factor will be the Government's approach to the key recommendation to remove learning disability and autism from the definition of mental disorder in the Mental Health Act.

Much work has been done in the Rome Review, as well as in reviews of the AWI and ASP legislation. In the next phase of our overarching review, we will need to make our own assessment of the work done in these other areas, determine what remains to be done, and then consider how best to test the idea of convergence of the respective Acts.

There are strong advocates for convergence, like Adrian, and others who consider that there are risks for some individuals which point away from convergence.

We have established Advisory Groups – Communications and Engagement; Compulsion; Capacity (and Support for Decision-Making); Child and Young People; and Social Economic and Cultural Rights.

It is intended that these groups, and others yet to be established, will look at key subjects and report into the Executive Team to assist in our progress towards recommendations about changes in the law.

Our work to date, and the focus of the Call for Evidence, should not cause concern about a narrowing of the scope of our review. We are grateful to Adrian for posing questions about this to allow us to clarify matters. The Terms of Reference have not narrowed or changed. We will exhaust our remit over the full course of the review, recognising that some work on AWI and ASP will be necessary in phase 2 to ensure proper equivalence in relation to all three pieces of legislation.

To address one important example of a concern about undue narrowing of focus, reference in our work to date to advance statements is not intended to rule out wider consideration of the matters mentioned by Adrian in relation to advance directives. At the first meeting of the Capacity Advisory Group, one member encouraged us, consistent with our approach to date, to be expansive and ambitious in our thinking, not confining ourselves to an examination of current law and practice. Interesting discussion ensued on some of the terminology around capacity assessment which we have resolved to address with our own glossary to assist us with the many questions to be considered, for example, to what extent does the wording of the legislation actually affect the clinical process of assessment. The Capacity Group is one of the groups in which crucial matters relevant to all three pieces of legislation will be considered.

In phase 2, we will continue with our approach of engaging and listening, always ready to adapt to the new methods of working and communicating being adopted by individuals and groups, lived experience and others. Having a further interim report in 6 months will allow a further opportunity to check progress against the Terms of Reference. We look forward to further constructive engagement with all those with an interest.

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

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

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Conferences

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

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

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.

We are taking a break over August, and hope that at least some of you are able to do so too. Our next edition will be out in September. 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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