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Contents

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Liberty Tactics: On the rise of 'Deprivation of Liberty Safeguards'

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300,000 detentions

The UK government estimates that 300,000 people in England and Wales are deprived of their liberty in connection with care arrangements made by others in their 'best interests' under the Mental Capacity Act 2005 (MCA).[1] To put this number in perspective, this is more than three times the prison population in England and Wales.[2] It is six times as many detentions for involuntary mental health treatment under the Mental Health Act 1983 (MHA).[3]

So, who are these people who are thought to be deprived of their liberty in connection with their care arrangements? Official statistics tell us that the majority of them are older adults; 83% are over retirement age, and a staggering 1 in every 14 people over the age of 85 in England and Wales may be deprived of their liberty.[4] More than half of this group are people living with dementia, and around one fifth are people with neurodevelopmental differences like learning disabilities or autism. Some may also have brain injuries or neurodegenerative conditions.[5]

Where are these 300,000 people 'detained'? The majority are deprived of their liberty in care homes. Some are detained in acute hospital settings

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[1] Department of Health and Social Care, Impact assessment of the Mental Capacity (Amendment) Act 2019 (Impact Assessment, 2021).

[2] Georgina Sturge, UK Prison Population Statistics. (Briefing Paper, House of Commons Library 2022).

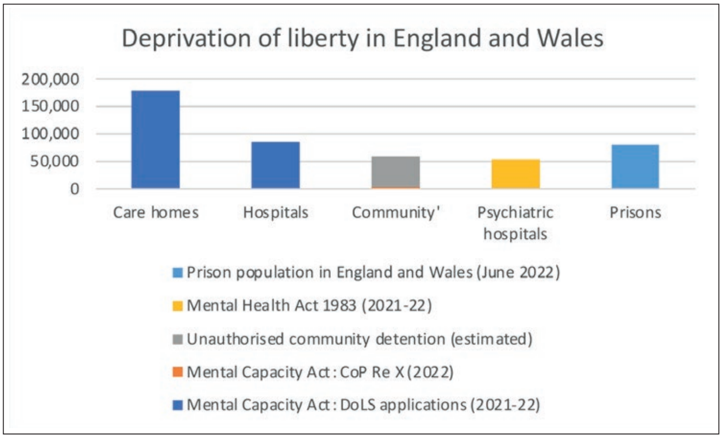
[3] NHS Digital, 'Mental Health Act Statistics, Annual Figures, 2021-22' (2022) *https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2021-22-annual-figures*

[4] NHS Digital, 'Mental Capacity Act 2005, Deprivation of Liberty Safeguards - 2021-22' (2022) NHS DIGITAL 2022. Mental Capacity Act 2005, Deprivation of Liberty Safeguards - 2021-22.

[5] NHS Digital, 'Supplementary information: DoLS activity by disability group during reporting period 2017-18', (2019). *https://digital.nhs.uk/data-and-information/find-data-and-publications/supplementary-information/2019-supplementary-information-files/dols-activity-by-disability-group-during-reporting-period-2017-18*

for medical treatment for *physical* conditions, such as in the case of an older person with dementia who has had an illness or a fall, and restrictions are being used to keep them in hospital for the treatment and whilst they wait for discharge to be arranged. Only around 5000 are detained in *'mental health establishments for psychiatric treatments.'*[6] This is because the main legislation regulating detention in mental health settings is the MHA, not the MCA.

There are also an estimated 58,000 people who are deprived of their liberty in 'community' settings, which could include specialist services providing care with housing, such as *'supported living'.*[7] This also potentially encompasses people who may be living in ordinary domestic homes, and even those being cared for by their family.



Non-paradigmatic detentions

It is probably clear that this situation that I am describing does not resemble what lawyers sometimes refer to as the 'paradigm' case of detention, that of the prisoner in his cell.[8]

Most of us prefer not to think of care homes as places of detention; we think of them – as the previous Official Solicitor Alastair Pitblado once put it, before he passed away – as nice places with *'roses around the front door'.*[9] Yet it is interesting to observe how common the theme of 'escape' from

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[6] NHS Digital (2022). See footnote 4.

[7] Department of Health and Social Care (2021). See footnote 1.

[8] Neil Allen, 'The (Not So) Great Confinement' [2015] 5(1) Elder Law Journal 45.

[9] Mithran Samuel, 'Many deprived of Liberty without Safeguards, warn Experts', [2012] Community Care *https://www.communitycare.co.uk/2012/02/29/many-deprived-of-liberty-without-safeguards-warn-experts/*

a care home is in popular culture, in books and films like *Grandad's Great Escape*,[10] *The Great Escape from Woodlands Nursing Home*,[11] *The Hundred-Year-Old Man Who Climbed Out of the Window and Disappeared*,[12] the science fiction novel and film *Cloud Atlas*,[13] the animated Disney/Pixar film *Up*,[14] and Leonora Carrington's wonderfully surreal *The Hearing Trumpet*.[15]

At some level, within our cultural unconscious, we do entertain the notion that there is something *carceral* about care homes, that they are places that we may enter involuntarily, may not be able to leave at will, and where we might come under the authority of others in our everyday lives. But interestingly these fictional accounts rarely feature *law* as part of this carceral experience,[16] and it is never law – but rather grand or surreal adventures – that liberates these inmates.

Even more paradoxical and troubling are situations of 'domestic deprivation of liberty', where a person is categorized as deprived of their liberty yet living in a place that is – in legal terms at least – a private domestic home. This can include people living in more formal care settings known in England as *'supported living', 'independent living'* or *'assisted living'*, where a person may have their own tenancy and receives support from a homecare provider. These were originally set up to guarantee older and disabled people the kinds of choice and control that most people take for granted in our lives, so it is troubling that now tens of thousands of people might be considered to be 'detained' in these places.

Then there are the people who are living with their families, who are considered deprived of their liberty either by care provided by the family or from external providers. We know relatively little about these situations, but published cases indicate that families can find this an enormously distressing label on their living situation. However, other cases also show that family-based care can sometimes involve very restrictive practices, for example, a carer tying someone into a wheelchair and confining them to a padded room within the family home.[18]

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[10] David Walliams, *Grandpa's Great Escape* (Harper 2015).

[11] Joanna Nell, *The Great Escape from Woodlands Nursing Home* (Hodder & Stoughton 2020).

[12] Jonas Jonasson, *The Hundred-Year-Old Man Who Climbed Out of the Window and Disappeared* (Abacus 2015).

[13] David Mitchell, *Cloud Atlas* (Sceptre 2004).

[14] Pete Docter (Dir) *Up* (distributed by Disney/Pixar 2009).

[15] Leonora Carrington, *The Hearing Trumpet* ((Penguin Classics, 1974).

[16] Law is referenced in *Up*, where the court orders that the main protagonist, Carl, be sent to an assisted living facility, after he accidentally injures a construction worker, and also in Joanna Nell's *The Great Escape from Woodlands Nursing Home* where 'guardianship' is threatened for some residents.

[17] See, for example, *Re AEL* [2021] EWCOP 9.

[18] *SCC v MSA & Ano*r [2017] EWCOP 18.

There are important differences between the situations of people who are deprived of their liberty in residential care and community settings and the more familiar situation of mental health detention. I refer to the former as *'social care detention'*, a phenomenon that is often connected with 'legal capacity' regimes, and where the measures and restrictions serve a range of purposes, including keeping a person safe in everyday life, or managing particular safeguarding concerns. Unlike mental health detention, they are rarely about 'treatment' so much as long-term care. Social care detention in England is many managed by local authorities (not health bodies) and its lead professionals are often social workers, acting as professional 'Best Interests Assessors' or leading teams that manage the deprivation of liberty safeguards.

Gradients of restriction and resistance

Social care detention spans wide gradients of restriction, and gradients of resistance. The restriction gradient ranges from people experiencing direct coercion, including physical, mechanical or chemical restraint, or even seclusion (isolating a person in a room for a prolonged period of time), right through to someone who might never be directly physically coerced but others supervise their actions and movements and exercise control in other, often less visible, ways.

The resistance gradient encompasses those who object to living arrangements and any restrictions (for example, complaining of being a *'prisoner'*,[19] or asking to return home,[20]), through to those whose behaviour *'challenges'* and who may be distressed about or resist *something* but it can be hard to clarify what; through to those who are acquiescent, ambivalent, inchoate, institutionalized, intimidated, or even… positively happy with their care, their living arrangements, and living the life they want to live.
We are talking, therefore, about a very varied and paradoxical form of 'detention', which differs from other more familiar and paradigmatic situations of deprivation of liberty.

How did we get here?

In many countries, social care detention does not exist. I do not mean that older and disabled people are more restricted in Britain than anywhere else. Rather, I mean that social care detention typically follows from *recognition* of already-existing situations as a 'deprivation of liberty', and regulating them accordingly. These are generally not *new situations* in a factual sense, rather they are a new regulatory framing for problems that already existed.

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[19] *JE v DE & Ors* [2006] EWHC 3459 (Fam).

[20] *CC v KK and STCC* [2012] EWHC 2136 (COP).

Liberty tactics play a central role in this: activists, litigators, academics, lawmakers and others strive to *label* certain living arrangements as a deprivation of liberty, in order to call for a particular legal and social response. Here I provide an (abridged) account of the genealogy of social care detention from my book, *Deprivation of Liberty in the Shadows of the Institution*,[21] explaining how liberty tactics played a central role in the emergence of social care detention in Britain in the twentieth century. In the next sections I explore where else this process of recognition (and regulation) of social care detention is occurring, before turning to consider *why* liberty tactics are deployed.

Carceral era: C18 until 1950s

We can trace the paradoxes of social care detention back over 250 years, to the beginnings of what the socio-legal historian Clive Unsworth called the *'carceral era'* in the *'tutelary relationship'* between people with mental disabilities and those exercising a paternalistic supervisory jurisdiction over them.[22] In the late eighteenth century a new *'trade in lunacy'* emerged, with a proliferation of private *'madhouses'* that incarcerated people deemed *'mad',* on behalf of (and paid for by) their families or local parishes. Stories of *'wrongful confinement'* and appalling conditions in madhouses and charitable asylums caused growing alarm amongst newspaper readers and reformers, who successfully campaigned for the 1774 Madhouses Act to regulate so-called *'lunacy institutions'.* [23] This first instance of what I call the *'law of institutions'* had two functions: *'safeguards for individual liberty',* to prevent people being inappropriately confined, and licensing and inspection systems to supervise the conditions within *'lunacy institutions'.*

As in many industrialized countries, the nineteenth century saw growing numbers of people with mental disabilities confined to lunacy institutions - including charitable and public asylums, workhouses, private asylums and - in the twentieth century - *'mental deficiency colonies'.* During the carceral era, the law of institutions grew in scope and complexity, culminating in the 1890 Lunacy Act – the *'triumph of legalism'.* [24]

From 1890 until 1960, almost anyone who was 'kept as a lunatic' by someone who was remunerated for this work would have been legally categorized as 'detained'. This included asylums and workhouse-based care, but it also included people in less paradigmatic sites of detention, such

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[21] Lucy Series (2022) *Deprivation of Liberty in the Shadows of the Institution* (Bristol University Press 2022).

[22] Clive Unsworth, *'Mental Disorder and the Tutelary Relationship: From Pre- to Post-Carceral Legal Order'* [1991] 18(2) Journal of Law and Society 254.

[23] Roy Porter, *Mind-forg'd Manacles* (Harvard University Press 1987).

[24] Kathleen Jones, *A History of the Mental Health Services* (Routledge & Kegan Paul 1972).

as small charitable *'idiots asylums'* and schools for children with learning disabilities.[25] It also included care provided within the private homes of clergy or doctors, paid for by the families of wealthy *'single patients'*.[26]

So, although our present-day situation feels paradoxical and surprising, there are historical precedents for it. However, even during the height of 'legalism', lunacy legislation never treated so-called *'private lunatics',* cared for wholly by families within the family home, as detained and in need of liberty safeguards. Yet by the late nineteenth century the Lunacy Commissioners successfully argued for safeguarding powers to check on their care and treatment, arguing that they were perhaps the most vulnerable of all.[27]

Post-carceral era: 1950s until the present day

The second half of the twentieth century saw two major shifts towards what Unsworth called the post-carceral era of the *'tutelary relationship'*. The first shift was the de-legalisation and *'informalisation'* of the care of people who today might be labelled as lacking 'mental capacity'. The Mental Health Act 1959 repealed almost all carceral-era lunacy and mental deficiency laws. From 1960 onwards, most mental health treatment and confinement care was 'informal', without any formal procedures for admission or confinement. Although mental health detention of 'resistant' patients continued to be formally regulated by mental health law (becoming known as 'sectioning'), the Mental Health Act 1959 was rarely used for the confinement and care of people with learning disabilities, dementia and other longer-term cognitive impairments. They were likened to compliant 'children' who would do as they were told without need of *'legal compulsion'*,[28] and their resistance or objections were generally regarded as insufficiently 'purposeful' or 'persistant' to require legal compulsion.[29] In this mid-century era of 'doctor knows best', clinical judgement was rarely challenged and 'safeguards' were viewed as largely unnecessary and hampering treatment.

A parallel post-carceral shift was ideological and material, and eventually led to the closure of most of these paradigmatic carceral era spaces of

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[25] Peter Carpenter, 'The Bath Idiot and Imbecile Institution' [2000] 11(42) History of Psychiatry, 163.

[26] Akihito Suzuki, *Madness at Home* (University of California Press 2006); Sarah Wise, *Inconvenient People* (Random House 2012).

[27] Ibid.

[28] Lord Percy, *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1954-1957* (Cm 169, HMSO: 1957).

[29] Lucy Series, 'Of Powers and Safeguards', in Jean McHale and Atina Krajewska (eds), *Re-imagining Health and Care Law* (Edward Elgar Publishing, in press). Pre-print available: https://research-information.bris.ac.uk/en/publications/of-powers-and-safeguards

confinement, ushering in the era of 'care in the community'. This was partly linked to wider calls for deinstitutionalisation[30] and human rights for people with mental disabilities,[31] as well as the marketisation of health and social care.[32] Progressive professionals called for the *'normalisation'* of the lives of people with learning disabilities,[33] and *'person centred'* care.[34] Patients, disabled people and radical professionals increasingly contested medical and welfare professional hegemonies. Psychiatric 'survivors' called for the abolition of forced treatment altogether, whilst disabled people demanded rights to *'independent living',* and *'choice and control'* over their care and support.[35]

The administrative structures and services to deliver these changes were distinguished from the 'health care' provided by the NHS, and go by the name 'social care' in England and Wales. Social care's main legislative vehicle is the Care Act 2014. Publicly funded social care is administered by local authority social services, and delivered by a mixed economy of (mainly) for-profit care providers, some (dwindling) charitable providers, and (very few) publicly run services. There is, however, a significant gap between the radical post-carceral ideologies of care, and the realities of what social care does in fact deliver. In this gap fall our present day paradoxical situations of social care detention.

Many industrialised countries can share similar stories of de-institutionalisation, shifts to community care, and a chasm between post-carceral ideology and its material realities. However, two pivotal moments took the UK down a less travelled path to the paradoxes of social care detention.

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[30] D Kritsotaki, V Long, and M Smith, *Deinstitutionalisation and After: Post-War Psychiatry in the Western World* (Springer International Publishing 2016).

[31] United Nations 1971. Declaration on the Rights of Mentally Retarded Persons. Proclaimed by General Assembly resolution 2856 (XXVI) of 20 December 1971; United Nations 1975. Declaration on the Rights of Disabled Persons. Proclaimed by General Assembly resolution 3447 (XXX) of 9 December 1975.

[31] R Means, S Richards, and R Smith, *Community Care: Policy and Practice* (4th edn, Palgrave Macmillan 2008).

[33] Wolf Wolfensberger, et al., *The Principle of Normalization in Human Services* (National Institute on Mental Retardation, Toronto 1972); King's Fund, 'An Ordinary Life: Comprehensive Locally-based Residential Services for Mentally Handicapped People' (1980, reprinted 1982).

[34] Tom Kitwood, *Dementia Reconsidered: The Person Comes First* (Open University Press 1997).

[35] Peter Campbell, 'From Little Acorns – The Mental Health Service User Movement', in Andy Bell and Peter Lindley (eds), *Beyond the Water Towers: The Unfinished Revolution in Mental Health Services 1985-2005* (Sainsbury Centre for Mental Health 2005); John Evans, 'The Independent Living Movement in the UK' (The Independent Living Institute 2003) http://www.independentliving.org/docs6/evans2003.html#1

The Bournewood case

The first pivotal moment was the *Bournewood* case.[36] Bournewood Hospital was once a Georgian madhouse, then a Victorian *'lunatic asylum',* then a *'mental deficiency colony',* and eventually a *'mental handicap hospital'*.[37] By the 1990s, its patients were being transferred to live 'in the community'. HL was an autistic man who had spent most of his childhood and early adulthood in Bournewood Hospital. In 1997, he was living 'in the community' with a couple, Mr and Mrs E, who cared for him in their home. One day HL became distressed and agitated at his day centre by a change in his routine. Unable to contact his carers, a social worker and GP were called, who sedated him and brought him to Bournewood Hospital. HL was admitted for assessment, *informally* (without using the MHA), in his *'best interests'.*

For Mr and Mrs E, it was like a member of their family *'had gone missing'* and they tried to get him home again.[38] However, the hospital staff prevented them from visiting HL (in case he tried to leave), and refused their requests to take him home. Since HL was not detained under the MHA, there was no obvious legal mechanism, such as a tribunal, for carers or relatives to challenge his admission. They consulted lawyers, who based their legal strategy on the premise that although HL was not subject to the MHA he was in fact (unlawfully) *de facto* 'detained' at Bournewood Hospital. They sought a writ of habeas corpus, relying on this medieval remedy to force the doctors to account for their actions. They also argued that – being *'informal'* – HL's confinement lacked any clear legal basis and was therefore false imprisonment.

Why did HL's lawyers do this? There were other legal avenues they could theoretically have pursued that did not involve describing HL as 'detained'. They could have argued before the High Court that the admission was not in HL's best interests,[39] but in this era before the de-medicalisation of best

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[36] *R v Bournewood Community and Mental Health NHS Trust Ex p. L* [1997] EWCA Civ 2879; *R v Bournewood Community and Mental Health NHS Trust Ex p. L* [1998] UKHL 24; HL v UK [2004] ECHR 720.

[37] Chersey Museum, 'From Manor House to Medicine: The History of Botleys Park & St. Peter's Hospital' (2023) *https://chertseymuseum.org/st_peters_hospital*

[38] Equality and Human Rights Commission, 'Film: The Bournewood case' (undated) *https://www.youtube.com/watch?v=pz5Ecovjs4w*

[39] This would have been through an application to the High Court under its *'declaratory jurisdiction'*, which had been relatively recently established in *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1 (CA).

interests[40] the doctors' authority would have been difficult for his carers to rebut.[41] Had they been in the USA, perhaps they might have argued that HL's confinement was a form of disability discrimination, as in the landmark USA Supreme Court deinstitutionalisation judgment in *Olmstead*.[42] The Disability Discrimination Act 1995 - the UK's counterpart to the landmark Americans with Disabilities Act 1990 (relied upon in *Olmstead*) - had recently come into force. But perhaps the legislation was too new, an equalities gambit too uncertain, and liberty tactics had a much better-established tradition in British mental health law, where habeas actions had been used for centuries to challenge *'wrongful confinement'* of *'alleged lunatics'*.[43]

HL's lawyers immediate strategy was - counterintuitively - to get the hospital to formally detain HL under the MHA. This would make various mechanisms available which they could then use to contest his confinement. The High Court did not agree that HL was de facto detained, but the Court of Appeal did. Consequently, the hospital 'sectioned' HL under the MHA. This enabled his carers to request a tribunal and secure an independent psychiatric report. The independent report stated that HL did not need to be in hospital, and so the hospital discharged him back to live with Mr and Mrs E, where he remains today. Liberty tactics were therefore effective in securing HL's release.

But the Court of Appeal ruling aroused real controversy: if HL was detained, then so might be up to 100,000 other people like him, in hospitals and even nursing homes, where the MHA did not apply.[44] The hospital appealed to the House of Lords, which held (by a majority) that that HL had not been 'detained', noting that *he had never actually tried to leave* nor 'objected', and so the 'restraints' on him were hypothetical and not *actual*. Even if he were detained, they held (unanimously) that the doctors had acted lawfully because they were acting in HL's 'best interests' and so could rely on the

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[40] When the High Court proclaimed its jurisdiction to 'declare' what was in the best interests of a person who lacked capacity in *Re F* (Ibid), it chose to adopt the so-called *Bolam* standard. *Bolam* refers to an English court case which established that so long as a doctor acts 'in accordance with a practice accepted at the time as proper by a responsible body of medical opinion skilled in the particular form of treatment' they do not act negligently (*Bolam v Friern Hospital Management Committee* [1957] 1 WLR 583). The effect of this was that so long as doctors acted in accordance with some 'responsible body of medical opinion' – even if it were not seen as 'best practice' - they could claim to be acting in the best interests of the patient, making it very hard to challenge their decisions (even for other medical professionals). Best interests eventually came to include social and emotional considerations, *Re A (Male Sterilisation)* [2000] 1 FLR 549, but this came too late for the Bournewood litigation.

[41] Philip Fennell, 'Doctor knows best? Therapeutic Detention under Common Law, the Mental Health Act, and the European Convention', (1998) 6(3) Medical Law Review 322.

[42] *Olmstead v. L.C.*, [1999] 527 U.S. 581 (USA Supreme Court).

[43] Series (2022). See footnote 21.

[44] *Bournewood* [1998] UKHL 24.

defence of 'necessity'.[45] This meant that even in situations where a person's family were clearly objecting, doctors could confine the person in their 'best interests', without any requirement for independent oversight, safeguards or obvious means for the person or others to challenge it on their behalf.

HL's carers pursued their challenge to the European Court of Human Rights (ECtHR). In 2004 the Strasbourg court ruled that HL *had* been deprived of his liberty, in the meaning of article 5 of the European Convention on Human Rights (ECHR), since he was subject to *'continuous supervision and control'* and *'not free to leave'.*[46] Furthermore they held that his detention had been unlawful, noting the *'dearth of safeguards'* for informal patients like HL, in contrast with those available to patients formally detained under the MHA and required by article 5.

The ECtHR's judgment in *HL v UK* judgment was handed down in late 2004, just as the MCA was nearing the end of its Parliamentary passage. It seems to have been unanticipated by the government, but having recently introduced the Human Rights Act 1998 (HRA), which required public bodies to comply with the ECHR, the ruling in *HL v UK* could not easily be ignored. The litigation therefore forced the government to address what became known as 'the Bournewood gap' – the thousands of people in hospitals (and care homes) who were now believed to be unlawfully deprived of their liberty without the safeguards required by article 5 ECHR. Consultation respondents did not want patients like HL to come under the MHA,[47] so the government responded by inserting new 'deprivation of liberty safeguards' (DoLS) into the MCA, which came into force in 2009.

Why did HL's carers pursue liberty tactics?

Why did HL's carers pursue the complaint that HL had been unlawfully detained to the Strasbourg Court, long after HL had been returned home? They could have let things lie and got on with their lives. But Mr and Mrs E felt that *'it couldn't be allowed to stand'* because the same thing could still happen to HL *'if he was ever out having a bad day in public'* or to *'any other autistic person'.*[48] They continued to campaign for the rights of people like HL for decades.[49]

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[45] In *Re F* [1990] 2 AC 1 (CA) it was held that doctors acting in the 'best interests' of patients who 'lack capacity' can rely upon the common law defence for any 'reasonable' acts of care or treatment that would ordinarily require a person's consent.

[46] *HL v UK* [2004] ECHR 720.

[47] Department of Health, *Protecting the Vulnerable: the "Bournewood" Consultation: Summary of Responses* (Report, 2006).

[48] Equality and Human Rights Commission, 'Transcript of Evidence to the Inquiry: Mr Graham Enderby and Scott Moncrieff, Harbour and Sinclair Solicitors, in EHRC Human Rights Inquiry' (2008).

[49] Philip Fennell, 'Graham Enderby obituary' *The Guardian* (11 March 2020).

But perhaps Mr and Mrs E could have argued instead that he had been deprived of his right for respect for home, family and private life under article 8 ECHR, instead of arguing on deprivation of liberty grounds? There is a view, today, that these article 8 rights better capture the 'nub of the matter', as many of conflicts at the heart of social care detention are less about measures to keep a person safe, but about whether they can live at home, or with their family, or engage in particular activities.[50]

One reason for pursuing liberty tactics may have been that 'deprivation of liberty' is a potent – and arguably highly accurate – label for 'calling out' the grim realities of what HL's carers and legal team observed happening to him and others like him; a rationality I will return to below. Another strategic reason was that, as HL's carers put it, *'being sectioned seemed to give him some more rights and they couldn't stop us visiting'.* [51] They wanted the procedural accountability measures that are inherent in the right to liberty so that – in Mr E's words *'you can't just take people away because you feel like it'.* [52] Their legal team – Lucy Scott-Moncrieff and Robert Robinson – were experienced mental health lawyers, used to working with the levers and 'rights' of the MHA to challenge confinement on behalf of their clients. This was not always successful, of course, but from their standpoint the lack of *any* levers to pull on behalf of informal patients would have been a striking omission.

Later, Scott-Moncrieff and Robinson would argue that the MHA should have been extended to cover patients in HL's situation.[53] Both had also been members of the Mental Health Act Commission, which monitored the conditions and rights of detained hospital patients. The Commission frequently expressed concern over their lack of jurisdiction to monitor informal patients like HL, whom they began to refer to as the '*de facto* detained'.[54] The Mental Health Act Commission welcomed the ruling in *HL v UK* as addressing 'unregulated, 'informal' deprivation of liberty', foregrounding their discussion with a quote from a patient who – having become an informal patient *'found myself without rights and with no-one I could appeal to'.* [55]

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[50] *London Borough of Hillingdon v Neary* [2011] EWHC 1377 (COP); Law Commission, *Mental Capacity and Deprivation of Liberty: A Consultation Paper,* (Consultation Paper, 222 2015); Neil Allen [2015] 5(1) Elder Law Journal 45.

[51] Equality and Human Rights Commission (2008). See footnote 48.

[52] Equality and Human Rights Commission, Film: The Bournewood case.

[53] Robert Robinson and Lucy Scott-Moncrieff, 'Making Sense of Bournewood' [2005] Journal of Mental Health Law 17.

[54] Mental Health Act Commission, *The Third Biennial Report of the Mental Health Act Commission 1987-89.* (Report, 1989); Mental Health Act Commission, *Placed amongst Strangers: Twenty Years of the Mental Health Act 1983 and Future Prospects for Psychiatric Compulsion* (2003).

[55] Mental Health Act Commission, 'In Place of Fear?', in *Eleventh Biennial Report* 2003–2005 (Report, 2005) p161.

Cheshire West

The DoLS came into force in 2009, but by then the government had let it be known that earlier estimates of 100,000 detained were overblown. The government viewed *Bournewood* as an *'extreme'* set of circumstances, anticipating only 21,000 DoLS applications in the first year.[56] In fact initially only 7,157 DoLS applications were made in England, and the numbers rose slowly for the first five years.[57]

However following *HL v UK* growing numbers of cases came before the domestic courts arguing over the very meaning of 'deprivation of liberty' when applied to 'incapacitated' patients in 'social care' settings. The courts' rulings were complex, contradictory, and controversial. The result was widespread uncertainty over what did in fact constitute a 'deprivation of liberty', particularly for less paradigmatic settings, such as a care home or in the community, and particularly for people at the less extreme ends of the restriction and resistance gradients. Anyone not confined in a psychiatric hospital, or whose family was not demanding that they return to live at home, was unlikely to be considered deprived of their liberty.

Then, in 2014, the Supreme Court was asked to rule on the meaning of 'deprivation of liberty' for three people with learning disabilities whose situations were far from paradigmatic (*P v Cheshire West and Chester Council and another; P and Q v Surrey County Council,* known as *Cheshire West*).[59] MIG and MEG were sisters with learning disabilities, aged 17 and 18, who had been removed from their families as children under public law child protection proceedings. Initially both lived with foster carers, but whilst MIG continued to live with her foster mother, MEG's foster placement had broken down and she was moved to *'an NHS facility, not a care home, for learning disabled adolescents with complex needs'.* Meanwhile P, whose case was conjoined to MIG and MEG's in the Supreme Court hearing, was a man in his 30s with Down Syndrome, who had previously been living with his mother, but who had been moved by the local authority (authorised by the Court of Protection) to live in a supported living style setting – a small bungalow, with three other young disabled adults. All three people regularly left their settings to go to college, or on outings.

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[56] Department of Health, *Mental Health Bill Regulatory Impact Assessment Revised Version June 2007* (2007).

[57] Health and Social Care Information Centre, *Mental Capacity Act 2005, Deprivation of Liberty Safeguards (England) Annual Report, 2013-14* (Report, 2014) *https://digital.nhs.uk/data-and-information/publications/statistical/mental-capacity-act-2005-deprivation-of-liberty-safeguards-assessments/mental-capacity-act-2005-deprivation-of-liberty-safeguards-england-annual-report-2013-14*

[58] Series (2022). See footnote 21.

[59] *P v Cheshire West and Chester Council and another; P and Q v Surrey County Council* [2014] UKSC 19.

Each of them occupied different positions on the gradients of restriction and resistance. MIG appeared positively happy living with her foster mother, whom she *'loved'* and called *'mummy'.* She was 'supervised' in the sense that someone would always know where she was and what she was doing, but she did enjoy some privacy in her bedroom with the door closed. Although MIG's carers *would* have physically intervened had she tried to leave without someone accompanying her, she never had, and so she had never been directly physically coerced.

MEG, on the other hand, did experience physical restraint to manage *'occasional outbursts of challenging behaviour towards the other three residents'*. MEG was also administered Risperidone for 'anxiety'– a sedating antipsychotic that is sometimes viewed as 'chemical restraint'. [60] The Supreme Court also recorded that MEG *'mourned the loss'* of her relationship with her foster mother and *'wished she was still living with her'.*

It is unclear (and not discussed) how P came to live in his placement, and what his feelings towards it were. However the High Court judgment recorded that although his caregivers made every effort to make his life as 'normal' as possible, ultimately *'his life is completely under the control'* of staff, he went nowhere without their *'support and assistance'* and his

> *'occasionally aggressive behaviour, and his worrying habit of touching and eating his continence pads, require a range of measures, including at times physical restraint, and, when necessary, the intrusive procedure of inserting fingers into his mouth whilst he is being restrained'.*[61]

In the High Court, Parker J had concluded that neither MIG nor MEG were deprived of their liberty.[62] The Court of Appeal upheld that judgment.[63] Wilson LJ particularly emphasised the *'relative* ***normality****'*[64] of their living arrangements – it not being *'a hospital designed for compulsory detentions like Bournewood'* – and repeated the view that Parker J adopted in the High Court, that they were '***happy***'[65] in their respective environments' and therefore not *objecting.*

In parallel proceedings, Baker J had ruled in the High Court that P was deprived of his liberty, emphasising the level of supervision, control and

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[60] NHS England, *Stopping Over-Medication of People with a Learning Disability, Autism or Both* (STOMP) (2017).

[61] *Cheshire West and Chester Council v P & Anor* [2011] EWHC 1330 (Fam).

[62] *Surrey County Council v MEG & MIG v Anor* [2010] EWHC 785 (Fam).

[63] *P & Q v Surrey County Council* [2011] EWCA Civ 190.

[64] Emphasis in the original judgment.

[65] Emphasis in the original judgment.

physical intervention he experienced.[66] In the Court of Appeal, Munby LJ held that Baker J had erred, emphasising the 'objective' and benign 'purpose' of the arrangements. The Court of Appeal held that when determining whether or not a person is deprived of their liberty, the relevant 'comparator' was *'not the normality of the life of the able-bodied man or woman on the Clapham omnibus'*[67] but rather *'the life of someone with the relevant condition'* [2]. In other words, if it were *normal* for a person with a similar disability to MIG, MEG or P to be so restricted, then it would be unlikely to be a deprivation of liberty. The consequence of this, as critics would point out, was that people with disabilities would experience a higher threshold of restriction before they were entitled to the 'safeguards' of article 5.[68]

The 'acid test' of deprivation of liberty

Acting on behalf of MIG, MEG and P, but not on their instruction,[69] the Official Solicitor – Alastair Pitblado – appealed both these Court of Appeal judgements, and the cases were conjoined for the hearing in the Supreme Court. Lady Hale – who has played a critical role in the development of mental capacity law[70] - gave the leading judgment. Citing the UN Convention on the Rights of Persons with Disabilities (CRPD), Lady Hale stressed that disabled people *'have the same human rights as the rest of the human race'* and so the test of whether or not a person is deprived of their liberty should be universal; the same for a disabled person as it would be for her.

Citing the ECtHR's ruling in *HL v UK* and subsequent cases such as *Stanev v Bulgaria*[71], she concluded that the 'acid test' of whether a person is deprived of their liberty is whether they are *'under continuous supervision and control'* and *'not free to leave'.* The 'acid test' relates to the so-called 'objective' limb of the legal test of whether or not a person is deprived of their liberty; a person's *physical* situation.[72] Under the 'acid test' it does not matter whether the intentions of caregivers are benevolent, whether the person is at 'home' or in an 'institution', nor whether their living arrangements are 'comfortable'

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[66] *Cheshire West* and *Chester Council v P* (High Court). See footnote 61.

[67] The 'Clapham Omnibus' is simply a London bus heading to Clapham, but the phrase the "man on the Clapham omnibus" features in English jurisprudence to describe a regular or ordinary person.

[68] Ben Troke, 'The Death of Deprivation of Liberty Safeguards (DOLS)?' [2012] 3(2) Social Care and Neurodisability 56.

[69] Parties who 'lack the capacity to litigate' are not permitted to instruct a solicitor, and so their litigation friend (in this case the Official Solicitor) conducts the litigation in their best interests.

[70] Caroline Hunter and Erica Rackley, *Justice for Everyone: The Jurisprudence and Legal lives of Brenda Hale* (Cambridge University Press 2022).

[71] *Stanev v Bulgaria* [2012] ECHR 46.

[72] *Storck v Germany* [2005] ECHR 406.

nor their life 'enjoyable'. *'In the end',* said Hale, *'it is the constraints that matter': 'A gilded cage is still a cage.'*

What about 'happiness'? Lady Hale *'found this the most difficult aspect of the case.'* Noting the case of *HL v UK* she accepted that *'there are some people who are not capable of expressing a view either way and this is probably the case with both MIG and MEG'.* She observed that HL's *'compliance'* was not enough for the ECtHR to deny him the relevant safeguards. Because the claimants were all held to lack the relevant mental capacity to consent to the care arrangements, none could be said to be *consenting* to their arrangements, regardless of how happy or content they might appear to be.

Aftermath

In the year that followed the Supreme Court's ruling in *Cheshire West*, the number of DoLS applications grew from under 20,000 a year to over 200,000, and carried on increasing until the Covid pandemic. It spawned satellite litigation about children in care, and critically ill children and adults in intensive care, or receiving (or being denied) medical treatments. It led to a dramatic increase in the number of coronial inquests for 'deaths in state detention', mainly older people who had died of natural causes whilst subject to DoLS.[73] It led to enormous backlogs in the DoLS system; the government acknowledges that hundreds of thousands of people are unlawfully detained without safeguards. Local authorities are left wondering *'how best to break the law'.*[74] In short, *Cheshire West* caused utter chaos.

The government asked the Law Commission to develop a more *'proportionate'* and *'flexible'* system to provide safeguards for the estimated 300,000 people who were now legally categorised as deprived of their liberty.[75] Legislation was passed 2019 for new 'Liberty Protection Safeguards',[76] but these remain unimplemented, the government citing the sheer *'complexity'* of the problem and the resources required.[77] More cynically, perhaps this government is uninterested in reforms anchored in human rights, and views grappling with the paradoxes of social care detention as unlikely to win votes in the coming general election.

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[73] Series (2022). See footnote 21.

[74] Joint Committee on Human Rights, *The Right to Freedom and Safety: Reform of the Deprivation of Liberty Safeguards* (HC 890, HL paper 161, 2018).

[75] Law Commission, *Mental Capacity and Deprivation of Liberty* (Law Com No 372, 2017).

[76] Mental Capacity (Amendment) Act 2019.

[77] Health and Social Care Committee, Oral Evidence: Adult Social Care (HC 1327, 2023).

Is this happening elsewhere in the world?

Sometimes it can seem as if England and Wales are a peculiar outlier in regulating social care detention. It is probably true that *Cheshire West* means that we have a more far-reaching framework for recognizing and regulating deprivation of liberty in comparison with other countries. But in research for my book, I found that many other countries - particularly countries with close historical ties to Britain, and some other countries subject to the ECHR - also recognise and regulate social care detention.

Starting with Northern Ireland, it has recently begun implementing its own 'deprivation of liberty safeguards'.[78] As part of the UK, Northern Ireland is bound by the Supreme Court's 'acid test' definition of deprivation of liberty in *Cheshire West*. However, at the time of writing there was no published data on how many DoLS applications are received there, nor on deprivation of liberty in domestic or other settings, so it is hard to assess the impact of the 'acid test' there.

Scotland has recognized its own sizeable *'Bournewood gap'* since 2014.[79] However, the problem has been postponed through successive consultations on reforming both mental health and capacity law. The most recent review noted an *'increasingly urgent need'* to address it, but calling for a *'proportionate'* response, that avoided subjecting people in a *'domestic setting with family or foster care style relationships'* to state *'monitoring'* in the absence of other concerns.[80]

The islands of Jersey, Guernsey and Gibraltar[81] have also adopted systems similar to DoLS, but use different terminology – speaking of *'significant restrictions on liberty'* or *'significant restriction of a person's personal rights'* instead of *deprivation* of liberty. Jersey and Gibraltar's systems explicitly excludes 'domestic' settings, whereas Guernsey's explicitly includes these.

The Republic of Ireland, which is a signatory to the ECHR, is still consulting on its own possible system of safeguards. Ireland, too, prefers to avoid the explicit language of 'deprivation of liberty' and instead speaks of *'admission decisions'*.[82] The initial proposals included only deprivation of liberty within

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[78] Mental Capacity Act (Northern Ireland) 2016 c18; The Mental Capacity (Deprivation of Liberty) Regulations (Northern Ireland) 2019.

[79] Scottish Law Commission, Report on Adults with Incapacity (Scot Law Com No 240, 2014).

[80] Scottish Mental Health Law Review, Final Report: Executive Summary and Recommendations (Report, 2022).

[81] Capacity and Self-Determination (Jersey) Law 2016; Capacity (Bailiwick of Guernsey) Law 2020; Lasting Power of Attorney and Capacity Act 2018 (Gibraltar).

[82] Department of Health (Ireland), *The Deprivation of Liberty Safeguard Proposals: Report on the Public Consultation* (Report, 2019).

a 'relevant facility', that is to say, only care homes and hospitals and not supported living or 'domestic' settings. They consulted on a definition that closely resembled the 'acid test' yet did not mention *Cheshire West* explicitly.[83] The matter remains under consideration.

Social care detention is also recognized and regulated in several European countries with very different legal traditions, such as Germany, Austria, Switzerland,[84] the Czech Republic,[85] and Poland.[86] In several other countries there are calls from activists, academics or organisations concerned with upholding people's rights - such as ombudsmen or monitoring bodies - who have called for their countries to formally recognize and regulate social care detention. This is often linked to systems for monitoring places of detention under treaties like the UN Optional Protocol on the Convention Against Torture (OPCAT),[87] which has reiterated that public and private 'social care' settings can constitute places of detention.[88] Countries where activists, academics and other advocates are currently deploying liberty tactics to argue for the recognition and regulation of social care detention include Slovenia,[89] Cyprus,[90] Croatia,[91] France[92] Australia,[93] Canada[94] and the USA.[95]

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[83] Department of Health (Ireland), *Deprivation of Liberty: Safeguard Proposals: Consultation Paper* (Consultation Paper, 2017).

[84] Walter Boente, 'Some Continental European Perspectives on Safeguards in the Case of Deprivation of Liberty in Health and Social Care Settings', [2017] 23 International Journal of Mental Health and Capacity Law *http://dx.doi.org/10.19164/ijmhcl.v2017i23.632*

[85] Public Defender of Rights, Protection against Ill-Treatment 2016: *Report of the Public Defender of Rights as the National Preventive Mechanism* (Submission to the UN SPT, 2017)

[86] Polish Commissioner for Human Rights, *'RPO w sprawie lepszej ochrony praw mieszkańców domów pomocy społeczne*j (RPO on Better Protection of the Rights of Residents of Social Welfare Homes)' (Submission to the UN SPT, 2018).

[87] United Nations 2006, Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) New York: 18 December 2002.

[88] UN Sub-committee on the Prevention of Torture, 'Draft General Comment No. 1 on Places of Deprivation of Liberty (article 4)' (2023), *https://www.ohchr.org/sites/default/files/documents/hrbodies/spt-opcat/call-inputs/draft-GC1-on-art1-for-public-consultation-en.pdf*

[89] Human Rights Ombudsman of the Republic of Slovenia, *National Preventive Mechanisms Report 2017* (Submission to the UN SPT, 2018).

[90] Commissioner for the Administration and Protection of Human Rights (Cyprus), *Review on the Action of the National Preventive Mechanism for the Years 2018 and 2019* (Submission to the UN SPT, 2019).

[91] Ombudsman of the Republic of Croatia, *Report on the Performance of Activities of the National Preventive Mechanism* (Submission to the UN SPT, 2017).

[92] Contrôleur Général des Lieux de Privation de Liberté, *Annual Report 2012* (Submission to the UN SPT, 2012).

[93] Laura Grenfell, 'Aged Care, Detention and OPCAT' [2019] 25(2) *Australian Journal of Human Rights* 248; K Chandler, B White and L Willmott, 'Safeguarding Rights to Liberty and Security where People with Disability are Subject to Detention and Restraint: A Practical Approach to the Adjudication, Interpretation and Making of Law (Part Two)' [2018] 25(4) Psychiatry, Psychology and Law 550.

In France and Australia, liberty tactics are resisted by governments on the basis that social care detention is *not* detention.[96] Litigation arguing that people in social care settings are deprived of their liberty has (to date) been unsuccessful.[97]

In Australia, there are systems for regulating 'restrictive practices' in disability care services,[98] but these are not anchored in the concept of 'deprivation of liberty'; these systems focus on restrictions *within* a setting but not wider questions of *which setting* a person should live in. Submissions to the recent Australian Royal Commissions into quality and safety in aged care[99] and abuse and neglect in disability services[100] raised concerns about deprivation of liberty. Although the Royal Commission on Aged Care eschewed discussion of deprivation of liberty, the recent final report of the Australian Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability called upon the Australian government to recognise a broader definition of 'detention', which potentially included disability services and aged care facilities, in complying with OPCAT.[101] Meanwhile Australian activists and allies of 'detained' disabled people in care settings continue to litigate these issues, placing complaints about social care detention before the United Nations Committee on the Rights of Persons with Disabilities. At the time of writing it had not yet ruled on

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[94] Canadian Centre for Elder Law, 'Conversations about Care: The Law and Practice of Health Care Consent for People Living with Dementia in British Columbia', in *CCEL Report 10* (2019); The Canadian Centre for Elder Law, 'Elder and Guardianship Mediation' in *CCEL Report 5* (2012).

[95] M Kapp, 'The Voluntary Status of Nursing Facility Admissions: Legal, Practical, and Public Policy Implications' [1998] 24(1) New England Journal on Criminal and Civil Confinement 1; C Kazin 'Nowhere to Go and Chose to Stay: Using the Tort of False Imprisonment to Redress Involuntary Confinement of the Elderly in Nursing Homes and Hospitals', [1989] 137(3) University of Pennsylvania Law Review 903.

[96] Contrôleur Général des Lieux de Privation de Liberté, *Annual Report 2014* (Submission to SPT, 2014); Contrôleur Général des Lieux de Privation de Liberté, *Annual Report 2016* (Submission to UN SPT, 2016); Senate Standing Committee on Legal and Constitutional Affairs, *Supplementary Budget Estimates 2019-20: Attorney General's Department: LCC-SBE19-141 - OPCAT - National Preventive Mechanism* (Canberrra, Australia, 2019).

[97] Conseil d'État, Juge des référés No 439822 8 avril 2020 (France); *Skyllas v Retirement Care Australia (Preston) Pty Ltd* [2006] VSC 409 (Australia).

[98] Victorian Law Reform Commission, *People with Intellectual Disabilities at Risk: A Legal Framework for Compulsory Care Report* (Report, 2003).

[99] Royal Commission into Aged Care Quality and Safety, *Final Report - Volume 1: Summary and Recommendations.* (Report, Commonwealth of Australia 2021).

[100] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Final Report* (Report, Commonwealth of Australia 2022).

[101] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (2023) *Final Report Volume 11: Independent Oversight and Complaint Mechanisms* (Report, Commonwealth of Australia 2023).

any of these as admissible,[102] but further cases are pending where it may consider the issues.

So although the situation in England and Wales is an outlier in terms of the sheer *scale* of the issue, we are arguably merely the 'canary in the coalmine'. Many other countries have adopted, or are adopting, similar systems for recognizing and regulating social care detention. Activists, academics and others continue to deploy liberty tactics – arguing that their governments should also recognise that care homes and other 'community' settings may be places of detention. What can other countries learn from our experience of liberty tactics?

Liberty tactics

Liberty tactics - calls to recognise a particular situation as a form of detention - have been deployed by: confined people; families, friends and other allies of confined people; civil society organisations and activists; reforming professionals; ombudsmen; monitoring bodies; lawyers; judges and others. What motivates them? I suggest we can discern (at least) three different strands of liberty tactics activism.

'Calling it out'

Some label a particular situation 'detention' or 'deprivation of liberty' to call fresh attention to the *carcerality* of certain practices and care arrangements. It is *deliberately* unsettling, upsetting culturally entrenched senses of legitimacy and *'roses around the door'* air of benevolence in social care. The *'calling it out'* strategy is a close neighbour of labelling restrictive practices and non-consensual treatment as forms of violence[103] or even torture.[104]

Liberty tactics may also rhetorically ask - as Lady Hale did in *Cheshire West*[105] - whether such practices would not clearly be considered a 'deprivation of liberty' for non-disabled people. This strategy helps to *recrystalise* the moral, social and legal status of people whose daily existence involves levels of

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[102] *DR v Australia* (14/2003) 19 May 2017, CRPD/C/17/D/14/2013; *MR v Australia* (16/2013) 5 July 2018 CRPD/C/18/D/16/2013; *Kendall v Australia* (15/2013) 29 April 2019 CRPD/C/21/D/15/2013; *Simon Bacher v Austria* (26/2014) 6 April 2018 CRPD/C/19/D/26/2014.

[103] J Cadwallader, C Spivakovsky, L Steele and D Wadiwel, 'Institutional Violence against People with Disability: Recent Legal and Political Developments' [2018] 29(3) Current Issues in Criminal Justice 259; C Spivakovsky and L Steele, 'Disability Law in a Pandemic: The Temporal Folds of Medico-legal Violence' [2021] Social & Legal Studies; Linda Steele, 'Temporality, Disability and Institutional Violence: Revisiting *In Re F*' [2017] 26(3) Griffith Law Review 378.

[104] Tina Minkowitz, 'The United Nations Convention on the Rights of Persons with Disabilities and the Right to be Free from Nonconsensual Psychiatric Interventions' [2006-7] 34 Syracuse Journal of International Law and Commerce 405.

[105] *Cheshire West* [2014] UKSC 19 [46].

restriction, supervision and intervention that would not be considered legitimate (or legal) for the general population. When one becomes a care recipient, all too often one becomes a legal ghost - half there, half not; liberty tactics are sometimes aimed at resolidifying lost legal personality.

Liberty tactics also align disability activism with a rich history of social justice campaigning. This is well illustrated by Ben-Moshe's description of a newsletter item produced by disabled activists in the USA.[106] It features a photograph of an older black man staring into space whilst sitting behind a barbed wire fence. The photo was taken by the activists on a trip to the Martin Luther King Jr Centre and is of a man in a nursing home that borders the centre. The newsletter comments:

> *'Having one symbol of liberty juxtaposed next to that symbol of oppression reminded us all of how easily people with disabilities in this country can lose their freedom because of the institutional bias in long term care.'* [107]

But one never *simply* names something a deprivation of liberty; this powerful phrase carries powerful consequences in Western legal systems.

The reformers

Looking to the long Anglo-Welsh history of liberty safeguards, liberty tactics began life as a means for the friends of confined individuals to secure their release by seeking a writ of *habeas corpus* from the courts - dating (at least) as far back as *Rex v Turlington* (1761) 97 ER 741. Their pleas for 'liberty' were taken up by journalists, politicians, reforming psychiatrists and lawyers, and other activists, seeking a more *systemic* response to the problem of wrongful confinement. Concerned about situations where the *wrong* people had been confined to madhouses or asylums, and the conflicts of interest inherent in the system, they sought a system of safeguards that could regulate entry and exit from institutional confinement. A central tenet of liberty tactics used as a means for reform, then, is that some people *do* and some people *do not*, need to be confined, and that there are experts (usually psychiatrists) who can play an important 'sorting' role within these administrative and medico-legal systems of safeguards.

Today, in Australia and France, reformers deploying liberty tactics argue that disability and aged care facilities (equivalent to care and nursing homes in England and Wales) should fall within OPCAT frameworks for independent monitoring of places of detention. Their goal – similar to the eighteenth-

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[106] Liat Ben-Moshe, *Decarcerating Disability: Deinstitutionalization and Prison Abolition.* (University of Minnesota Press 2020).

[107] ADAPT Incitement newsletter, described and quoted in Ben-Moshe, ibid, 255.

century reformers concerned about the appalling conditions in private madhouses and charitable asylums - is to insert new layers of oversight into closed care settings, to prevent the most severe abuses, and - ideally - to raise standards to a level that the public would consider acceptable (albeit not want to experience directly themselves).

In England and Wales, reformers - like Mr and Mrs E and their legal team - deploy liberty tactics to secure individual accountability measures, to enable people to *challenge* confinement on behalf of a specific person, as well as securing oversight from specialist monitoring bodies linked to OPCAT.

But why were liberty tactics also deployed in situations - as with MIG, MEG and P - where nobody wanted to challenge their confinement? Nobody in *Cheshire Wes*t argued that they *should* live elsewhere, or even that there was anything specific wrong with their care arrangements. Alastair Pitblado, the Official Solicitor who acted on behalf of MIG, MEG and P in *Cheshire West*, commenting in a public seminar on the case said that *'Quite often people need protection, but not by the state assuming control without any regulation of that control'.*[108] Lady Hale's judgment in *Cheshire West* also stressed the importance of independent oversight of care. What follows is taken from her opening paragraph:

> *'This case is about the criteria for judging whether the living arrangements made for a mentally incapacitated person amount to a deprivation of liberty. If they do, then the deprivation has to be authorised, either by a court or by the procedures known as the deprivation of liberty safeguards… If they do not, no independent check is made on whether those arrangements are in the best interests of the mentally incapacitated person, although of course the health or social care bodies who make the arrangements do so in the hope and belief that they are the best which can practicably be devised. It is no criticism of them if the safeguards are required. It is merely a recognition that human rights are for everyone, including the most disabled members of our community, and that those rights include the same right to liberty as has everyone else.'*

Later on, Lady Hale stressed that because of the *'extreme vulnerability of people like P, MIG and MEG'* we should *'err on the side of caution'* in deciding what constitutes a deprivation of liberty, as they need a *'periodic independent check'* on whether their arrangements are in their best interests.[109]

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[108] Seminar organised by One Crown Office Row, 'Dignity, Death and Deprivation of Liberty: Human Rights in the Court of Protection'. This seminar was filmed and the video was shared online. Partial transcript of this discussion is on file with author.

[109] *Cheshire West* [2014] UKSC 19 [57].

For reformers the main goal of liberty tactics is regulatory control over the supervisory, restrictive and sometimes coercive practices that are recognised to be practiced in social care. To achieve this, it is not always necessary to explicitly give these practices the jarring label of 'deprivation of liberty' (see, for example, the approaches in the Republic of Ireland, Jersey, Guernsey and Gibraltar), simply to persuade (often reluctant) governments of the legal necessity of introducing such safeguards to comply with article 5 ECHR.

The abolitionists

Liberty tactics may also be deployed by abolitionists; those whose goal is the eradication of *all* carceral practices directed towards disabled people. In this context, social care detention signifies carceral residue that has not been eradicated by the shift towards care in the community, and the incompleteness of deinstitutionalization.

I borrow the term *'abolitionist'* from the prison abolition movement in the USA which seeks to eliminate *all* forms of carceral punishment. Abolition feminism has led to new interest in intersectional aspects of abolitionism, including disability.[110] It does not ignore or deny the harms and risks that the carceral responses purport to mitigate. Rather, abolitionism means acknowledging – and refusing to accept - the risks and harms of the carceral response itself. Abolition feminism resists the either/or binaries of carceral panaceas, the idea that *either* one accepts carcerality *or* one accepts particular societal harms; that one may *only* work for total abolition and not strive to provide interim responses that are needed now.[111] Abolition movements hold space for the idea that there is no single solution, no single philosophical formulation, draft legislation, or social policy: *'often there are no magical solutions that fit all parties',* the terms need to be negotiated for each case.[112] They also acknowledge that often solving the problems in front of us often requires us to look upstream.[113]

Ben-Moshe's work draws connections with 'deinstitutionalisation' in disability and the prison abolition movement.[114] Although scholarship linking disability and prison abolitionism is relatively scarce,[115] there are

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[110] A Davis, G Dent, E Meiner and B Richie, *Abolition. Feminism.* Now. (Penguin 2022).

[111] Ibid.

[112] Liat Ben-Moshe, 'Alternatives to (Disability) Incarceration', in L Ben-Moshe, C Chapman and A C Carey (eds), *Disability Incarcerated: Imprisonment and Disability in the United States and America* (Palgrave Macmillan 2014).

[113] Sheila Wildeman, 'Disabling Solitary: An Anti-Carceral Critique of Canada's Solitary Confinement Litigation', in C Spivakovsky, L Steele and P Weller (eds), *The Legacies of Institutionalisation: Disability, Law and Policy in the 'Deinstitutionalised' Community* (Hart 2020).

[114] Ben Moshe (2020). See footnote 106.

[115] C Spivakovsky, L Steele and P Weller (eds) *The Legacies of Institutionalisation: Disability, Law and Policy in the 'Deinstitutionalised' Community* (Hart 2020).

some important overlaps. Here I am discussing only abolitionist activities that are focused wholly or mainly on abolishing carceral practices that are directly specifically towards disabled people, not the wider issues relating to prison abolition.

The UN Convention on the Rights of Persons with Disabilities (CRPD) became a crucible and catalyst for calling for the *abolition* of all disability-specific carceral practices - including involuntary institutionalisation, confinement, restrictive practices and involuntary treatment. Many of those closely involved with the development and drafting of the CRPD, including Tina Minkowitz, a psychiatric survivor, activist and lawyer - contend that article 14 CRPD - the right to liberty - explicitly prohibits *all* forms of disability-specific detention, because it states that *'the existence of a disability shall in no case justify a deprivation of liberty'.*[116] The UN Committee on the Rights of Persons with Disabilities also regards disability-specific forms of detention, including detention on mental health grounds, to violate the CRPD.[117] Arlene Kanter, another USA-based scholar, lawyer and activist closely connected to the development of the CRPD, relies on the right to live independently and be included in the community (article 19 CRPD) as establishing the material and social conditions required to ensure that disabled people are not involuntarily institutionalised and have equal opportunities to others to live where and with whom they live.[118]

Curiously, however, the CRPD Committee and those closely linked to the development of the CRPD have paid relatively little attention to social care detention. Social care detention is not explicitly acknowledged or discussed in the Committee's statements on deprivation of liberty[119], legal capacity[120], independent living[121] or deinstitutionalisation[122] - all places where one might imagine the mass 'detention' of disabled people in 'community care' settings, in connection with legal capacity systems, might

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[115] C Spivakovsky, L Steele and P Weller (eds) *The Legacies of Institutionalisation: Disability, Law and Policy in the 'Deinstitutionalised' Community* (Hart 2020).

[116] Minkowitz. See footnote 104.

[117] UN Committee on the Rights of Persons with Disabilities, 'Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities'. Adopted during the Committee's 14th session, (Geneva, September 2015).

[118] Arlene Kanter, *The Development of Disability Rights Under International Law: From Charity to Human Rights* (Routledge 2015).

[119] Committee on the Rights of Persons with Disabilities (2015). See footnote 117.

[120] Committee on the Rights of Persons with Disabilities 'General comment No 1 (2014) article 12: Equal recognition before the law' (adopted 19 May 2014). UN Doc CRPD/C/GC/1.

[121] Committee on the Rights of Persons with Disabilities, 'General comment No. 5 on article 19: Living independently and being included in the community.' Adopted on 29 August 2017). UN Doc CRPD/C/18/1.

[122] Committee on the Rights of Persons with Disabilities, 'Guidelines on Deinstitutionalization, including in Emergencies' (2022) UN Doc CRPD/C/5.

be worth mentioning. Despite the Committee's focus on mental health detention, they have yet to recognise and discuss the thorny problem of social care detention.

However, Catalina Devandas, as the UN Special Rapporteur on Disability, and Claudia Mahler, the UN independent expert on the enjoyment of all human rights by older persons, have recently written reports acknowledging that disabled and older people might be deprived of their liberty in a range of care settings, including residential care and even domestic settings. They describe *all* forms of deprivation of liberty predicated on disability or age - even in combination with other grounds - as violating international human rights law.[123] Their aim, then, is both to label social care detention, and to abolish it.

In her 2019 report, Devandas defined 'deprivation of liberty' as being *'confined to a restricted space or placed in an institution or setting, not free to leave,* and without free and informed consent'. Similarly, Mahler's report defines older people as deprived of their liberty if:

> *'they are confined to a specific space or placed in a public or private institution, for different reasons, without permission to leave at will, and when the arrangements taken to restrict their freedom were made without their free and informed consent'.*

Each definition shares important elements with the *Cheshire West* acid test and could potentially apply on a similar scale.

Problems

Our experience in England and Wales can help reformers, abolitionists and other activists reflect on their ultimate goals and whether liberty tactics are the most effective means to tackle these.

What problems are we trying to solve with 'liberty tactics'?

An important question for anyone deploying liberty tactics, is what are the problems you are trying to solve? What practices and situations do you want to bring an end to, and what better future do you hope to bring about?

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[123] Catalina Devandas Aguilar, 'Report of the Special Rapporteur on the rights of persons with disabilities' (Human Rights Council, Fortieth session, 25 February–22 March 2019) UN Doc A/HRC/40/54; Claudia Mahler, 'Older Persons Deprived of Liberty: Report of the Independent Expert on the Enjoyment of all Human Rights by Older Persons' (Published at the United Nations on 13 September 2022) UN Doc A/HRC/51/27.

For many of us who have worked within or drawn upon social care, there are many problems that cause concern. The mere *existence* of institutional models of care (such as care homes, nursing homes and some models of supported living) is a concern to those of us who would like to a see a world in which - as Social Care Future puts it:

> ***'everyone** has 'the support, resources and opportunities to live in the place we call home, with the people and things that we love, in communities where we look out for one another, doing the things that matter to us'.*[124]

As I explore in my book,[125] *home* is diametrically opposed to the sociological realities of institutional living. It is more than mere shelter or the place where a person lives, it is a living, breathing, multifaceted concept - a rich 'decision space' that incorporates a *'locus of control'* for the individual to build their own micro-jurisdiction, where they feel safe, connected with people they care about and the place surrounding them, somewhere that reflects and sustains their identity: *'scaffolding' for the self'.*[126]

Despite decades of deinstitutionalisation, *'person centred'* care and calls for *'independent living'* and a *'gloriously ordinary life'* for everyone who draws upon care and support, this vision is distressingly far from the reality of adult social care in the UK.[127]

Others may be more relaxed about institutional models of care but wish to tackle specific carceral practices: 'blanket rules', physical, chemical and mechanical restraint and seclusion, restrictions on visits from family and friends, the widespread confinement practised during (and beyond) the Covid pandemic, and - at the extreme end of the spectrum - abuse, neglect and violence within care services. Some simply want to raise the quality of provision, to ensure it is more 'person-centred', giving people more opportunities to do *'activities'* that are meaningful for them, and more say over their everyday care.

There are doubtless countless other problems within the social care landscape that we might want to fix, but can liberty tactics help us fix any of these?

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[124] Neil Crowther, *Talking about a Brighter Social Care Future* (Social Care Future 2019).

[125] Series (2022). See footnote 21.

[126] Hilde Lindemann, 'Holding One Another (Well, Wrongly, Clumsily) in a Time of Dementia' [1999] 40 Metaphilosophy 416.

[127] House of Lords Adult Social Care Committee, 'A "gloriously ordinary life": Spotlight on Adult Social Care' (HL Paper 99, 2022).

Problems for reformers

Reformers do not want to abolish the system as it stands, but they do want to improve it. They may be uneasy about institutional care but perhaps view it as an economic or practical necessity for some older and disabled adults. However, they want to soften the harsher edges of the system, ensure that people are slotted into the best possible places within it, leveraging the best possible arrangements that the system can deliver and driving up standards across the board. Often reformers work within the existing system - as social care practitioners, lawyers, regulators, providers - and see abolitionist goals as fanciful pipe dreams. Reformers want tools that they can roll up their sleeves and use *today* to tackle the injustices they see all around them. They are not willing to wait for utopia to arrive.

For refomers, liberty tactics can prove useful. We saw how they can help individuals, such as HL, challenge confinement to a specific place in order to return to live with his carers. The *Cheshire West* acid test converted 'deprivation of liberty' from confinement in a particular type of accommodation, to a fluid set of 'arrangements' which encompasses not only the *places* they are confined, but the *ways in which* this is achieved. This means that liberty safeguards can potentially be used to tackle specific carceral practices, as well as resolve disagreements over *where* a person lives.[128] Social workers write about strategically using their role within the DoLS to challenge inappropriate placements in care homes, as well as specific restrictive practices, situations where a person was not being listened to and their preferences could (and should) have been accommodated.[129] During the long reform process for the DoLS, lawyers took to Twitter to describe (anonymised) accounts of when they successfully used the DoLS to challenge care arrangements on behalf of their clients, and secure something better for them - not necessarily 'liberty', but perhaps returning home, or moving to a better care setting, a particular restriction being removed, reinstating contact with a loved one, even being reunited with a beloved pet.[130] For the individuals concerned, these are no small victories.

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[128] Lucy Series, 'On Detaining 300,000 People: The Liberty Protection Safeguards' 25 International Journal of Mental Health and Capacity Law *https://www.northumbriajournals.co.uk/index.php/ijmhcl/article/view/952* .

[129] Lorraine Currie, 'Deprivation of Liberty Safeguards - a Personal Overview of the Safeguards Post-Cheshire West' [2016] 6 Elder Law Journal 181; R Hubbard and K Stone, *The Best Interests Assessor Practice Handbook* (Bristol University Press 2020); E James, R Mitchell and H Morgan, *Social Work, Cats and Rocket Science: Stories of Making a Difference in Social Work with Adults* (Jessica Kingsley Publishers 2019).

[130] These are found under s 21a. s 21A is the provision of the MCA that enables people who are subject to a DoLS authorisation to challenge it in court.

Reformist liberty tactics therefore *can* be useful when the system provides *actually existing alternatives*. But in an increasingly parched landscape of care, the options to support people *'to live in the place we call home, with the people and things that we love… doing the things that matter to us'* are limited. For liberty tactics to be effective, reformers really need stronger social and economic rights to social care – enforceable rights to live at home, with adequate support, with choice and control over how one is supported. These rights are contained in article 19 CRPD, but far from delivered on the ground. And more fundamentally, we need the political will, and economic and social systems to deliver these rights.

When better alternatives are not forthcoming, DoLS systems must authorize the least bad of all options, which may itself still be very restrictive or undesirable.[131] Reformist practitioners dislike doing this, hesitating to refer to problematic care arrangements as in someone's 'best interests',[132] but ultimately liberty safeguards merely sort people between the different options, they do not create better alternatives. This raises the risk that indirectly, liberty safeguards can end up *legitimating* and potentially normalizing some of the very problems they aim to resolve, by giving the imprimatur of authorization on situations that are far from ideal.[133]

A further difficulty is that the further you stretch these systems of safeguards over large populations the thinner you spread resources. In England and Wales there is now a backlog of 124,145 unprocessed DoLS applications, and because of the significant age skew in social care detention over 47,000 people died waiting for the application to be processed.[134] Some of these cases involve very serious concerns that should have been put before the court,[135] although it is worth remembering that they might not have attracted attention at all before DoLS and *Cheshire West*. By exposing the sheer scale of carcerality in the modern landscape of care, social care detention stretches liberty safeguards wide and thin, and sometimes beyond breaking point.

Finally, the *Cheshire West* acid test dissolves the boundaries between 'home' and 'institution', between public and private care arrangements, and has begun to extend its regulatory machinery into that most private space of care: the family home. At present – because the DoLS do not

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[131] E.g. *North Yorkshire CC v MAG & Anor* [2016] EWCOP 5.

[132] Law Commission, 'Mental Capacity and Deprivation of Liberty' (Law Com No 372, 2017).

[133] Allen (2015) See footnote 8.

[134] NHS Digital (2022). See footnote 4.

[135] Local Government Ombudsman, 'Investigation into a complaint against Staffordshire County Council. Reference number: 18 004 809' (2019).

cover domestic settings – only a tiny fraction of these cases end up in court.[136] From those that have, we know that families find this extremely distressing and it can harm their working relationships with courts and professionals.[137] Politically, the consequences of labelling wholly domestic care arrangements may be toxic. *Cheshire West* has already been used by the government to argue for repeal of the HRA.[138] I believe that if domestic care arrangements are more routinely labelled as a 'deprivation of liberty' the public and political backlash could be considerable and directed towards human rights more generally.

What benefit do liberty tactics bring in wholly domestic situations of family-based care? The Care Act 2014 and the MCA provide tools for responding to concerns where family-based care is inadequate or raises safeguarding concerns. Certainly, both statutes and their implementation could be improved, but labelling family-based care a 'deprivation of liberty' adds little that could not be done without it. Ultimately the machinery of article 5 ECHR and the law of institutions were designed to interlock with the *institutional* administrative and legal machinery, not families. I suggest, following Ben-Moshe, Chapman and others,[139] that whilst there can be carceral aspects to some familial care, we can also draw strategic distinctions in how we approach this. Liberty tactics may not always be the best approach.

Problems for abolitionists

Are liberty tactics useful for disability-carceral abolitionists, who seek to eradicate all carceral practices and spaces in the care of disabled people?

Disability-carceral abolitionists face a definitional problem. If - as Malher and Devandas do - they adopt definitions of social care detention similar to the *Cheshire West* acid test, then they may end up incorporating (as we have) situations where the person is not only not *'acquiescent'* with their confinement (as HL was purported to be in *Bournewood*), but positively *happy* with their care and living arrangements. Potentially MIG might fall in this category, since as far as we know she was positively happy living where she is, and was not actively coerced in any way. If we cannot incorporate a person's *subjective* experience into our analysis of 'deprivation of liberty' and carcerality, we may encounter difficulties distinguishing between the situations we seek to bring to an end to, and our positive goals.

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[136] Ministry of Justice, 'Family Court Statistics Quarterly: September to December 2022' (2023) https://www.gov.uk/government/statistics/family-court-statistics-quarterly-october-to-december-2022

[137] Re AEL [2021] EWCOP 9.

[138] Ministry of Justice, *Human Rights Act Reform: A Modern Bill Of Rights* (CP 588, 2021).

[139] L Ben-Moshe, C Chapman and A C Carey (eds), *Disability Incarcerated: Imprisonment and Disability in the United States and America* (Palgrave Macmillan 2014).

Scott-Moncrieff and Robinson wrote (before *Cheshire West*) that if the 'key' to HL's being deprived of his liberty in *Bournewood* was his being subject to *'continuous supervision and control'* and *'not free to leave',* then this was equally true when he was at home, and happy, with Mr and Mrs E, since they would not simply allow him to leave the house without someone going with him to ensure he was safe.[140] Since the DoLS were introduced, there have been many other cases - such as Steven Neary - where people successfully challenged their confinement in order to secure their release to the place they wanted to live.[141] However, after *Cheshire West* the very council that had unlawfully detained Steven in a care home, concluded that he was also deprived of his liberty when living in his own home, where he was happy, with a team of personal assistants who supported him to do what he wanted to do.[142]

To address this dilemma, disability-carceral abolitionists might turn to another element of definition of deprivation of liberty: *consent*. Both Mahler and Devandas incorporate an absence of *'informed consent'* into their definition. The received wisdom of British mental capacity laws hold that a person who 'lacks mental capacity' simply cannot give a legally valid consent, no matter how clear their wishes and feelings are about their living arrangements. But abolitionist readings of the CRPD offer a potential way out of this paradox.

Many disability-carceral abolitionists, including the CRPD Committee itself, read article 12 of the CRPD on equal recognition before the law as calling for the abolition of all mechanisms for *'denial of legal capacity'* and *'substitute decision making',* and their replacement with a framework of *universal* legal capacity and supported decision making.[143] It is not easy to summarise the complexities of this position in a sentence or two (although I will gamely try!), but in essence this perspective holds that someone who 'lacks mental capacity' - like MIG - *could* give a legally valid consent to her care arrangements, provided that there was strong evidence that it aligned with her *'will and preferences'* in terms of where and with whom she lived and how she was supported, and this was attended by robust 'safeguards' to protect against conflicts of interest, undue influence and to protect

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[140] R Robinson and R Scott-Moncrieff. See footnote 53.

[141] London Borough of *Hillingdon v Neary* [2011] EWHC 1377 (COP).

[142] Mark Neary, 'Lady Hale Returns to Cowley' (Blog post in *Love, Belief and Balls*, 2017) *https://markneary1dotcom1.wordpress.com/2017/05/09/lady-hale-returns-to-cowley/*

[143] Committee on the Rights of Persons with Disabilities (2014) (see footnote 120; L Series and A Nilsson, 'Article 12: Equal Recognition Before the Law', in Bantekas, Stein and Anastasiou (eds), Commentary on UN Convention on the Rights of Persons with Disabilities (Oxford University Press 2018).

her human rights.[144] In other words, insofar as MIG does experience some element of *'supervision and control'* regarding her care, in order to keep her safe, MIG's subjective experience of it could transform its carcerality into something else.

This position is not without difficulties. Would it leave people like MIG without any safeguards, as Lady Hale and others feared? Arguably the *Cheshire West* acid test is a useful red flag for highlighting situations with strong carceral tendencies and risks, but 'safeguards' could be linked to article 12 CRPD rather than 'deprivation of liberty. The wider context of *Cheshire West* was the sheer absence of safeguards around the MCA in general, which has a highly 'informal' architecture for even the most serious substitute decision making, and the lack of any routine independent monitoring of quasi-domestic support arrangements.[145] Liberty tactics were desirable in this context, because they successfully forced the (reluctant) government to establish procedures for scrutiny and safeguards that were not otherwise available in the English system. But a more willing government could attach robust safeguards to 'valid consent' in situations like MIG's.

Will there not be situations where a person's wishes and feelings are unclear, or open to (mis)interpretation? Undoubtedly, once we are in the terrain of 'mental incapacity' we are dealing with complexity and competing interpretations (and interests). HL - despite being extremely distressed, agitated, and being routinely restrained in hospital[146] - was nevertheless depicted in the judgments as *'compliant'* and *'not objecting'.* MEG - who 'attacks' her co-residents and *'wishes'* she lived with her foster carer still - was described by Parker J as *'happy'* and *'consenting'* in a *'non legal'* way.[147] The courts and many professionals have yet to develop skilled and thoughtful ways of exploring and understanding the wishes of people with cognitive impairments.

We need a new *'jurisprudence of the will'* to counteract centuries of viewing people with cognitive impairments as *'non-volitional',*[148] and we need to learn from the grassroots work of organisations pioneering *'person-centred'* approaches and peer advocates who have grappled with these questions for decades. This will, of course, never be straightforward (just as 'best

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[144] L Series, 'Making sense of *Cheshire West'* in C Spivakovsky, L Steele and P Weller (eds), *The Legacies of Institutionalisation: Disability, Law and Policy in the 'Deinstitutionalised' Community* (Hart 2020).

[145] Series (2022). See footnote 21.

[146] Health Service Ombudsman, Annual Report for 2001-2 (Case No. E. 2280/98-99, 2001).

[147] *Surrey County Council v MEG & MIG v Anor* [2010] EWHC 785 (Fam) [234].

[148] Series (In press). See footnote 29.

interests' are not), but surely any regime that purports to care about the rights of disabled people should be directed towards engaging as best it can with what a person *wants*, what makes them tick, and whether they are happy or not? It should not be possible, at the culmination of a Supreme Court judgment about the right to liberty, to still be left wondering what the three people at the heart of the case *felt* about their living situation, to have such scant attention paid to this pivotal question.

This approach was suggested during the recent reforms to the MCA.[149] A proposed amendment to the MCA would have enabled someone like MIG to 'consent' to care arrangements that might otherwise constitute a deprivation of liberty, but the time was not right - the government simply could not countenance it.[150] It is of course open to the courts to consider it - there is a long history in England of judicial innovation in matters of legal capacity and consent,[151] although safeguards would be vital. A similar proposal has been made in Ireland.[152]

More problematic for abolitionists are situations where jettisoning all supervisory or restrictive measures could result in significant risks of harm to the person. Taking the *Cheshire West* appellants by way of example, part of the reason that *'continuous supervision and control'* was exercised over MIG, MEG and P by their caregivers was to address concrete, immediate and often very serious risks. MIG and MEG were said to be unsafe around road traffic, and P would sometimes remove, tear up and try to eat his (soiled) incontinence pads, which had required an emergency hospital visit for choking. Without some form of 'supervision' and the possibility of (physical) intervention it is hard to see how these risks could be managed, at least in the short term, pending work to address them.

One response may be that there are many possible constellations of living arrangements, care relationships, power dynamics, that can respond to risks. HL and Steven Neary are good illustrations of this. Disability-carceral abolitionists are therefore committed to the painstaking work of finding better alternatives for each individual. This is why discussion of 'deprivation of liberty' and carcerality more generally can never be disentangled from

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[149] Suggested by Alex Ruck Keene KC, and backed by the Joint Committee on Human Rights, but rejected by the government. The text of the proposal can be found in: Joint Committee on Human Rights, *Legislative Scrutiny: Mental Capacity (Amendment) Bill* (Report, HC 1662 HL 208, 2018).

[150] Series (2020). See footnote 144.

[151] Philip Fennell, 'Mental Capacity' in L Gostin, J McHale, P Fennell, D McKay and P Bartlett (eds), *Principles of Mental Health Law* (Oxford University Press 2001); Peter Bartlett, *Blackstone's Guide to The Mental Capacity Act 2005* (OUP 2008). See in particular Chapter 2.

[151] See evidence of the Centre for Disability Law and Policy to Department of Health (Ireland) (2019). See footnote 83.

the realisation of the CRPD as a whole, including its socio-economic and cultural dimensions. The abolitionist position is *not* 'libertarian' but rather - as Minkowitz puts it - *transformative.*[153] Or as the Abolition and Disability Justice Collective put it:

> *'Abolition is not limited to ending spaces and practices of incarceration and policing. Fundamentally, abolition is also about reimagining new ways of life such that a world in which prisons, policing and other carceral systems as solutions to social problems becomes unthinkable. Abolitionism is also not just about creating new responses to crises but creating a new world in which we thrive such that less crises happen in the first place.'*

This *must* be our direction of travel. But whilst we are on that road (and I suspect we may be on that road for a very long time, if we ever do reach our destination) it is hard to see how to avoid situations where supervision and direct intervention are sometimes needed to avoid situations with very real, immediate and serious risks. Much of the CRPD-linked abolitionist literature focuses almost exclusively on mental health detention, where the risks (and responses) are typically very different; there is very limited discussion of the complexities of social care detention. However, I have yet to read a disability rights text, or speak with someone committed to even the most abolitionist readings of the CRPD, who would have simply let P choke, or let MIG or MEG walk in front of traffic. We find these situations extremely difficult to talk about - and some I suspect would prefer that we did not - but they are real, and they affect many hundreds of thousands of people, so let us go there in good faith.

300,000 solutions

Historians of the carceral era speak of the *'institutional panacea'* - the Victorian idea that for every social problem there is a carceral institutional solution: prisons for crime, workhouses for poverty, asylums for madness, mental deficiency colonies for 'the feeble minded', and so on. In the post-carceral era we moved from societies organised around what Foucault called *'disciplinary'* institutions towards what Deleuze called *'societies of control'.*[154] Carcerality has been transformed, but not eradicated. For every social problem, now, there is a *control* solution.

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[153] Tina Minkowitz, 'CRPD and Transformative Equality', [2017] 13 International Journal of Law in Context 77.

[154] Giles Deleuze, 'Postscript on the Societies of Control', [1992] 59 October 3.

Liberty tactics mirror the simplistic logics of the institutional panacea: they offer simple-sounding solutions to highly complex problems: Regulate! Liberate! Yet we cannot simply solve these problems by repealing a law or knocking down buildings, or even creating new laws or new buildings (although this may help). Because underneath 300,000 detentions, are 300,000 complex situations, and 300,000 unique individuals in unique relationships and social worlds.

Unpicking the *'clustered injustices'*[155] that result in 300,000 detentions requires radical upstream action: the total re-organisation of how we *provide* social care and the economic structures that underpin it, the transformation of our cultural beliefs around disability, incapacity, age, and unpicking the normalisation of restriction and institutionalisation. But even this transformative agenda will leave complex problems at the level of the individual, and their particular constellation of needs, relationships and life situation. And even here, uncomfortable as it is to say it, there are some situations where it may be genuinely extremely difficult - and perhaps sometimes impossible - to remove all layers of supervision and control, even where we have done all we can to deepen and strengthen relationships of support and open up a person's life possibilities. And if we lean too hard on interpretivist approaches to consent, in pursuit of the goal of abolition, they will rapidly distort.

Feminist and disability abolitionists know this; they do not promise to pull the answers to your hardest cases out of thin air, but nor do they deny or ignore the challenges and complexities. Genuine abolitionists resist the temptation to replace one set of seeming-panaceas with another. 300,000 detentions calls for the relentless pursuit of 300,000 solutions.[156]

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[155] Luke Clements, *Clustered Injustice and the Level Green* (Legal Action Group 2020).

[156] This research was funded by the Wellcome Trust as part of a Society and Ethics Research Fellowship, grant number 200381/Z/15/Z.

The Use of the Declaratory Jurisdiction of the High Court in the Field of Health and Social Care in Northern Ireland

Michael Potter, BL

Introduction

A substantial part of health and social care provision in Northern Ireland comprises the care of vulnerable adults, including those who lack decision-making capacity. Frequently health and social care decisions must be made for vulnerable people who lack capacity (i.e. are incapacitous), and those decisions must be made in accordance with the prevailing law, which includes both legislation and common law.[1] In circumstances where uncertainty or disagreement exists about a proposed intervention for a patient, a court may be asked to adjudicate and 'declare' that the proposed intervention would be lawful. In Northern Ireland such a judicial determination requires the High Court's exercise of its inherent jurisdiction, often known as the 'declaratory jurisdiction'. This article considers how the declaratory jurisdiction currently operates in the field of adult health and social care in Northern Ireland.

Relevant principles of law

A number of legal principles apply in this area of health and social care law. Autonomy – an individual's right to make decisions about their life and affairs. Capacity – the ability of an individual to make specific decisions about their care and treatment and to consent to a proposed intervention. Consent – the need for the agreement of an individual with capacity to a proposed intervention by another in connection with their care, treatment or personal welfare. Necessity – a common law principle that can authorise a person to do an act in connection with the care, treatment or personal welfare of another person who lacks capacity to consent, if that act is necessary and in the individual concerned's best interests.

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[1] Relevant legislation includes the Health and Personal Social Services (NI) Order 1972; the Chronically Sick and Disabled Persons (NI) Act 1978; the Mental Health (NI) Order 1986; the Health and Social Care (Reform) Act (NI) 2009; and, the Mental Capacity Act (NI) 2016.

Legislation

In the United Kingdom, comprehensive mental capacity legislation is relatively new. Between 2000 and 2007, statutory frameworks for the care and treatment of incapacitous adults were introduced in other parts of the United Kingdom: in Scotland, the Adults with Incapacity (Scotland) Act 2000 and the Mental Health (Care and Treatment) (Scotland) Act 2003; and in England and Wales, the Mental Capacity Act 2005 (2005 Act) and the Mental Health Act 2007. Those legislative changes significantly curtailed the need for the inherent jurisdiction in Scotland, England and Wales.[2] Whereas the position in Northern Ireland has been, and continues to be, very different.

The Mental Capacity Act (Northern Ireland) 2016

The Mental Capacity Act (NI) 2016 (MCA) constitutes a major reform of mental capacity and mental health law in Northern Ireland. The legislation seeks to provide a comprehensive legal framework for the provision of care and treatment in the fields of mental capacity and mental health.[3] However, the MCA has still not been fully brought into force.[4] In December 2019, part of that legislation was brought into force; primarily for the purpose of promoting compliance with Article 5 of the European Convention on Human Rights in respect of deprivation of liberty.[5] At the time of writing, the Department of Health has not yet fixed a timescale for full implementation. When it is fully implemented, the legislation will put the declaratory jurisdiction onto a statutory footing for persons who fall within the definition of incapacity under the MCA.[6] This in turn will considerably reduce the need for the court to exercise its inherent jurisdiction in the field of health and social care, with recourse limited to cases where, for example, vulnerable persons fall outside the scope of the MCA but require protection under the law.[7] As a consequence of the partial implementation,

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[2] See Alexander Ruck-Keene 'The inherent jurisdiction: where are we now?' Local Government Lawyer, 23 January 2013.

[3] See Lucy Series, *Deprivation of Liberty in the Shadows of the Institution* (Bristol University Press 2022) 22.

[4] It is also notable that the MCA as enacted does not provide for the civil detention of adults with capacity. Under the Mental Health (Northern Ireland) Order 1986 (MHO) a person with capacity can be detained if the relevant statutory criteria are met. If the MCA as originally enacted is brought fully into force, that would constitute a significant change in the law in respect of adults with mental disorder who are posing a significant risk of physical harm to themselves or others.

[5] See the Mental Capacity (2016 Act) Commencement No 1 (Amendment) Order (Northern Ireland) 2019 No.190; and the Mental Capacity (Deprivation of Liberty) (No.2) Regulations (Northern Ireland) 2019.

[6] See Part VI of the MCA.

[7] See Alexander Ruck-Keene 'The inherent jurisdiction: where are we now?' Local Government Lawyer, 23 January 2013; *Re SA (Vulnerable Adult with Capacity: Marriage)* [2006] 1 FLR 867; *DL v A Local Authority and others* [2013] Fam 1; *KW Re (Costs following withdrawal of proceedings)* [2020] NIFam 11; *Health and Social Care Trust v O* [2020] NIFam 23.

whilst deprivation of liberty can be authorised by the MCA, the default legal basis for other interferences with a person's autonomy (e.g. invasive medical treatment) remains the common law doctrine of necessity. The focus of this article is on the use of the declaratory jurisdiction in that context.

The Human Rights Act 1998

The Human Rights Act 1998 (HRA) was brought into force in October 2000. A number of the provisions contained in the European Convention on Human Rights (ECHR) have application in this field, notably: Article 2 – the right to life; Article 3 – the prohibition of torture and inhuman and degrading treatment; Article 5 – the right to liberty; Article 6 – the right to a fair hearing; Article 8 – respect for private and family life; Article 9 – freedom of thought, conscience and religion; Article 10 – freedom of expression; and, Article 14 – prohibition of discrimination. In reaching health and social care decisions, courts must identify and take into account relevant human rights considerations.

When considering whether a declaratory order should or must be obtained before care and or treatment can be provided, HRA considerations are of central importance. Historically, a declaratory order performed the function of 'declaring' whether proposed care or treatment was in accordance with law, thereby clarifying the law as relevant to a specific health or welfare decision. However, this article will consider how the declaratory jurisdiction can perform two additional functions to ensure compliance with the HRA and the ECHR, i.e. authorising care and or treatment; and, supplementing the law.

The development of the inherent jurisdiction

In 1989, in the case of *Re F,* the Judicial Committee of the House of Lords (House of Lords) developed the declaratory jurisdiction of the court in respect of health and social care decision-making.[8] *Re F* concerned an application for a declaration that it was lawful to sterilise a mentally incapable adult woman with a serious learning disability, to prevent her becoming pregnant. The professionals managing her care believed it was not in her best interests to become pregnant, because she would not be able to cope with pregnancy or motherhood. The High Court Judge, Scott Baker J, granted the application, thereby permitting the operation. The Official Solicitor appealed, contending the Judge did not have jurisdiction

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[8] *Re F (Mental Patient: Sterilisation)* [1989] 2 All ER 545. For the historical position in England and Wales, see L Gostin, J McHale, P Fennell, R Mackay and P Bartlett *Principles of Mental Health Law and Policy* (Oxford University Press 2010).

to make such an order. The Court of Appeal upheld the Judge's decision. In his judgment Lord Donaldson of Lymington MR made the following seminal statement about the use of the inherent jurisdiction:

> *…the common law is the great safety net which lies behind all statute law and is capable of filling gaps left by that law, if and in so far as those gaps have to be filled in the interests of society as a whole. This process of using the common law to fill gaps is one of the most important duties of the judges.*[9]

The Official Solicitor further appealed to the House of Lords, to obtain clarification of the substantive law and procedure applicable in the exercise of the declaratory jurisdiction. The House of Lords upheld the lawfulness of the operation. It clarified both the legal principle permitting intervention where a person lacks capacity to consent, and the criterion to be applied to determine whether the proposed intervention was justified in a particular case. Noting that there was no established authority on the legal basis for intervention, Lord Goff stated:

> *On what principle can medical treatment be justified when given without consent? We are searching for a principle upon which, in limited circumstances, recognition may be given to a need in the interests of the patient that treatment should be given to him in circumstances where he is (temporarily or permanently) disabled from consenting to it. It is this criterion of a need which points to the principle of necessity as providing justification.*[10]

On the basis of the principle of necessity, the inherent jurisdiction permits a court to adjudicate on an application and, if it so finds, to make a declaration that proposed care and or treatment is in the patient's best interests and lawful. Lord Brandon stated the law in the following terms:

> *I turn […] to the jurisdiction to make Declarations […] This jurisdiction is under the inherent jurisdiction of the High Court […]. The substantive law is that a proposed operation is lawful if it is in the best interests of the patient, and unlawful if it is not […] What is required from the court is […] an order which establishes by judicial process […] whether the proposed operation is in the best interests of the patient and therefore lawful, or not in the patient's best interests and therefore unlawful.*[11]

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[9] *F v West Berkshire Health Authority* [1990] 2 AC 1 page 13; see also *Re T (A Child)* [2021] 3 WLR 643, paragraphs 65-67.

[10] *Re F (Mental Patient: Sterilisation)* [1989] 2 All ER 545, at 564.

[11] *Re F (Mental Patient: Sterilisation)* [1989] 2 All ER 545, at 557.

In Northern Ireland, the *Re F* decision remains as influential today as it was in 1989. The leading mental health law academic Phil Fennell summarised the import of the decision as follows:

> Re F (Mental Patient: Sterilisation) *established the principle, derived from the common law doctrine of necessity that patients who lack capacity to consent may be given treatment which is necessary in their best interests. Consequently doctors have a power and a common law duty to give to a mentally incapacitated adult treatment which is necessary in the patient's best interests.*[12]

The inherent jurisdiction in Northern Ireland

In *Belfast Health And Social Care Trust v PT & Anor,*[13] McBride J considered the history and ambit of the inherent jurisdiction in health and social care cases:

> *[20] The doctrine of parens patriae provides the legal basis for surrogate decision-making on behalf of incapacitated adults. This jurisdiction was first exercised by the Crown and was later transferred to the Chancery Courts. This jurisdiction was believed to have been rendered obsolete with the coming into force of Mental Health legislation. It soon became clear however that there were gaps in the legislation in relation to many welfare decisions. In* Re F (A Mental Patient: Sterilisation) *[1990] 2 AC 1 the House of Lords invoked the inherent declaratory jurisdiction of the High Court to make a declaration with regard to the sterilisation of a mentally handicapped woman. Since that time, the inherent jurisdiction of the court has been invoked to meet an increasing number of cases involving non-medical issues. As Dame Elizabeth Butler-Sloss P noted in* Re A (Local Authority) *[2004] 1 FLR 541 paragraph 96:*
>
> > *"Until there is legislation passed which will protect and oversee the welfare of those under a permanent disability the courts have a duty to continue, as Lord Donaldson of Lymington MR said* Re F (Medication: Sterilisation):
> >
> > > *"To use the common law as the great safety net to fill gaps where it is clearly necessary to do so.""*
>
> *Thus the inherent jurisdiction of the High Court exists where there are gaps in the legislation.*

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[12] L Gostin, J McHale, P Fennell, R Mackay and P Bartlett *Principles of Mental Health Law and Policy* 171.

[13] [2017] NIFam 1.

> [21] *The inherent jurisdiction of the court has, as appears from* Re SA (Vulnerable Adult with Capacity: Marriage) *[2005] EWHC 2942 and* Local Authority X v MM *[2007] EWHC 2003 and* Re PS (An Adult) *[2007] EWHC 623, been invoked in relation to a wide range of welfare issues. In* Re SA *Munby J observed at paragraph 45:*
>
>> *The court can regulate everything that conduces to the incompetent adult's welfare and happiness.*

McBride J also summarised applicable legal principles in respect of the use of the inherent jurisdiction for vulnerable adults, stating:

> *[25] The following principles can therefore be distilled from the existing jurisprudence relating to the High Court's inherent jurisdiction:*
>
> *(a) The inherent jurisdiction can be invoked in respect of adults who lack capacity. As noted in* Re SA *[2005] EWHC 2902 it can also be invoked in respect of vulnerable adults who do not lack capacity.*
> *(b) The jurisdiction can only be exercised where 'gaps' exist in the legislation. If the matter is covered by legislation then the inherent jurisdiction cannot be invoked. In England and Wales the Mental Capacity Act 2005 now regulates the jurisdiction over persons who lack mental capacity. Similar legislation has not yet been implemented in Northern Ireland. Therefore the inherent jurisdiction of the court continues to be exercised in relation to welfare decisions, in respect of incapacitated adults.*
> *(c) The test governing the operation of the inherent jurisdiction is "best interests".*
> *(d) The inherent jurisdiction must be exercised in accordance with law and in particular must be compatible with the Human Rights Act and the European Convention on Human Rights ("ECHR").*[14]

The case of *Belfast Health and Social Care Trust v PT & Anor* involved an application for a declaratory order in respect of a deprivation of liberty, as the MCA deprivation of liberty provisions were not yet in force. The Court granted an order permitting the deprivation of the patient's liberty, to enable compliance with ECHR Article 5. McBride J stated:

> *[49] The court can authorise a deprivation of liberty under its inherent jurisdiction if it is in PT's best interests. Therefore, if the Trust obtains a court order depriving PT of his liberty, this would be in accordance with a procedure prescribed by law. When such an order is sought the incapacitated individual should be afforded legal representation*

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[14] *Belfast Health And Social Care Trust v PT & Anor* [2017] NIFam 1 paragraph 25.

> *and in this case the Official Solicitor was appointed to act to represent his interests. I further find that the deprivation in this case is not arbitrary. The Convention allows certain individuals to be deprived of their liberty on the basis that "their own interests may necessitate their detention" - ECHR guide on Article 5, paragraph 85 and* Guzzardi v Italy.

This is an example of the courts using the inherent jurisdiction to authorise an intervention and thereby ensure compliance with the ECHR.[15] Subsequently, in December 2019, the MCA was partially brought into force, establishing a statutory framework permitting a relevant authority to obtain a Deprivation of Liberty (DOL) authorisation in respect of an incapacitous person.[16] Consequently, in respect of deprivation of liberty, the scope of the declaratory jurisdiction significantly reduced. Its application confined to cases where neither mental health nor mental capacity legislation applies, but intervention nonetheless may be legally justified. For example, in relation to vulnerable persons who require protection, but do not fall within the statutory definition of incapacity. [17]

The partial implementation of the MCA has created a somewhat anomalous legal position in respect of people whose care plan involves deprivation of liberty, as well as other significant interferences with their autonomy (e.g. invasive medical treatment). In such a case, the inherent jurisdiction is used in conjunction with the DOL framework to ensure the lawfulness of other forms of health and social care intervention, with the common law principle of necessity premising such other interventions.[18] In that context, it is important to acknowledge that the use of the doctrine of necessity has been subject to criticism by the European Court on Human Rights on grounds that its operation is arbitrary and lacking in safeguards.[19] However, the declaratory jurisdiction is a flexible instrument and can be used to

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[15] See also *NS (Inherent Jurisdiction: patient: liberty: medical treatment)* [2016] NIFam 9.

[16] See the MCA: section 9, sections 24-27 and schedule 1.

[17] In determining whether intervention in such cases is lawful, a court must negotiate the tension between the alleged need for intervention to protect the individual or others, and the autonomy and liberty of the individual, taking into account their rights under statute (including the HRA and the ECHR) and common law. See *Health and Social Care Trust v O* [2020] NI Fam 23. See also: *A Health and Social Care Trust v JU* [2023] Fam 12, where the Court's interpretation of the powers of a guardian under Part II of the Mental Health (Northern Ireland) Order 1986 provided the relief sought; notably said interpretation constituted a significant departure from the reasoning of the Court of Appeal in *JMCA v Belfast Health and Social Care Trust* [2014] NICA 37.(See also: *PT,* at paragraph 33.) The legal definition of capacity is centrally relevant to such consideration; see Emma Cave, 'Protecting Patients from their Bad Decisions: Rebalancing Rights, Relationships and Risk' Medical Law Review(2017) Nov; 25 (4): 527-553.

[17] Such declaratory applications are colloquially referred to as 'DOLs plus' applications, an acknowledgement that to comply with applicable law, the proposed care and/or treatment may require a declaratory order as well as a DOL.

[18] *HL v UK* [2004] 40 EHRR 761 paragraphs 116-124.

address such concerns, e.g. by placing adequate procedural safeguards in an order.[20]

The role of the court

The declaratory jurisdiction is exercised in the Family Division of the High Court. The Office of Care and Protection administers the cases brought before the High Court. In *NS (Inherent jurisdiction: patient: liberty: medical treatment)*,[21] Keegan J stated that a two-fold test was applicable in declaratory cases, namely: (a) whether the patient has the capacity to provide a legally valid consent to the proposed care and treatment; and, (b) whether the proposed care and treatment is necessary and in the patient's best interests. Where appropriate, the court exercises its jurisdiction to declare that a proposed act or omission is lawful.[22]

In cases where there is no dispute about the need for the proposed care and/or treatment, the declaratory jurisdiction performs other important functions in relation to interventions that may have a significant impact upon the health and welfare of an individual (e.g. amputation of a limb or the removal of life support). A court order protects the patient from an intervention that is not in their best interests. An order also protects the public authority and professionals involved in the care and treatment, from subsequent adverse criticism or claims.[23] A simple rule of thumb operates: the more significant the intervention, the greater the case for seeking a declaratory order.[24] In *Re S*, [25] Lord Bingham MR stated:

> *…in cases of controversy and cases involving momentous and irrevocable decisions, the courts have treated as justiciable any genuine question as to what the best interests of a patient require or justify. In making these decisions the courts have recognised the desirability of informing those involved whether a proposed course of conduct will render them criminally or civilly liable; they have acknowledged their duty to act as a safeguard against malpractice, abuse and unjustified action; and they have recognised the desirability, in the last resort, of decisions being made by an impartial independent tribunal.*[26]

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[20] For example, see *PT*, paragraphs 49-52.

[21] [2016] NIFam 9.

[22] See section 23 of the Judicature Act (NI) 1978. The court can also provide injunctive relief where appropriate. See *Re L (Vulnerable Adults with Capacity: Courts Jurisdiction)* [2011] Fam 189 and *A Local Authority v DL* [2012] 3 WLR. 1439.

[23] Simon Halliday, Adam Formby and Richard Cookson 'An assessment of the Court's role in the withdrawal of clinically assisted nutrition and hydration from patients in the permanent vegetative state' [2015] Medical Law Review 556-587.

[24] In certain cases, an order may be required by law to satisfy the HRA and the ECHR, e.g. where an incapacitous person is being removed from their family home into residential care, This is discussed below.

[25] *Re S (Hospital Patient: Court's Jurisdiction)* [1996] Fam 1.

[26] At page 18.

Making an application

Declaratory applications are usually, though not exclusively, brought by the Health and Social Care Trust responsible for the patient's care and treatment.[27] Practitioners will most frequently encounter such cases where a health and/or social care intervention is proposed in respect of a client or the relative of a client. The procedure for declaratory applications was set down by the House of Lords in *Re F*, where Lord Brandon stated:

> *(1) Applications for a declaration that a proposed operation on or medical treatment of a patient can lawfully be carried out despite the inability of such patient to consent thereto should be by way of originating summons issuing out of the Family Division of the High Court. (2) The applicant should normally be those responsible for the care of the patient or those intending to carry out the proposed operation or other treatment, if it is declared to be lawful. (3) The patient must always be a party and should normally be a respondent. In cases in which the patient is a respondent the patient's guardian ad litem should normally be the Official Solicitor. In any cases in which the Official Solicitor is not either the next friend or the guardian ad litem of the patient or an applicant he shall be a respondent. (4) With a view to protecting the patient's privacy, but subject always to the judge's discretion, the hearing will be in chambers, but the decision and the reasons for that decision will be given in open court.*[28]

Current practice in the Family Division (Office of Care and Protection) in Northern Ireland still broadly accords with the procedure established in *Re F*. It is a flexible procedure which can be adapted to suit the circumstances of the case. The Plaintiff is normally a Health and Social Care Trust. Proceedings are commenced by issuing a summons in the Office of Care and Protection. The patient is the Defendant who can be represented by the Official Solicitor in its capacity as Guardian ad Litem or by a Next Friend (usually a family member).[28] Other parties with an interest in the proceedings (e.g. family members, close friends or relevant public authorities) can be named as Notice Parties and the court can grant them permission to participate in the proceedings by giving evidence and making submissions. The summons is supported by affidavit evidence and a draft order is attached to assist the court. The application is premised on reports provided by relevant professionals, e.g. psychiatrists, anaesthetists, surgeons, psychologists and

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[27] An application could be brought by a patient, on behalf of a patient or by another interested party e.g., a relative. Legal aid may be available, e.g., for a patient or where a family member is acting as the patient's Next Friend in the litigation.

[28] *Re F (Mental Patient: Sterilisation)* [1989] 2 All ER 545, page 558.

[29] The Official Solicitor may be asked to participate in the proceedings even if not acting on behalf of the patient.

social workers. The relief sought is usually declaratory in nature, but the court also can issue injunctive relief, where appropriate.[30]

When appointed, the Official Solicitor prepares a report addressing the relevant legal and factual issues. The Official Solicitor, or one of her team of solicitors, will attempt to make contact with relevant persons, including the patient, close relatives and, where appropriate, friends. A central focus is the patient's perspective and what that individual would want in the circumstances. The report makes recommendations to the court in relation to the relevant issues, including whether the proposed relief is in the patient's best interests.

A hearing is arranged as soon as is convenient. In cases of urgency, hearings can be arranged at very short notice, e.g. an urgent lifesaving operation. The length of the proceedings depends upon the complexity of the issues and the nature and extent of any dispute between the parties. Witnesses are questioned: examined; cross-examined; and, re-examined. Submissions are made by the parties. Notice parties can be afforded the opportunity to give evidence, make submissions or otherwise make their views known to the court. The court may give a judgment at the end of the hearing or may reserve judgment to be delivered at a later date. Where the parties are presenting reasonable arguments on valid issues, the civil law principle that the loser pays the winner's costs is not the default principle, and rarely will be apposite. Consequently, costs are not ordinarily awarded in declaratory cases, meaning each side bears its own costs.[31]

The test for capacity

In *NS (Inherent jurisdiction: patient: liberty: medical treatment)*, relying on the case of *Re MB (Medical Treatment)*,[32] Keegan J stated the test for capacity in the following terms:

> *A court should approach the crucial question of competence bearing in mind the following principles – every person is presumed competent to consent to, or to refuse, medical treatment unless and until that presumption is rebutted. A competent woman may choose, even for irrational reasons not to have medical intervention, even though the*

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[30] *Re S (Hospital Patient: Courts Jurisdiction)* [1996] Fam 1. See also *Re L (Vulnerable Adults with Capacity: Courts Jurisdiction)* [2011] Fam 189 and *A Local Authority v DL* [2012] 3 WLR 1439. In Northern Ireland in September 2020 in a case brought by the Belfast Health and Social Care Trust, injunctive relief was granted by the Court under the inherent jurisdiction to prevent a relative visiting a patient where the relative had previously harmed the patient. The decision is not reported.

[31] *KW Re (Costs following withdrawal of proceedings)* [2020] NIFam 11.

[32] [1997] 2 FLR 426.

> *consequence may be of death of or serious handicap to the child she bears or her own death.*
>
> *A person lacks capacity if some impairment or disturbance of mental function rendered the person unable to make a decision whether to consent to, or refuse treatment, such an incapacity existed where: a person was unable to comprehend or retain information material to the decision and was unable to use the information and weigh it in the balance as part of the process of making the decision required.*[33]

In 2019, the MCA was partially brought into force. The new statutory test for capacity, which applies in deprivation of liberty cases, is set out at sections 3-4 as follows:

> *Meaning of "lacks capacity"*
>
> ***3.***— *(1) For the purposes of this Act, a person who is 16 or over lacks capacity in relation to a matter if, at the material time, the person is unable to make a decision for himself or herself about the matter (within the meaning given by section 4) because of an impairment of, or a disturbance in the functioning of, the mind or brain.*
>
> *(2) It does not matter—*
> *(a) whether the impairment or disturbance is permanent or temporary;*
> *(b) what the cause of the impairment or disturbance is.*
>
> *(3) In particular, it does not matter whether the impairment or disturbance is caused by a disorder or disability or otherwise than by a disorder or disability.*
>
> *Meaning of "unable to make a decision"*
>
> ***4.***— *(1) For the purposes of this Part a person is "unable to make a decision" for himself or herself about a matter if the person—*

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[33] This paraphrases Lady Justice Butler Sloss's language, who stated: "(4) *A person lacks capacity if some impairment or disturbance of mental functioning renders the person unable to make a decision whether to consent to or to refuse treatment. That inability to make a decision will occur when (a) the patient is unable to comprehend and retain the information which is material to the decision, especially as to the likely consequences of having or not having the treatment in question; (b) the patient is unable to use the information and weigh it in the balance as part of the process of arriving at the decision.[…]"*

> *(a) is not able to understand the information relevant to the decision;*
> *(b) is not able to retain that information for the time required to make the decision;*
> *(c) is not able to appreciate the relevance of that information and to use and weigh that information as part of the process of making the decision; or*
> *(d) is not able to communicate his or her decision (whether by talking, using sign language or any other means);*
>
> *and references to enabling or helping a person to make a decision about a matter are to be read accordingly.*
>
> *(2) In subsection (1) "the information relevant to the decision" includes information about the reasonably foreseeable consequences of—*
> *(a) deciding one way or another; or*
> *(b) failing to make the decision.*
>
> *(3) For the purposes of subsection (1)(a) the person is not to be regarded as "not able to understand the information relevant to the decision" if the person is able to understand an appropriate explanation of the information.*
>
> *(4) An appropriate explanation means an explanation of the information given to the person in a way appropriate to the person's circumstances (using simple language, visual aids or any other means).*

In declaratory cases, notwithstanding the partial implementation of the MCA, a court can take cognisance of the statutory test contained in sections 3 and 4.[34] Such an approach could promote harmonisation of law and consistency in judicial decision making.[35]

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[34] In *Belfast Health And Social Care Trust v PT & Anor* [2017] [2017] NIFam1, taking into account relevant legislative developments elsewhere in the United Kingdom, McBride J held there was no distinction between section 3 of the Mental Capacity Act 2005 and the common law. (See paragraph 29 of the judgment.) The MCA's statutory test for capacity now is in force and applicable to deprivation of liberty authorisation. That test – as specified at sections 3 and 4 of the MCA - is based on the test in sections 2 and 3 of the 2005 Act. It is to be expected that the courts will take cognisance of the MCA statutory test for capacity, when adjudicating on the issue of capacity under the common law.

[35] However, Emma Cave's article, 'Protecting Patients from their Bad Decisions: Rebalancing Rights, Relationships and Risk' Medical Law Review (2017) Nov; 25 (4): 527-553, should be noted in this context. Therein, she distinguishes between the statutory definition of capacity under the 2005 Act, and the definition of capacity under common law. She contends that the courts within the inherent jurisdiction can rely on the broader common law definition of incapacity, in order to afford greater legal protection for vulnerable people at risk of harm.

Capacity is issue-specific. There is a presumption that a person has decision-making capacity in respect of any issue. That presumption is rebuttable. Where there is uncertainty or a dispute about a person's decision-making capacity in respect of any issue, a court can determine that individual's capacity on the balance of probabilities, taking into account all relevant evidence, including that of experts. If capacity is not dispute, and the court is satisfied that the patient lacks capacity in relation to the specific issue or issues in question, the court moves to consider the proposed care and/or treatment.

Determining the best interests of the patient

Where the patient lacks capacity in relation to a relevant issue, the focus moves onto the lawfulness of the proposed care and/or treatment, i.e. whether it is necessary and in the patient's best interests. In making such a determination, the court must take into account the evidence adduced and submissions made, i.e. all relevant considerations brought to the court's attention. In most cases, the Trust is the Plaintiff and adduces evidence and makes submissions in support of the proposed option, i.e. the proposed care and/or treatment for the patient concerned. The Official Solicitor will have provided a report identifying the patient's wishes and perspective, as well as can be identified from available sources. The Official Solicitor expresses a view on the relief sought and the patient's best interests. Other parties (Defendants or Notice Parties) may lead evidence and/or make submissions, in support of either the Plaintiff's proposal or alternative options.

In *Belfast Health and Social Care Trust v PT & Anor,*[36] McBride J conducted a review of the authorities on the best interests jurisdiction, stating:

> *As has been noted in a number of cases the court has power to grant whatever relief in declaratory form as is necessary to safeguard and promote the incompetent adult's welfare and interests. As Munby J went on to observe in* Re SA *at paragraphs [96-97]:*
>
> > *"It is elementary that the Court exercises its powers by reference to the incompetent adult's best interests."*
>
> *Best interests' depends on the particular circumstances of each case. It goes beyond medical interests and it takes into account ethical, social, moral and welfare considerations including the recognition of emotions*

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[36] [2017] NIFam 1 at paragraph 23.

and human relations. In *Re GM* [2011] EWHC 2778 Hedley J at paragraph 21 set out the broad scope of best interests, when she said:

> *"If one asks what has to be taken into account in considering the best interests of any human being … the answer is a very wide-ranging one: his health, his care needs, his needs for physical care and his needs for consistency. There is of course, more to human life than that, there is fundamentally the emotional dimension, the importance of relationships, the importance of a sense of belonging in the place in which you are living, and the sense of belonging to a specific group in respect of which you are a particularly important person."*

Given the MCA's partial implementation in Northern Ireland, the statutory provisions on best interests decision-making contained in the MCA (sections 2, 7 and 8) only apply to those provisions that have been brought into force, e.g. the DOL provisions. Nonetheless, when exercising its inherent jurisdiction, the court can take cognisance of, and give due regard to, relevant legislative developments in this jurisdiction. Accordingly, it appears pertinent to set out section 7 in full, as follows:

Best interests

7.— (1) This section applies where for any purpose of this Act it falls to a person to determine what would be in the best interests of another person who is 16 or over ("P").

(2) The person making the determination must not make it merely on the basis of—

(a) P's age or appearance; or

(b) any other characteristic of P's, including any condition that P has, which might lead others to make unjustified assumptions about what might be in P's best interests.

(3) That person—
(a) must consider all the relevant circumstances (that is, all the circumstances of which that person is aware which it is reasonable to regard as relevant); and

(b) must in particular take the following steps.

(4) That person must consider—

(a) whether it is likely that P will at some time have capacity in relation to the matter in question; and

(b if it appears likely that P will, when that is likely to be.

(5) That person must, so far as practicable, encourage and help P to participate as fully as possible in the determination of what would be in P's best interests.

(6) That person must have special regard to (so far as they are reasonably ascertainable)—

(a) P's past and present wishes and feelings (and, in particular, any relevant written statement made by P when P had capacity);

(b) the beliefs and values that would be likely to influence P's decision if P had capacity; and

(c) the other factors that P would be likely to consider if able to do so.

(7) That person must—

(a) so far as it is practicable and appropriate to do so, consult the relevant people about what would be in P's best interests and in particular about the matters mentioned in subsection (6); and

(b) take into account the views of those people (so far as ascertained from that consultation or otherwise) about what would be in P's best interests and in particular about those matters.

For the definition of "the relevant people" see subsection (11).

(8) That person must, in relation to any act or decision that is being considered, have regard to whether the same purpose can be as effectively achieved in a way that is less restrictive of P's rights and freedom of action.

(9) That person must, in relation to any act that is being considered, have regard to whether failure to do the act is likely to result in harm to other persons with resulting harm to P.

> *(10) If the determination relates to life-sustaining treatment for P, the person making the determination must not, in considering whether the treatment is in the best interests of P, be motivated by a desire to bring about P's death.*
>
> *(11) In subsection (7) "the relevant people" means—*
>
> > *(a) any person who at the time of the determination is P's nominated person (see section 69);*
> >
> > *(b) if at the time of the determination there is an independent mental capacity advocate who is instructed under section 91 to represent and provide support to P, the independent mental capacity advocate;*
> >
> > *(c) any other person named by P as someone to be consulted on the matter in question or on matters of that kind;*
> >
> > *(d) anyone engaged in caring for P or interested in P's welfare;*
> >
> > *(e) any attorney under a lasting power of attorney, or an enduring power of attorney, granted by P; and*
> >
> > *(f) any deputy appointed for P by the court.*[37]

Since the enactment of the 2005 Act, the courts in England and Wales have developed their jurisprudence on best interests determinations, based on section 4 of the 2005 Act.[38] Commonly stated principles drawn from the England and Wales authorities, which accord with current practice in Northern Ireland, include the following:

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[37] However, a Judge can usefully take section 7 into account only to the extent that it is meaningful. By reason of the partial implementation of the MCA, the provisions in respect of advocates, lasting powers of attorney and court deputies, have not yet been brought into force.

[38] See, e.g. *Wyatt v Portsmouth NHS Trust* [2006] 1 FLR 554; *NHS Trust v MB (a child represented by CAFCASS as guardian ad litem)* [2006] 2 FLR 319; *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67; *Great Ormond Street Hospital for Children NHS Foundation Trust v Yates* [2018] 4 WLR 5; *London NHS Foundation Trust v E* [2019] 166 BMLR 185; *Knight (A Child) Re* [2021] EWCA Civ 362; *Fixsler v Manchester University NHS Foundation Trust* [2021] 4 WLR 123; *London North West University Healthcare NHS Trust v M* [2022] EWCOP 13.

1. The object of the exercise is to identify the best option for the person concerned. The matter must be decided by the application of an objective approach which involves determining what are the best interests of the patient.[39]
2. Best interests are used in the widest sense and include every kind of consideration capable of impacting on the decision. Those include considerations such as: medical; emotional; sensory (pleasure, pain and suffering); and, instinctive (the human instinct to survive). It is impossible to weigh such considerations mathematically, but the court must do its best to give due weight to all the relevant considerations in a particular case, and reach a determination that is in the individual's best interests.[40]
3. All cases are fact-specific, and are determined solely on the facts of the individual case.[41]
4. The court attempts to ascertain what the patient would have wanted, taking into account the individual's: (a) past and present wishes and feelings; and, (b) relevant beliefs and values.
5. The expressed views and opinions of relevant persons, e.g. family members, who have participated in the litigation (including those contained in the Official Solicitor's report) are taken into account.[42]
6. The evidence of the professional experts is carefully considered. Due consideration is given to the associated risks and likely outcome of any given option.
7. Relevant human rights considerations are taken into account, e.g. ECHR Article 8 (private and family life).
8. The court considers all available options brought to its attention. Additionally, the court may inquire about other options that could be available and worth considering.
9. A balance sheet identifying the considerations that militate for and against each option may be of assistance.[43]

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[39] *Knight (A Child), Re* [2021] EWCA Civ 362. at para 13(iv).

[40] *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67 at para 39.

[41] *NHS Trust v MB (a child represented by CAFCASS as guardian ad litem)* [2006] 2 FLR 319*; Knight (A Child), Re* [2021] EWCA Civ 362 at para 13(ix).

[42] See section 4(7) of the Mental Capacity Act 2005. It is worth noting that section 7(11) of the MCA identifies a number of relevant people who should be consulted in best interests decision-making, including *"anyone engaged in caring for P or interested in P's welfare"; "any other person named by P as someone to be consulted on the matter in question or on matters of that kind"*; and, a person with an enduring power of attorney. This provision is currently in force only in respect of deprivations of liberty and a number of other limited matters. (See the Mental Capacity (2016 Act) Commencement No.1 (Amendment) Order (Northern Ireland) 2019 No.190.) Notwithstanding, under common law it is to be expected that on any given issue consultation will be approached in an inclusive manner and involve such persons.

[43] *Re A* [2000] 1 FLR 549 at page 560*; Wyatt v Portsmouth NHS Trust* [2006] at para 87; *Re S* 71 BMLR 188.

10. A comprehensive or global approach is required to ensure all relevant considerations are taken into account when arriving at the decision.[44]

Applying for a declaratory order: a matter of good practice or a legal requirement?

Most day-to-day interventions do not require a declaratory order.[45] Usually, proposed care and treatment can be provided in accordance with the common law principle of necessity where:

(a) the person has been assessed as incapacitous as regards the intervention in question; and,
(b) there is clarity and consensus that the proposed care and treatment is necessary and in the individual's best interests.

Unless the proposed intervention is of a sufficiently significant or serious nature, any disagreement amongst family and carers should be resolvable without recourse to a court, possibly with input from, or consultation with, a social worker or the general practitioner.

An application for a declaratory order is warranted only in a relatively small number of cases. It is advisable to bring an application where the intervention is of a serious nature and there is a lack of consensus about the proposed course amongst persons with a valid interest in the decision. For example, in the medical realm, it could be where the issue concerns an irreversible life-changing operation, such as amputation of a leg, or the withdrawal of life support. In deciding whether to bring an application, consideration should be given to two issues: (i) whether a declaratory order should be sought as a matter of good practice; and, (ii) whether a declaratory order is legally required. When considering whether an order is required, the HRA becomes a central focus. To ensure compliance with the HRA and the ECHR, the declaratory jurisdiction sometimes can perform additional functions, beyond 'declaring' the law, e.g. by 'authorising' care and/or treatment; and/or, supplementing the legal framework.

In *Re F*, the House of Lords stopped short of holding that an order was required in the case of the proposed sterilisation of an incapacitous adult. Lord Brandon carried the majority (of four to one) by holding that a declaration was highly desirable as a matter of good practice, given

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[44] *Re GM* [2011] EWHC 2778.

[45] The provision of care that involves a deprivation of liberty requires legal authorisation to comply with the HRA and ECHR Article 5. However, that can be obtained under the MCA and the DOLs provisions that were brought into force in December 2019.

the invasive and irreversible nature of the operation in question. However, it was not required as a matter of law or good practice. He stated:

> *…although involvement of the court is not strictly necessary as a matter of law, it is nevertheless highly desirable as a matter of good practice. In considering that question, it is necessary to have regard to the special features of such an operation. These features are: first, the operation will in most cases be irreversible; secondly, by reason of the general irreversibility of the operation, the almost certain result of it will be to deprive the woman concerned of what is widely, and as I think rightly, regarded as one of the fundamental rights of a woman, namely, the right to bear children; thirdly, the deprivation of that right gives rise to moral and emotional considerations to which many people attach great importance; fourthly, if the question whether the operation is in the best interests of the woman is left to be decided without the involvement of the court, there may be a greater risk of it being decided wrongly, or at least of it being thought to have been decided wrongly; fifthly, if there is no involvement of the court, there is a risk of the operation being carried out for improper reasons or with improper motives; and, sixthly, involvement of the court in the decision to operate, if that is the decision reached, should serve to protect the doctor or doctors who perform the operation, and any others who may be concerned in it, from subsequent adverse criticisms or claims.*[46]

In his judgment Lord Griffiths advanced a different ideological position, contending that an order should be required as a matter of law:

> *…. I cannot agree that it is satisfactory to leave this grave decision with all its social implications in the hands of those having the care of the patient with only the expectation that they will have the wisdom to obtain a declaration of lawfulness before the operation is performed. In my view the law ought to be that they must obtain the approval of the court before they sterilise a woman incapable of giving consent and that it is unlawful to sterilise without that consent. I believe that it is open to your Lordships to develop a common law rule to this effect.*[47]

However, Lord Griffiths accepted that his colleagues were not in agreement with him, and in the end adopted Lord Brandon's approach. Whereas Lord Goff adopted a more stringent approach than Lord Brandon, i.e. that as a matter of good practice sterilisation should not be performed on a person lacking capacity, without an order from the court declaring that such an operation was lawful.[48]

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[46] *Re F (Mental Patient: Sterilisation)* [1989] 2 All ER 545 at 552.

[47] *Re F (Mental Patient: Sterilisation)* [1989] 2 All ER 545, at 561.

[48] *Re F (Mental Patient: Sterilisation)* [1989] 2 All ER 545, at 568.

Airedale NHS Trust v Bland[49] involved an application to withdraw life support. Tony Bland was injured in the Hillsborough Stadium disaster, and had been left in a persistent vegetative state. There was no prospect of recovery, and he was kept alive by life support that included artificial nutrition and hydration. The family and medical team formed the view that it was not in his best interests to prolong his life. The Court held that as a matter of good practice, an application for declaratory relief should be made before life prolonging treatment could be withdrawn from the patient. Thus, Lord Goff's approach in *Re F* was applied in the Bland case. Lord Goff stating[50]:

> *I turn finally to the extent to which doctors should, as a matter of practice, seek the guidance of the court, by way of an application for declaratory relief, before withholding life-prolonging treatment from a PVS patient. Sir Stephen Brown P considered that the opinion of the court should be sought in all cases similar to the present. In the Court of Appeal Sir Thomas Bingham MR expressed his agreement with Sir Stephen Brown P in the following words (see p 842, ante):*
>
> > *"This was in my respectful view a wise ruling, directed to the protection of patients, the protection of doctors, the reassurance of patients' families and the reassurance of the public. The practice proposed seems to me desirable. It may very well be that with the passage of time a body of experience and practice will build up which will obviate the need for application in every case, but for the time being I am satisfied that the practice which Sir Stephen Brown P described should be followed."*

Consequently, the law was somewhat unclear. Whilst a distinction can be drawn between something which is desirable as a matter of good practice and required as a matter of good practice; what is the legal significance of such a distinction? Ambiguity arises from the courts' requiring something as a matter of good practice: arguably either something is required by law or it is not. It is not unlawful to fail to obtain an order - whether recommended or required as a matter of good practice; albeit it may be ill-advised. Such ambiguity persisted for a number of years. For example, *Practice Direction (declaratory proceedings: incapacitated adults)* provided as follows:

> *The need for court involvement*
> *3. Case law has established two categories of case that will in virtually all cases require the prior sanction of a High Court Judge. The first is sterilisation of a person (whether a child or an adult) who cannot consent to the operation:* Re B (a minor) *(w*ardship: sterilisation) *[1987] 2 All ER*

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[49] [1993] AC 789.

[50] At page 873.

> *206, [1988] AC 199 and* Re F (mental patient: sterilisation) *[1989] 2 All ER 545, [1990] 2 AC 1. The second is the discontinuance of artificial nutrition and hydration for a patient in a vegetative state:* Airedale NHS Trust v Bland *[1993] 1 All ER 821 at 833, [1993] AC 789 at 805…* (My emphasis)[51]

The HRA's enactment inevitably led to litigation in the field of health and social care about the domestic law's compatibility with the ECHR. In a case involving a child, *Glass v United Kingdom*, the patient was severely mentally and physically disabled.[52] Following an operation, his condition was deteriorating and the medical team wanted to use diamorphine to alleviate his distress. The patient's family was opposed to the use of diamorphine and in the event of his heart stopping, wanted him to be resuscitated. Contrary to the family's wishes, the patient was treated with diamorphine and a 'Do Not Resuscitate' (DNR) order placed on his medical notes. The family demanded that the use of diamorphine be stopped, but his medical team refused to stop the treatment, unless the family agreed to the patient not being resuscitated. The family took matters into its own hands, intervened in the care and resuscitated the patient. Thereafter his condition improved and he went home the next day. The family brought legal proceedings claiming that the medical care and treatment interfered with the family's rights under ECHR Article 8. The European Court found that the doctors and the Hospital Trust had breached Article 8 by failing to seek a court order in the given circumstances where: the patient was a child; the patient's parent and legal proxy was not consenting to the course of treatment; and, it was not an emergency situation.

Did the decision in *Glass v United Kingdom* constitute a sea change in the law; precipitating an enhanced role for the courts to authorise certain health care decisions for incapacitous patients when the ECHR was engaged? It did not take long for that question to be answered. The following year, Oliver Burke, who had a cognitive degenerative brain condition, sought a judicial review of the General Medical Council Guidance entitled Withholding and Withdrawing Life-prolonging Treatments: Good Practice in Decision-making (Guidance). As part of his legal challenge, he contended that the Guidance failed to adequately address the legal requirement for obtaining judicial authorisation for the withdrawal of artificial nutrition and hydration in relevant circumstances, arguing the alleged failure constituted a breach of Articles 2, 3 and 8 of the ECHR. The application succeeded at first instance: Munby J found certain parts of the Guidance unlawful on the ground that it failed to reflect the legal requirement that in specified circumstances artificial nutrition and hydration (ANH) may not be withdrawn without prior judicial authorisation.[53] At paragraph 214 (g) of his judgment, he stated:

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[51] [2002] 1 All ER 794

[52] [2004] 39 EHRR 15.

[53] *R (Burke) v General Medical Council* [2005] 2 WLR 431.

> *(g) Where it is proposed to withhold or withdraw ANH the prior authorisation of the court is required as a matter of law (and thus ANH cannot be withheld or withdrawn without prior judicial authorisation): (i) where there is any doubt or disagreement as to the capacity (competence) of the patient; or (ii) where there is a lack of unanimity amongst the attending medical professionals as to either (1) the patient's condition or prognosis or (2) the patient's best interests or (3) the likely outcome of ANH being either withheld or withdrawn or (4) otherwise as to whether or not ANH should be withheld or withdrawn; or (iii) where there is evidence that the patient when competent would have wanted ANH to continue in the relevant circumstances; or (iv) where there is evidence that the patient (even if a child or incompetent) resists or disputes the proposed withdrawal of ANH; or (v) where persons having a reasonable claim to have their views or evidence taken into account (such as parents or close relatives, partners, close friends, long-term carers) assert that withdrawal of ANH is contrary to the patient's wishes or not in the patient's best interests.*

The Court of Appeal overturned that finding, rejecting the contention that the HRA, and the *Glass* decision, had changed the law and judicial authorisation was now required in certain clinically-assisted nutrition and hydration (CANH) cases.[54] Lord Phillips addressed the judicial sanction argument arising from the Glass decision in the following terms:

> *This was not a decision which made "a significant and potentially very important change in English law". The European Court of Human Rights did no more than consider the implications of the doctors' conduct in the light of what the European court understood to be English law. The true position is that the court does not 'authorise' treatment that would otherwise be unlawful. The court makes a declaration as to whether or not proposed treatment, or the withdrawal of treatment, will be lawful. Good practice may require medical practitioners to seek such a declaration where the legality of proposed treatment is in doubt. This is not, however, something that they are required to do as a matter of law. For these reasons declaration (6) made by Munby J misstated the law* [55]

Mr Burke lodged an application with the European Court on Human Rights, contending that the Court of Appeal decision was in breach of the ECHR.[56] The application was declared inadmissible. At page 8 of the admissibility

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[54] *R (Burke) v General Medical Council* [2005] 85 BMLR 1.

[55] *R (Burke) v General Medical Council* [2005] 85 BMLR 1, paragraph 80.

[56] *Burke v United Kingdom* ECHR Application 19807/06.

decision, the Court addressed the need for judicial sanction of a medical decision:

> *Insofar as the applicant argues that there is insufficient protection in that a doctor might reach a decision to withdraw ANH without being under an obligation to obtain the approval of the court, the Court would refer to the Court of Appeal's explanation that the courts do not as such authorise medical actions but merely declare whether a proposed action is lawful. A doctor, fully subject to the sanctions of criminal and civil law, is only therefore recommended to obtain legal advice, in addition to proper supporting medical opinion, where a step is controversial in some way. Any more stringent legal duty would be prescriptively burdensome - doctors, and emergency ward staff in particular, would be constantly in court – and would not necessarily entail any greater protection.*

Following the Court of Appeal's decision in Burke, the law was clarified in Practice Note: (Official Solicitor: Declaratory Proceedings: Medical and Welfare Decisions for Adults who Lack Capacity).[57] As can be seen from the following extracted paragraphs of the Practice Note, the approach established in *Re F* is adopted, i.e. in certain medical treatment cases declaratory relief may be desirable as a matter of good practice, but judicial sanction is not required:

> ***[5]*** *There are certain categories of medical treatment cases in which case law has established that a court application should be made:*
>
> *(1) where it is proposed to withdraw artificial nutrition and hydration from a patient in the permanent vegetative state:* Airedale NHS Trust v Bland *[1993] AC 789, [1993] 1 FLR 1026…*
>
> *(2) the sterilisation for contraceptive purposes of a person who cannot consent* – Re S (Adult Patient: Sterilisation) *[2001] Fam 15, [2000] 2 FLR 389 … and*
>
> *(3) certain termination of pregnancy cases* – D v An NHS Trust (Medical Treatment: Consent: Termination) *[2003] EWHC 2793 (Fam), [2004] 1 FLR 1110.*
>
> ***[6]*** *As a matter of good practice medical practitioners should seek a declaration, particularly in relation to withdrawal or withholding of*

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[57] [2006] 2 FLR 373.

life sustaining treatment, where the legality of so doing is in doubt – see R (Burke) v General Medical Council (Official Solicitor and Others Intervening) *[2005] EWCA Civ 1003, [2005] 2 FLR 1223:*

> *In general, any serious treatment decision where there is a disagreement between those involved and those close to the patient, where the treatment proposed may involve the use of force to restrain the patient or otherwise may be resisted by the patient or where there are doubts and difficulties over the assessment of either the patient's capacity or best interests should be referred to the court.*

[7] *Welfare decisions may need to be referred to the Court when there is disagreement between the patient›s family or carers, and those with a duty of care toward the patient, commonly a local authority, over issues such as:*

(1) place of residence, care arrangements or contact with family members or others – see Re F (Adult: Court's Jurisdiction) *[2001] Fam 38, [2000] 2 FLR 512 and* Re S (Adult's Lack of Capacity: Carer and Residence) *[2003] EWHC 1909 (Fam), [2003] 2 FLR 1235; or*

(2) an adult's capacity to marry – see Re E (an Alleged Patient); Sheffield City Council v E *and* S *[2004] EWHC 2808 (Fam), [2005] Fam 326, [2005] 1 FLR 965 (*Sheffield City Council v E*).*

In England and Wales, the enactment of the 2005 Act and establishment of the Court of Protection led to a decline in the use of the inherent jurisdiction. This Practice Direction represents a synopsis of the legal position before the Court of Protection developed its statute-based jurisprudence. It also provides a useful guide to the common law position, that continued to operate in Northern Ireland.[58]

Withdrawal of clinically assisted nutrition and hydration ("CANH"): An NHS Trust v Y

In 2019 the Supreme Court considered the proposed withdrawal of CANH in the case of *An NHS Trust v Y.*[59] The patient's family and medical team were agreed that it was not in his best interests that he continued to receive further treatment. The patient by his litigation friend (the Official Solicitor)

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[58] See for example *Health and Social Services Trust v PM & Anor* [2007] NIFam 13.

[59] *An NHS Trust v Y [2019] AC 978.*

contended there was a legal requirement to seek a court order before CANH could be withdrawn. In the High Court, O'Farrell J found there was no such requirement. The Supreme Court dismissed the appeal; holding that where professional guidance was followed and the medical professionals and the family or relevant interested persons were in agreement about the proposed course, there was no requirement to make an application to the court for an order. Lady Black, giving the unanimous decision of the Court, stated:

> *I do not consider that it has been established that the common law or the Convention, in combination or separately, give rise to the mandatory requirement, for which the Official Solicitor contends, to involve the court to decide upon the best interests of every patient with a prolonged disorder of consciousness before CANH can be withdrawn. If the provisions of the 2005 Act are followed and the relevant guidance observed, and there is agreement upon what is in the best interests of the patient, the patient may be treated in accordance with that agreement without application to the court.*

Guidance subsequently issued by the Court of Protection in England and Wales took the *Y* decision into account.[60] It advised that consideration must be given to making an application where the decision is finely balanced, or there is: a difference of medical opinion; a lack of agreement from those with an interest in the person's welfare; or, a conflict of interest on the part of those making the decision.

Notably, the Guidance further advised that where the decision relates to the provision of life-sustaining treatment, and any of those factors are present, an application must be made to the Court of Protection to ensure compliance with ECHR Article 2 - the right to life. The relevant paragraphs in the guidance are set out in full:

Situations where consideration should be given to bringing an application to court

> ***[8]*** *If, at the conclusion of the medical decision-making process, there remain concerns that the way forward in any case is:*
>
> *(a)* ***finely balanced****, or*
>
> *(b) there* ***is a difference of medical opinion****, or*

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[60] *Applications relating to Medical Treatment: Guidance Authorised by the Honourable Mr Justice Hayden, The Vice President of the Court of Protection [2020] EWCOP 2.*

*(c) a **lack of agreement** as to a proposed course of action from those with an interest in the person's welfare, or*

*(d) there is **a potential conflict of interest** on the part of those involved in the decision-making process (not an exhaustive list)*

*then it is highly probable that an application to the Court of Protection is appropriate. In such an event consideration **must** always be given as to whether an application to the Court of Protection is required.*

[9] *Where any of the matters at para [8] above arise and the decision relates to the provision of life-sustaining treatment an application to the Court of Protection **must** be made. This is to be regarded as an inalienable facet of the individual's rights, guaranteed by the European Convention on Human Rights ('ECHR'). For the avoidance of any doubt, this specifically includes the withdrawal or withholding of clinically assisted nutrition and hydration.*

[10] *In any case which is not about the provision of life-sustaining treatment, but involves the serious interference with the person's rights under the ECHR, it is 'highly probable that, in most, if not all, cases, professionals faced with a decision whether to take that step will conclude that it is appropriate to apply to the court to facilitate a comprehensive analysis of [capacity and] best interests, with [the person] having the benefit of legal representation and independent expert advice'. This will be so even where there is agreement between all those with an interest in the person's welfare.*

[11] *Examples of cases which may fall into para [10] above will include, but are not limited to:*

(a) where a medical procedure or treatment is for the primary purpose of sterilisation;

(b) where a medical procedure is proposed to be performed on a person who lacks capacity to consent to it, where the procedure is for the purpose of a donation of an organ, bone marrow, stem cells, tissue or bodily fluid to another person;

(c) a procedure for the covert insertion of a contraceptive device or other means of contraception;

(d) where it is proposed that an experimental or innovative treatment to be carried out;

(e) a case involving a significant ethical question in an untested or controversial area of medicine.

The decision in *NHS Trust v Y* makes it clear that the courts do not need to be involved if the decision-making accords with relevant legislation and guidance, and is uncontroversial.[61] In Northern Ireland, a comparable regulatory framework is not in place at the time of writing. The relevant MCA provisions have not been brought into force, and there is no relevant statutory Code of Practice. Consequently, the Supreme Court's reasoning is not directly applicable. Hence, in certain cases where a declaratory application would not be brought in England and Wales, it could be advisable to bring such an application in Northern Ireland.

ECHR Articles 2 and 3 and the declaratory jurisdiction[62]

Where ECHR Article 2 is engaged, the State must ensure that an adequate regulatory framework is in place (the systems duty), and as relevant adequate measures taken to protect life (the operational duty).[63] Also, the State has an obligation under Article 3 to take positive steps to prevent serious breaches of personal integrity amounting to inhuman and degrading treatment.[64] In Northern Ireland, given the current paucity of legislative provision and guidance, a failure to obtain judicial approval for proposed care and/or treatment may result in a breach of the HRA and the ECHR. As discussed above, prior to the implementation of the

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[61] Commentary on the case is to be found on the 39 Essex Court website at https://www.39essex.com/information-hub/case/nhs-trust-and-others-respondents-v-y-his-litigation-friend-official-solicitor wherein it states: *"Whilst the judgment is undoubtedly welcome at many levels, the handing back of this responsibility does carry with it the real need to ensure that the MCA is understood and applied with care and with attention to its spirit, as well as its letter, in the clinical context."*

[62] Article 2 – Right to life - *(1)Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law. (2) Deprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force which is no more than absolutely necessary: (a) in defence of any person from unlawful violence; (b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained; (c) in action lawfully taken for the purpose of quelling a riot or insurrection."* Article 3 – Freedom from torture - *No one shall be subjected to torture or to inhuman or degrading treatment or punishment.*

[63] See *R (on the application of Maguire) Appellant v His Majesty's Senior Coroner for Blackpool and Fylde and another (Respondents)* [2023] UKSC 20; paragraphs 49-56; *A Health and Social Care Trust v JU* [2023] NI Fam 12.

[64] See *A v United Kingdom* [1999] 27 EHRR 611, *Z v United Kingdom* [2002] 34 EHRR 97 and *Pantea v Romania* [2005] 40 EHRR 627; see generally Lord Lester, Lord Pannick and J Herberg *Human Rights Law and Practice* (3rd edn, Lexis 2009) at para 4.3.20-21.

DOL provisions, the declaratory jurisdiction was utilised to meet the requirements of ECHR Article 5 in the cases of PT and NS. Similarly, the exercise of the declaratory jurisdiction could be utilised to ensure positive obligations arising under articles 2 and 3 are identified and met. Moreover, the courts can play an enhanced role in appropriate cases, by declaring the common law, and thereby supplementing the law, to ensure an adequate regulatory framework is in place which complies with the systems duty under Article 2. The courts also may play a vital role in clarifying the steps that a relevant authority must take to comply with the Article 2 operational duty or its Article 3 obligations.

The import of ECHR article 8 in social care decision-making[65]

In the field of social care, a proposed intervention potentially engaging a person's Article 8 rights may require judicial sanction.[66] The case of *Neary and another v Hillingdon London Borough Council* involved a disabled adult, Steven Neary, who lived with his father Michael Neary. On 30 December 2009, following Mr Neary requesting temporary respite care, Steven was placed into the care of the local authority. The next day, he was transferred to a support unit.[67] However, contrary to the wishes of Steven and his father (both objecting from early January 2010), he was kept in local authority care until December 2010, without a court order. From April to December 2010 the Council relied on the deprivation of liberty provisions under the 2005 Act, to authorise his placement in the support unit. In October 2010, following a recommendation by a Best Interests Assessor, the local authority lodged an application with the Court of Protection. Peter Jackson J found that the Council had breached ECHR Articles 5 and 8.

In his judgment, Peter Jackson J stated as follows:

> *[19] The environment in which local authorities operate in the field of adult care is not legally coherent and bristles with intricate regulation. An overview of the landscape is to be found the judgment of Munby LJ in Re A (a child) (deprivation of liberty), Re C (vulnerable adult) (deprivation of liberty) [2010] EWHC 978 (Fam) 1363 at [63]–[69], [2010] 2 FLR 1363 at [63]–[69].*

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[65] Article 8 – Right to respect for private and family life - (*1) Everyone has the right to respect for his private and family life, his home and his correspondence. (2) There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety, or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.*

[66] A person's ECHR Article 8 rights can be engaged in many different ways, e.g. through an interference with privacy, correspondence, family rights or a person's physical or mental integrity. This article focuses upon the transfer of a patient from home into residential care.

[67] [2011] 4 All ER 584.

> *[20] Nonetheless, two central principles are clear.*
>
> *[21] The first is that it is undoubtedly lawful for actions to be taken by families and local authorities, acting together on the basis of a careful assessment of the best interests of incapacitated persons. The vast majority of arrangements are made in this way and involve no breach of the rights of the persons concerned. Where there is a deprivation of liberty (referred to as a "DOL") a specific statutory code exists to provide safeguards.*
>
> *[22] T*he second central principle concerns cases of disagreement. The ordinary powers of a local authority are limited to investigating, providing support services, and where appropriate referring the matter to the Court. If a local authority seeks to regulate, control, compel, restrain, confine or coerce it must, except in an emergency, point to specific statutory authority for what it is doing or else obtain the appropriate sanction of the court: again see Re A *and the authorities referred to therein.*
>
> *[23] The origin of this basic legal principle is to be found in an era long before the invention of local authorities as we know them. Chapter 29 of Magna Carta 1297 provides that:*
>
> > *"No freeman shall be taken or imprisoned, or disseised of his freehold, or liberties, or free customs, or outlawed, or exiled, or any otherwise destroyed; nor will we not pass upon him, nor condemn him, but by lawful judgment of his peers, or by the law of the land."*
>
> *[24] As the Court of Appeal has recently said, this right to freedom is a fundamental constitutional right:* TTM v Hackney LBC *[2011] EWCA Civ 4. It will certainly not lose its importance in the field of adult social care, with an ageing population increasing the responsibilities of families and the State. Decisions about incapacitated people must always be determined by their best interests, but the starting point is their right to respect for their family life where it exists. The burden is always on the State to show that an incapacitated person's welfare cannot be sustained by living with and being looked after by his or her family, with or without outside support.*

Subsequently, in *Re AG*, Sir James Munby P asserted that *"Local authorities must seek and obtain appropriate judicial authority before moving an incapacitous adult from their home into other accommodation. Local authorities themselves do not have the power to do this"*'[68] However, that raises an issue as to whether a court order is needed in every such case.

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[68] [2015] EWCOP 78 paragraph 56.

Alex Ruck Keene contends that a court order is not required where the proposed move does not interfere with the Article 8 autonomy rights of the person concerned. He explains as follows:

> *I would, though, not have sought to uphold the blanket statement by the President. In other words, I would not have sought to argue – not least because I suspect very strongly that he could not have intended to hold – that it is never possible without judicial sanction to move a person from their own home to a care home (or from a hospital to a care home on discharge, another situation in which there are no obvious statutory powers). Rather, I would argue that it will depend on the degree to which the move in question represents an interference with the autonomy rights enjoyed by the person as an aspect of their rights under Art 8 ECHR (rights that are not lost simply because decision-making capacity is lost: see* A Local Authority v E *[2015] EWHC 1639 (COP) at para [124]). There will be some circumstances in which the interference with the individual's Art 8 rights will be such that it can only be by involving the Court of Protection that the decision-making process can be said to be sufficiently rigorous to meet the necessary procedural requirements. This most obviously the case where the person concerned is objecting to the move, but I would not limit it solely to such cases. In such cases, a public authority that seeks to proceed without seeking the involvement of the court, will not be complying with its obligations under s 6 of the HRA 1998 to act compatibly with the ECHR. So it is possible to spell out a form of duty to go to court, albeit by an indirect route.*
>
> *But those circumstances will not arise in every case (nor, indeed, would they arise in every case involving serious medical treatment). And in such cases, it seems to me – and I would be so bold as to suggest that the President would agree – that the sanction of the court is not required, and a properly MCA-compliant assessment of capacity and best interests will suffice to ensure that the public authority in question can discharge its powers confident in the knowledge that it can benefit from the defence under s 5 of the MCA 2005. Put another way, true compliance with s 5 of the MCA 2005 would constitute a sufficiently rigorous decision-making process to satisfy the implicit procedural requirements of Art 8 ECHR.*[69]

In Northern Ireland, Health and Social Care Trusts have sought the permission of the court to transfer patients into residential care in a number of cases.[70]

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[69] See Alex Ruck Keene, 'Powers, defences and the 'need' for judicial sanction' [2016] Elder Law Journal 244; and Alex Ruck Keene, 'Powers, defences and the 'need' for judicial sanction: an update' available on the 39 Essex Chambers website within the Mental Capacity Resource Centre at *https://www.mentalcapacitylawandpolicy.org.uk/wp-content/uploads/2019/09/Section-5-Article.pdf*

[70] *NS (Inherent Jurisdiction: patient: liberty: medical treatment)* [2016] NI Fam 9; *NS (No 2) (Enduring Power of Attorney: Inherent Jurisdiction)* [2017] NIFam 3; *In the matter of AK (Inherent Jurisdiction: Patient: Move to Residential Care: Contact)* [2021] NIFam 9; *Belfast Health and Social Care Trust v KL (the Patient) and ML and others* [2023] NIFam 3.

Two of the reported cases involved elderly persons and one involved a severely disabled young person. The proposed transfer of residence was opposed: in *NS* by the patient's son; in AK by the patient's mother and step-father; and, in KL by one of the patient's daughters. In all three cases, the declaratory relief sought was granted following an application by the relevant Trust and contested hearings before the court. In the most recent of the three cases, *Belfast Health and Social Care Trust v KL and others*, Rooney J stated:

> *[11] The relevant legal principles have been detailed by Keegan J in the matter of* AK (Inherent Jurisdiction: Patient: Moved to Residential Care: Contact) *[2021] NIFam 9. In the course of her judgment, Keegan J referred to the decision in* Hillingdon London Borough Council v Neary *[2010] 122 BLMR which is authority for the proposition that declaratory relief is required regarding the question of whether or not it is in the best interests of the person to be in residential care at all. As stated by the court, Article 8 of the European Convention on Human Rights ('ECHR') is engaged. In* Hillingdon*, the court also said at paragraph 33:*
>
> > *"Significant welfare issues that cannot be resolved by discussion should be placed before the Court of Protection, where decisions can be taken as a matter of urgency where necessary. The DOL scheme is an important safeguard against arbitrary detention. Where stringent conditions are met, it allows a managing authority to deprive a person of liberty at a particular place. It is not to be used by a local authority as a means of getting its own way on the question of whether it is in the person's best interests to be in the place at all. Using the DOL regime in that way turns the spirit of the Mental Capacity Act 2005 on its head, with a code designed to protect the liberty of vulnerable people being used instead as an instrument of confinement. In this case, far from being a safeguard, the way in which the DOL process was used masked the real deprivation of liberty, which was the refusal to allow Steven to go home."*[71]

In Northern Ireland, where a public authority proposes moving an incapacitous person from their home into residential care, a declaratory order is not required in every case. For example, if there is consensus amongst the interested parties (including the multi- disciplinary team and family) that residential care is in the patient's best interests; the patient

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[71] [2023] NIFam 3.

is not resisting the proposed move; and, the move does not otherwise interfere with the ECHR Article 8 rights of the patient, a declaratory order is not required.[72] However, where for example, the patient is refusing to be transferred into a proposed care facility or close relatives are contesting a proposed transfer, a declaratory order may be required to ensure compliance with the HRA and the ECHR.[73]

Conclusion

The inherent jurisdiction continues to play a central role in adult health and social care decision-making in Northern Ireland. A Trust must give careful consideration to the lodgement of a declaratory application, if a proposed intervention would significantly impact upon the life of an individual, and doubt or disagreement exists about either the capacity of the patient to consent or whether the proposed care and/or treatment would be in the patient's best interests. There are sound policy reasons for such an approach: the exercise of the declaratory jurisdiction safeguards the interests of the patient and the practitioners involved, and brings consistency and certainty to health and social care law and practice. Judicial sanction may be required where the proposed intervention engages the ECHR, e.g. where:

(a) Article 2 is engaged and an order is required to ensure an adequate regulatory framework is in place;
(b) Article 8 is engaged in circumstances where the proposed transfer of an adult from home into residential care is resisted by the patient and/or opposed by a close relative or other sufficiently interested party, and an order would ensure compliance with Article 8.

Future developments

In Northern Ireland, by reason of the MCA's partial implementation, the Health and Social Care Trusts remain significantly reliant on the inherent jurisdiction of the High Court, to ensure that care and treatment accords with all relevant legal requirements. Looking ahead, implementation of Part VI of the MCA will bring into force the new statutory jurisdiction of the High Court, effectively establishing a Court of Protection in Northern Ireland. That will modernise the law in Northern Ireland, bringing it more closely in line with the position in England and Wales. Moreover, the future

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[72] If ECHR Article 5 is engaged, the MCA's DOL framework may be applicable. See the MCA: section 9, sections 24-27 and schedule 1.

[73] The failure to seek a court order could also infringe the ECHR Article 6 Fair trial rights of a patient or other interested party.

implementation of the MCA in full will be accompanied by guidance in the form of Codes of Practice.[74]

In the meantime, however, a pressing need exists for guidance given the complexity and uncertainty arising under the prevailing law.[75] User-friendly guidance could assist Judges and others who are involved in health and social care decision-making for incapacitous and vulnerable adults.[76] It could be in the form of a compendium, specifying key principles, including autonomy, capacity, best interests and positive obligations arising under the ECHR. It also could outline relevant factors to consider when those principles are applicable, e.g. the views of the patient; the perspectives of close relatives and friends; the opinion of relevant experts; and, any recommendations made by the Official Solicitor or other public authorities.[77] Importantly, it would help fill the existing lacuna under Northern Ireland law, due to the absence of applicable legislation and codes of practice. That would provide some much needed clarity for both the courts and practitioners working in this field of law.

Michael Potter[78]

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[74] See the statutory duties placed on the Department of Health under section 288 of the MCA in respect of the issuance of Codes of Practice.

[75] Since in Northern Ireland it is the common law that applies rather than bespoke legislative provision, arguably there is an even greater need for a code of practice or other form of guidance to assist Judges and others in their decision making.

[76] This would accord with the principle-based approach which underpins the Mental Capacity Act (NI) 2016 – see Part I of the Act. See generally the Mental Capacity Act 2005 Code of Practice published in 2007.

[77] The Public Prosecution Service for Northern Ireland *Policy on Prosecuting the Offence of Assisted Suicide* is an example of how guidance can be usefully constructed to assist those involved in decision-making. This is a project the Department of Health might usefully consider.ed in decision-making. This is a project the Department of Health might usefully consider.

[78] I acknowledge and thank Gordon Anthony; Helen Bergin Solicitor Consultant MCA Team Directorate of Legal Services; Brice Dickson; Julie Knight, Solicitor; Paul McKeown, Associate Professor of Law, City, University of London; Eileen Regan, Northern Ireland Assembly; and, Alex Ruck Keene KC (Hon), 39 Essex Chambers, for their insightful comments on previous drafts. I am responsible for any errors.

Capacity – Navigating through your Regulatory Obligations

John Mackell, BL*

Introduction

As practitioners are all too aware, the legal profession is a highly regulated arena within which to operate. A clear regulatory framework will seek to maintain professional standards, protect members of the public along with the reputation of the profession and ensure, in so far as possible, a consistency of approach in the effective delivery of professional services.
Within the adopted regulatory framework there are continuous challenges to be aware of and ultimately addressed. The regulatory impact of service delivery was vividly illustrated in a decision of the Solicitors Disciplinary Tribunal of England and Wales ('SDTEW') recently. In the published decision of *SRA v Sonia Hunjan*[1] the solicitor faced allegations relating to work completed as part of property transactions. One of the complaints alleged that between June and July 2017 the solicitor facilitated the sale of a property in circumstances where she was on notice that her client, the owner of the property, lacked the relevant mental capacity to make decisions about the sale of the property. It was alleged the solicitor failed to undertake adequate enquiries as to her client's capacity.

Emails provided to the solicitor by the local authority raised doubts as to the capacity of the client to make decisions about her property and affairs, including decisions about the sale of her home. Given the content of the emails the SDTEW determined that the solicitor ought to have made enquiries about the client's mental capacity before proceeding with the sale. Such enquiries, according to the SDTEW could have been raised with the client, the client's sons, the local authority or the client's care home. No further enquiries were made, and the sale of the property proceeded.

The regulatory complaints were resolved at SDTEW through a proposed agreed outcome where the solicitor paid a fine in the sum of £15,000. It was also agreed that restrictions be placed on the solicitor's practice for

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[*] Former Head of Professional Conduct at the LSNI and Legal Advisor to the Commissioner for Older People of Northern Ireland.

[1] Case No. 12291-2021.

an indefinite period. Furthermore, the solicitor agreed to pay the Solicitors Regulation Authority's ('SRA') costs in the sum of £23,650.

The actions of the solicitor were deemed to have breached SRA principles, namely the requirement to act with honesty and in a way that encourages equality, diversity and inclusion. Evidently, the inaction of the solicitor on this occasion to complete adequate enquiries and to follow obvious red flags left her exposed to the risk of regulatory sanction, financial detriment and reputational damage.

The question for practitioners to ponder is whether such regulatory action may be taken by the Law Society of Northern Ireland ('LSNI') if similar facts were exhibited in this jurisdiction.

Capacity

A useful starting point to consider is exactly what is meant by a 'lack of capacity'. The Mental Capacity Act (Northern Ireland) Act 2016 ('the 2106 Act') helpfully describes at section 3(1), that a person aged 16 or over lacks capacity in relation to a matter if, at the material time, '*the person is unable to make a decision for himself or herself about the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain*'. Guidance available from the Law Society of England and Wales provides helpful practical considerations when dealing with a client where capacity may be an issue and illustrates the breadth of decisions that may be impacted where a client's capacity is in doubt.

> 'Mental capacity is the ability to make a particular decision. This includes both day-to-day decisions and more significant decisions that may have legal consequences, such as:
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> - buying, selling, mortgaging or charging a property;
> - entering into a contract;
> - making a will;
> - making a lasting power of attorney;
> - making a gift;
> - bringing or defending legal proceedings;
> - seeking a divorce.'[2]

The Principles within the 2016 Act make it clear that a person is not to be treated as lacking capacity unless it is established that the person lacks

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[2] https://www.lawsociety.org.uk/topics/client-care/working-with-clients-who-may-lack-mental-capacity

capacity in relation to the matter within the meaning given by section 3 above. As such, there is a natural professional obligation placed on a practitioner to undertake reasonable enquiries to determine whether their client has and maintains 'capacity'. This is all the more important where concerns are raised in that regard.

The challenge in everyday practice is to consider when and in what guise evidence is required to confirm capacity or to assuage concerns that there may be a lack of capacity. A useful barometer for capacity considerations in civil proceedings was set out in the judgment of *Chadwick LJ in Masterman-Lister v Brutton & Co*[3] whereby the presiding Judge advised that the question at hand was whether the client was:

> *'capable of understanding, with the assistance of such proper explanation (in broad terms and simple language) from legal advisers and other experts as the case may require, the matters on which their consent or decision was likely to be necessary in the course of those proceedings.'*

The requirement to assess the ability of a client to make decisions affecting their case may be assisted with the statutory criteria set out at section 4 of the 2016 Act. The approach requires an assessment of whether a person is unable to make decisions with consideration of the following descriptors:

(a) is not able to understand the information relevant to the decision;

(b) is not able to retain that information for the time required to make the decision;

(c) is not able to appreciate the relevance of that information and to use and weigh that information as part of the process of making the decision; or

(d) is not able to communicate his or her decision (whether by talking, using sign language or any other means);

The LSNI provides template letters to assist practitioners instruct a medical or psychological professional to undertake a medical assessment in a number of practice areas: making a gift, making an enduring power of attorney and making a will. The letter of instruction reminds the engaged professional that the standard of proof for any assessment of capacity is based on the balance of probabilities. The letters are available to download

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[3] *Mastrerman-Lister v Brutton & Co* [2003] All ER 162.

from the LSNI's website[4]. Given the experience of the *Hunjan* case it is always worth taking the time to make reasonable enquiries to assess capacity and to record this information on the file, not only for the ongoing substantive case or proceedings but also to reduce the likelihood of adverse regulatory action.

Complaints

The LSNI may investigate complaints relating to service and professional conduct. A client complaint may only arise from the solicitor's own client with a definition of 'client' provided by art. 3(2) Solicitors (NI) Order 1976 ('1976 Order'). The client includes, in relation to non-contentious business, any person who,

> *'as a principal or on behalf of another or as a trustee or executor or in any other capacity, has power, express or implied, to retain or employ, and retains or employs or is about to retain or employ, a solicitor, and any person liable to pay to a solicitor any costs for his services.'*

Solicitors ought to be aware therefore of where a client complaint may derive. As can be seen from the definition at art. 3(2) an executor of a Will has authority to raise a client complaint along with any person liable to pay a solicitor any costs for their services. In practical terms, a solicitor may find that a complaint is raised about their service delivery from someone they may not ordinarily consider as their client. This is particularly apt where there are issues relating to the 'capacity' of a particular person.

In relation to contentious business (generally business begun by the issue of proceedings), the client includes any person who as a principal or on behalf of another person retains or employs, or is about to retain or employ, a solicitor, and any person who is or may be liable to pay a solicitor's costs.

The current regime for dealing with client complaints is set out within the Solicitors (Client Communication) Practice Regulations 2008. If a solicitor receives a complaint from a client querying the service provided to a person where there are doubts about capacity, they are obliged to acknowledge the complaint within seven days and provide a substantive response within 28 days. The complaint must be raised within six months of the conclusion of the client's business or within six months of discovering the difficulty, whichever is later. If the complainant is dissatisfied with the in-house conclusion, they must complain to the LSNI within six months of conclusion of the in-house procedure. At present client complaints received are dealt

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[4] https://www.lawsoc-ni.org/new-precedent-letters-of-instruction-for-capacity-assessments-1

with by the Society's Client Complaints Committee. That Committee has the authority, pursuant to art. 41B of the 1976 Order to uplift files where they are satisfied that it is necessary to do so for the purpose of investigating any complaint made to the LSNI relating to the quality of any professional services provided by a solicitor.

In addition to a client complaint, the LSNI may receive a complaint alleging professional misconduct in so far as the dealings of a solicitor are concerned. Such complaints are investigated and adjudicated upon by the Society's Professional Conduct Committee. The judicial review case of *Kearney v Law Society of Northern Ireland*[5] at paragraph 7 gives an insightful overview of the regulatory arrangements followed by the Professional Conduct Committee:

> '7(vi) *The Council has appointed a Professional Conduct Committee ("PCC") whose powers include the power to investigate or make complaints in respect of the regulation of the professional practice, conduct and discipline of solicitors as set out in Part III of the 1976 Order and to discharge the Society's statutory duties in this regard.*
>
> *(vii) The Council has issued a handbook for the guidance of members of committees, and which provides an Appendix for the express delegation of its powers in relation to conduct and discipline to the PCC. The handbook further provides, at Appendix D, matters to be taken into account when exercising its powers which provides for a two-fold test in respect of referrals to the Tribunal:*
>
> *(1) by deciding whether there is sufficient evidence to bring disciplinary proceedings; and*
>
> *(2) if so whether within the objectives of the Society, such proceedings should be brought, or some alternative action taken.*
>
> *Appendix B further provides a list of non-exhaustive factors which might be taken into account when considering the public interest considerations which fall to be considered in the second limb of the test.'*

There are a number of factors to be considered when assessing whether it is in the public interest to bring disciplinary proceedings against a solicitor. Those factors, which are non-exhaustive, include the following:

- the seriousness of the conduct complained of;
- whether there is a risk of repetition;

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[4] *Kearney v Law Society of Northern Ireland* [2021] NIQB 29.

- whether the conduct has been remedied or is capable of being remedied;
- whether the solicitor presents a risk to members of the public;
- whether the need to uphold proper professional standards and public confidence in the individual and the profession would be undermined if proceedings were not brought;
- whether a lesser sanction such as a letter or advice or caution would be appropriate;
- whether the respondent has relevant previous history of findings against him or her;
- other personal circumstances of the respondent.

A referral to the Solicitors Disciplinary Tribunal ('SDT') is not, of itself, an adjudication on the standard of work exhibited in a particular matter. It is a decision that there is sufficient evidence for a referral to be made to the SDT. Ultimately, the SDT will make any final decision as to whether misconduct is found.

Needless to say, one of the factors relevant to whether a complaint is referred to the Tribunal relates to the importance of maintaining proper professional standards and public confidence in the profession. Clients who lack or may lack capacity are likely to be seen as a vulnerable cohort and any action or omission which leads to their detriment has the potential to impact the reputation of the profession.

Given the framework within which the LSNI operates is there potential for a solicitor to be referred to the SDT where a complaint is raised that they have failed to make reasonable enquiries as to the capacity of a client? The answer to that query rests within the regulations which govern the professional conduct of solicitors in this jurisdiction.

Solicitors (Northern Ireland) Order 1976

The 1976 Order provides the Law Society of Northern Ireland with the authority to make referrals to the Solicitors Disciplinary Tribunal. Article 44(i)(e) provides that complaints by the Law Society that a solicitor has been guilty of -

(1) professional misconduct or conduct tending to bring the profession into disrepute; or

(2) has contravened a provision of the 1976 Order or any regulation made thereunder;

shall be made to and heard by the Tribunal.

Solicitors Practice Regulations 1987

The Solicitors Practice Regulations 1987 ('the 1987 Regulations') are essential reading for any solicitor or prospective solicitor operating in Northern Ireland. Regulation 8(1) sets out a straightforward premise whereby *'a solicitor shall at all times carry out his work and conduct his practice to the highest professional standards'.*

Furthermore, regulation 12 directs that a solicitor shall not 'in any circumstances take any action which compromises or impairs, or is likely to compromise or impair:

> (a) his integrity;
>
> (b) his duty to act in the best interests of the client;
>
> (c) the good repute of the solicitor or of solicitors in general;
>
> (d) his proper standard of work.'

The case of *Bolton v Law Society*[6] reminds practitioners:

> *'that any solicitor who is shown to have discharged his professional duties with anything less than complete integrity, probity and trustworthiness must expect severe sanctions to be imposed upon him by the Solicitors Disciplinary Tribunal.'*

If acting for a client where doubts are raised about their capacity and such doubts are set out in a clear and unambiguous manner a solicitor should heed the warning from *Bolton* before proceeding further.

Similarly, it is fair to say that the reputation of the profession may not always be to the forefront of a practitioner's mind when completing work with the pressures of time, managing client expectations and advancing proceedings/transactions with a multitude of operational challenges. However, what *Bolton* makes clear, to maintain the reputation of the legal profession and sustain public confidence in the integrity of the profession *'it is often necessary that those guilty of serious lapses are not only expelled but denied readmission.... A profession's most valuable asset is its collective reputation and the confidence which that inspires'.*

It ought to be clear from the above that if a complaint is raised that a solicitor has failed to undertake adequate enquiries as to the capacity of a client there is potential for serious regulatory repercussions. Failing to

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[6] *Bolton v Law Society* [1994] 2 All ER 486.

make those enquiries, as in the case of *Hunjan*, may be considered a failure to act in the best interests of the client as well as potentially compromising the good repute of the solicitor and the wider profession in general. Where such professional failings are identified, a solicitor is left exposed to the potential of regulatory action. The failure to make use of available template letters from the Law Society to assist instruct third party experts for the assessment of capacity may leave a practitioner open to a complaint that they have not dealt adequately with the issue of capacity in a particular case.

It is worth considering the regulatory implications where a professional misconduct complaint is referred to the Tribunal.

The Solicitors Disciplinary Tribunal

The SDT is established under art. 43 of the 1976 Order. The SDT comprises solicitor members of not less than 10 years standing and lay members who are neither solicitors nor members of the Bar.

Where the SDT upholds a complaint of professional misconduct, they have wide ranging powers of sanction. Those powers of sanction include, as set out at art. 51, the authority to admonish a solicitor, a fine up to the sum of £3000, to restrict a solicitor from practising on their own account along with the power to suspend a solicitor as well as the authority to strike a solicitor's name from the roll of solicitors. The Tribunal may also direct a solicitor to pay the costs of the proceedings. Evidently, the repercussions for any solicitor where a professional misconduct complaint is found are significant and serious.

The publication of any Order arising from the SDT or any summary of such an Order shall be deemed to be absolutely privileged. A summary of outcomes from the SDT is published within the LSNI's Annual Report. The summary is generally published in anonymised form although where a solicitor is struck off or suspended the summary may name the solicitor involved. Separately, the LSNI ordinarily publicise the suspension or striking off of a solicitor in the Belfast Gazette and through in-house membership communications.

Conclusion

Solicitors are required to meet their regulatory obligations as per the 1987 Regulations. There is an onus on a solicitor to take reasonable steps to ensure that they maintain the highest professional standards.

The case of *Hunjan* acts as a timely reminder that the onus is on the solicitor to make reasonable and adequate enquiries to ensure that a client has capacity particularly where such concerns are raised with the solicitor during the course of proceedings or during the period of instruction. Failing to heed those warnings or failing to seek an assessment may leave the practitioner vulnerable to complaints either of a service nature or relating to their professional misconduct.

The clear regulatory onus placed on a solicitor in Northern Ireland is that they will not take any action that will compromise or impair their duty to act in the best interest of the client or the good repute of the solicitor or of solicitors in general. Can it be said with confidence that a failure to seek an assessment of capacity where concerns are raised or red flags exhibited will not adversely impact the reputation of the profession? Can such a failure to act reasonably be considered to be in the client's best interests?

The risk for practitioners is reputational, financial and ultimately regulatory. When operating within a regulatory framework it is better not to leave things to chance. When dealing with clients where capacity raises its head treat the matter seriously, take appropriate action and ultimately protect yourself from potential regulatory harm.

The Solicitor Executor: Some Reflections from Practice and Some Pitfalls

Part Two

Preparing the Will: Taking Instructions and Drafting Considerations

Sheena Grattan BL, TEP

Introduction

This is the second instalment of a three-part series which was inspired by the recollections of Northern Ireland solicitors of their most 'memorable' executorships. The imaginative idea of canvassing solicitors for real-life illustrations to inform an article for the *Journal of Elder Law and Capacity* was that of the late Heather Semple. Heather, latterly Head of Library and Information Services at the Law Society of Northern Ireland and Editor of this Journal, died after a short illness on 9th March 2022. The first part of this series,[1] published in the autumn of 2021 and when Heather was in rude health, concluded with a request for any reader with additional anecdotes on the subject-matter to email these to Heather with a view to including them in the next instalment. It is a poignant reminder to all of us as to how a matter of weeks can bring such fundamental changes to our lives.

In this second part of the series we look briefly at the issues that solicitors should be considering with their clients when those clients have expressed the wish that the solicitor should be appointed as an executor. The final instalment of the series will focus on issues which increasingly arise for the solicitor-executor in the early post-death phase, including renunciation (whether at the initiation of the solicitor or on foot of a 'request' from the

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[1] Sheena Grattan, 'The Solicitor Executor: Some Reflections from Practice and Some Pitfalls: Part One' [Winter 2020] JELC 54.

other executor(s) or the family), dealing with *Larke v Nugus*[2] requests and potential conflicts of interest.

Taking instructions and advising the testator

If one were to ask experienced probate solicitors to compile a list of 'top ten mistakes' when preparing wills, testators (and their advisers) not giving sufficient care to the choice of executors would likely feature on every list. Choosing the executor(s) is a decision which a testator should make with extreme care and this is a point which is worth repeating frequently. It is the writer's firm view that a significant number of the 'executor disputes'[3] which clog up the court lists of the Probate Master (at a rate which shows no sign of abating), could have been prevented if more care had been given to the choice of executor.

It is trite law that a testator may choose as his executor(s) a trust corporation,[4] a solicitor or other professional, or non-professionals such as family and friends – or any combination of these. What is best in any situation will depend on all of the circumstances of the case and the testator is entitled to be advised of the various "pros and cons" so as to make an informed choice, particularly where a professional executor is being instructed.

If the testator chooses not to appoint a family member – perhaps being all too aware of existing friction between the intended beneficiaries – the testator's solicitor is often the next in line, with his or her accountant being the other possible choice. If family members who are also beneficiaries are to be appointed as executors, and the will confers dispositive discretion upon the executors, the testator has the choice of including either an unlimited conflict of interests clause (whereby fiduciaries are authorised to exercise their discretions notwithstanding that they benefit personally) or a managed conflicts of interest clause, whereby there is a requirement on each occasion for there to be an 'Independent Executor' (as defined in the instrument).[5] Again, the testator's solicitor is often the most obvious and convenient choice as the non-interested fiduciary.

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[2] *Larke v Nugus* [2000] WTLR 1033

[3] Executor dispute' is used here to cover both disputes between executors and also between executors and beneficiaries.

[4] A 'trust corporation' is entitled to act as executor only if it satisfies the qualifying criteria set out in article 9 of the Administration of Estates (NI) Order 1979.

[5] The Standard Administrative Provisions of the Society of Trust and Estate Practitioners (STEP) adopt a managed conflicts of interest clause which requires an 'independent Trustee' (see, e.g., as regards Northern Ireland, Clause 9 of the STEP Standard Provisions (Northern Ireland Version, First Edition). Note that the Independent Trustee does not have to be a professional trustee.

The myth of the greedy solicitor executor

A recurrent theme in the press, particularly in the 'money' supplements of the broadsheets, is of professional will-drafters (including but not restricted to solicitors) generating additional fees by ensuring that they are appointed as executors. Often the rhetoric is of 'solicitors appointing themselves',[6] with few journalists taking the time to communicate accurately that solicitors preparing wills for clients take their clients' instructions and draft accordingly, or that clients can appoint whomever they wish to act as their executor, with the solicitor's role being to make sure that they have explained all of the options in order that the client can make an informed decision.

Much of the debate was precipitated by research conducted by the Office of Fair Trading (OFT) in 2010[7]. The OFT found that 43 per cent of participants who used the services of a professional will-drafter (no distinction was made between solicitors and others) appointed that will-drafter as executor. Of these almost a quarter (23 per cent) said that they had not been made aware of the likely charges.

Lessons from England and Wales – practice note on appointment of a professional executor

The ensuing collaboration between the OFT and the Solicitors Regulation Authority (SRA) resulted in the Law Society for England and Wales issuing a practice note in 2011 as to what its members should tell testators before that solicitor or a member of his or her firm is appointed as an executor in a will. There have been two further iterations (making only minor amendments), with the most recent having been issued on 22nd May 2023[8].

No equivalent edict has issued from the Law Society of Northern Ireland, but the English guidance is, as always, instructive as to prudent professional practice. It is submitted that the practice note contains nothing that a good, respectable solicitor will not have been doing already. The key theme running throughout is the duty of the solicitor to act in the best interests of the client and to ensure that the client is fully informed of all of the facts before making any decision.

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[6] For one illustration among many see Laura Whateley, the Times, November 2017, who refers to the 'guidelines for solicitors who wish to appoint themselves or their firm as executors in a will they are drafting.'

[7] Understanding the consumer experience of will-writing services, *https://www.sra.org.uk/globalassets/documents/consumer-reports/lsb-will-writing-reports.pdf?version=49675e*

[8] Appointment of a Professional Executor, *https://www.lawsociety.org.uk/topics/private-client/appointment-of-a-professional-executor*

In particular, the solicitor should inform the client that such appointment is not compulsory and that an executor can be (a) a professional – such as the solicitor or their firm – or (b) a lay person such as a family member. The solicitor should also provide an indication of the likely costs, making a distinction between (a) carrying out the administration of the estate (b) acting as an executor and (c) acting as a trustee arising from any continuing trusteeship. Information about fees and services should be clear and "up front", including the fact that fees may change in the future. The objective is transparency rather than a precise final figure – in essence, there should be no nasty surprises for the ultimate beneficiaries of the estate in due course.[9] The advice should, as a minimum, be recorded in writing within the attendance note but also preferably communicated with the testator.

Recording the testator's reasons

As noted in the Introduction, the question of whether a solicitor who has been appointed by a testator as an executor should, in due course, accept office or choose to renounce will be revisited in the final article of this series. In the writer's experience, professional executors are increasingly put under pressure to renounce by family members (often the residuary beneficiaries), a request which is invariably motivated by the hope of reducing legal costs (even if this is not the reason which is being articulated). Suffice to note at this juncture that the will-drafter's attendance note should also, if possible, record the testator's reasons for wishing to appoint the solicitor as executor, particularly if alternatives have been considered and rejected by the client.

Drafting considerations

A sufficiently flexible appointment clause

Many solicitors remain content to be appointed personally as an executor, particularly where they have known a client for a number of years and the client has specifically requested this (which many longstanding clients will do). Of course, the obvious risk in appointing an individual solicitor as executor is that he or she may retire or die prior to the testator's death. On this point, it is essential for legal firms to maintain a comprehensive register of wills, primarily so that at any given time they are immediately in a position to say what wills are being held and whether a will has been released (and when and to whom). Pertinent to the present subject-matter, they will also be in a position to know whether individual solicitors have

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[9] The obligations upon the sole solicitor-executor post-death in respect of proposed charging will be considered in the final instalment of this series.

been appointed as executor, so that the testator can be contacted in the event of the death or retirement of the solicitor in question.

One solution, of course, is to appoint "the firm" of solicitors, but as a partnership has no legal identity the appointment has to be of the individual partners. The difficulty is then that the partners can be expected to change from time to time. If the will is silent on the matter, an appointment of the partners in a particular firm means the partners at the date of the execution of the will.[10] Therefore, it has to be expressly provided in the will that it is the partners at the date of death who are being appointed.

More generally, the objective of the will-drafter is also to find a form of wording which provides for a number of contingencies including changes of personnel, a change of name or an amalgamation of the firm[11]. In the 1970s the following wording was approved in *Re Horgan*[12] by Latey J:

> *'I appoint the partners at the date of my death in the firm of [x] of [x] or the firm which at that date has succeeded to and carries on its practice to be executors and trustees of this my will (and I express the wish that two and only two of them shall prove my will and act initially in the trusts)'.*[13]

The increasing number of limited liability partnerships (LLPs) then raised complications as to how earlier appointments of the 'partners' of the former firm were to be regarded. This came to a head in 2003 when the Probate Registrar's Annual Conference decided that such appointments were ineffective. *Re Rogers*[14] was essentially a test case in which Lightman J, as he then was, held that the wishes of the testator should not be frustrated because the solicitors had altered the legal structure of the vehicle through which they carried on their practice, concluding that the profit-sharing members of the LLP were able to apply for the grant of probate on foot of the standard clause. However, the learned Judge appeared to make a distinction between salaried and unsalaried partners (the former seemingly not included within the scope of the standard clause).[15] The solution, which has been adopted by most standard precedent manuals, is for the will to define 'partner' as including a salaried partner.

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[10] This is the standard principle of construction when dealing with beneficiaries. In contrast, a will is construed as to property as at the date of death – enshrined in statute by article 17 of the Wills and Administration Proceedings (NI) Order 1994.

[11] For an illustration of a clause that was held insufficiently wide to cover the post-execution amalgamation of a firm, see *Estate of Yearwood* (1982) 30 SASR 169.

[12] *Re Hargan* [1971] P 50.

[13] Ibid at 61.

[14] *Re Rogers* [2006] 2 All ER 792.

[15] See Judith Morris, 'Re Rogers: A Solution for LLPs, but a Problem for Salaried Partners?' [2006] 5 PCB 303.

The Need for a Charging Clause is still alive and well

It is one of the cardinal principles of equity that those holding a fiduciary position such as trusteeship or executorship should not profit from it in the absence of express authorisation by the trust instrument or will. Like many principles of equity, however, this derived from an era when there existed a plethora of well-educated men who did not have to work for a living, and for whom acting as a trustee for family and friends provided a welcome distraction. But those days have long since gone. To quote James Kessler KC, *"[n]owadays no client of testamentary capacity will expect professional trustees to work for nothing."* [16]

All professionally drafted trusts and wills should contain a charging clause enabling a professional fiduciary to charge for his or her time. The focus of this article is the solicitor executor but if a will includes (or has the potential to include) on-going trusts, a charging clause should always be included even where professional trustees are not to be appointed initially. The replacement of trustees – by consent – is straightforward, but if for whatever reason a professional trustee is to be appointed as the new trustee, the absence of a charging clause may still necessitate an application to the court for authorisation of remuneration under section 41 of the Trustee Act (NI) 1958.

Changes were made to various aspects of the law governing charging clauses by the Trustee Act (NI) 2001 (hereafter 'the 2001 Act'). However, contrary to popular belief, these changes do not obviate the need to insert an express charging clause. They simply ameliorate the lot of the professional fiduciary by implying a charging clause in certain limited circumstances. Only trust corporations benefit from an automatic charging clause - section 29(1) of the 2001 Act confers the right to "reasonable remuneration" automatically on a trust corporation. A trustee who acts in a professional capacity[17] and who is not a trust corporation or a charitable trustee or a sole trustee is entitled to receive reasonable remuneration out of the trust funds for any services provided to or on behalf of the trust (including those capable of being performed by a lay trustee) only if each of the other trustees has agreed in writing that he may be remunerated for the services.[18]

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[16] J Kessler, A Berry, J Davies, M Ranson and C de Beneducci, *Drafting Trusts and Will Trusts* (15th edn, Sweet and Maxwell 2023). The writer has met many clients, all clearly of sound mind, who nonetheless expect professionals to work for nothing!

[17] The concept of acting in a professional capacity is defined in s 28(5) of the 2001 Act– and is much wider than solicitors.

[18] S 29(2) of the 2001 Act.

The 2001 Act makes two further changes to the law regarding express charging clauses. The traditional view was that a charging clause did not confer power to charge for work which a non-professional could have done unless this was expressly provided for in the instrument. In more modern times this view came to be disputed by some commentators, who suggested that there was nothing within modern jurisprudence which could justify charging clauses not being given their ordinary, natural meaning as with any other phrase in a will or trust instrument. Invariably, however, professional draftsmen were not prepared to take this chance with their livelihood and included a form of wording that left it in no doubt that work which a layperson could do was within its scope. Section 28(2) of the 2001 Act, which extends only to charging clauses in favour of trust corporations and trustees who are acting in a professional capacity, expressly provides that a charging clause is taken to include charges for layman's work unless there is a contrary intention.

The second change which the 2001 Act makes to express charging clauses in wills is that any payment made under such a clause will be considered as remuneration for services and not as a gift under a will.[19] This has implications both for the application of the witness-beneficiary rule and for the principles of abatement.

Prior to the enactment of the 2001 Act, if the executor (or his spouse) witnessed the will he was deprived of the benefit of the charging clause by virtue of article 8 of the Wills and Administration Proceedings (NI) Order 1994. Now the payment under a charging clause will no longer fail if a solicitor executor witnesses the will.

Prior to the Act, if there were insufficient assets in the estate to meet all the liabilities, the remuneration abated with the other pecuniary legacies, so it was important for the draftsman to expressly provide that the payment under the charging clause took priority over any other pecuniary legacies. Now any remuneration payment will be regarded as an administrative expense for the purposes of section 30(3) of the Administration of Estates Act (NI) 1955 and as such is payable in priority to pecuniary legacies. This can be particularly useful in insolvent estates as prior to the Act a professional executor may have been reluctant to extract a grant to such an estate for fear of not receiving payment under a charging clause.

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[19] S 28 of the 2001 Act.

The Statutory Duty of Care

It should be remembered that the 2001 Act, which expressly applies in relation to a personal representative administering an estate,[20] created a statutory duty of care,[21] which is essentially a duty to take such care and skill as is reasonable in the circumstances, incorporating both a subjective element and an objective element. The former imposes a higher standard on those professionals who hold themselves out as specialists in trust and estates work (such as members of STEP), while the latter focuses on the standards that can reasonably be expected of a member of the trustee's or executor's profession. It would seem that a solicitor who is appointed as an executor is expected to perform to the same standard as a reasonable solicitor, notwithstanding that he has no expertise whatsoever in trusts and probate work. This may have implications for those non-probate solicitors who agree to act as an executor for family or friends.[22]

Perhaps surprisingly the statutory duty of care only applies to the extent that it has not been expressly excluded or modified by the trust instrument.[23] In theory, therefore, a solicitor or other professional person who is requested to act as an executor (or trustee) by a client may ask for permission to insert a clause which excludes the duty of care. This leads us neatly on to the subject of exemption clauses more generally.

Exemption Clauses

It is submitted that professional executors who are charging for their services should not expect to benefit from a generous exemption clause which seeks to limit liability for negligence (or to exclude the statutory duty of care). However, it has been settled at all levels below the Supreme Court that even professional executors and trustees can exclude liability except for fraud – so long as the full scope of the clause has been drawn to the attention of the testator.[24]

In *Armitage v Nurse Millett LJ*[25], as he then was, observed that a *'full and fair explanation'* would be one which made it clear that the clause:

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[20] S 38(1).

[21] S 1 and 2.

[22] Note that it makes no difference that they act gratuitously. Neither the objective nor subjective components that make up s 1(1) of the 2001 Act is defined in relation to remuneration. A non-probate solicitor acting gratuitously for family or friends would probably be justified in modifying the duty of care so that no more is expected of him than of a lay trustee (see discussion below on exemption clauses).

[23] 2001 Act, Sch 1, para 7.

[24] *Bogg v Raper* (1998/1999) ITELR 267).

[25] *Armitage v Nurse* [1998] Ch 2

> *'…exempts the trustees from liability for loss or damage to the trust property no matter how indolent, imprudent, lacking in diligence, negligent or wilful he or she may have been, so long as he or she has not acted dishonestly'.*[26]

The Law Commission scrutinised exemption clauses after the enactment of the Trustee Act 2000,[27] in light of some disquiet expressed during the parliamentary process as to whether it was apposite for professional fiduciaries to exclude the statutory duty of care. Statutory intervention was not recommended,[28] but rather the trusts and estates industries were encouraged to adopt best practice. In response, STEP introduced a specific duty on members of the England and Wales Branch to disclose executor/trustee exemption clauses when drafting wills and trusts.[29] This duty, which is further restricted only to those instruments which are governed by the law of England and Wales, does not extend to members of the Northern Ireland branch of STEP. However, as with the English practice note in respect of the appointment of a solicitor-executor, the STEP Guidance does not create any responsibilities that should create a difficulty for the good solicitor. While acknowledging that some clients may require a more detailed explanation, the STEP Guidance states that it is in principle sufficient to write to the settlor/testator saying:

> *'I should also draw your attention to Clause [x]. This Clause provides that no executor of your will/trustee will be personally liable for any act by them in that capacity unless they are guilty of fraud. If you have any queries in relation to this, then please let me know.'*

In the course of her practice, the writer encountered a substantial number of widely drawn exemption clauses, including some from firms that would undoubtedly hold themselves out as specialising in wills and trusts. On occasions exemption clauses which purport to exempt solicitor-executors from liability for negligence have even been found in statutory wills. An audit trail of written advice and full disclosure of the implications was never in evidence. It is perhaps time for exemption clauses to be revisited by law reform bodies.

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[26] [1998] Ch 241 at 251.

[27] The English equivalent to the 2001 Act – the two enactments are broadly similar but with a few differences between the jurisdictions.

[28] Law Commission, Consultation Paper 171 (2003) and Final Report, Law Com 301 (July 2006).

[29] See Guidance Notes: STEP Practice Rule on Trustee Exemption Clauses found at *https://www.step.org/system/files/media/files/2020-03/STEPGuidanceNotes.pdf*

Funding Long-Term Residential Care

Barra Gorman, Chartered Financial Planner*

Introduction

Most people will be unaware of the potential costs of long-term residential care. In this article we will consider what can be done when it comes to advising families about care funding at the point of need and explore several potential funding options.

In many cases, a care funding adviser ('FA') will be dealing with an attorney acting on behalf of a relative. Whether it is the person needing care provision or their attorney, under Financial Conduct Authority ('FCA') guidance, such clients would be deemed a “vulnerable consumer” and especially susceptible to detriment. As such, the FA should work in line with their vulnerable client policy.

The vulnerability of consumers can be compounded by the fact that their appointed attorney may be under significant stress or emotional strain due to the health condition of a loved one who must enter care. This can make it difficult for them to fully understand the implications of the decisions they are making, or to advocate for their relative effectively.

In advance of considering financial planning options, initial discussions will seek to confirm:

- That all entitlements are being received;
- That the Health Trust/Local Authority has the correct interpretation of NHS continuing healthcare, the Mental Health (Northern Ireland) Order 1986 and the Mental Capacity Act (Northern Ireland) 2016 and the relevant charging regulations; and
- That legal advice is sought where necessary.

The care funding rules are new territory to most people. Taking responsibility for a relative’s wellbeing and the financing of their care can be daunting. With emotions running high, many 'what ifs' are asked. However, if the possibility of long-term residential care has been considered previously,

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and a resulting lifetime financial plan established, this can mitigate some of the uncertainty.

National awareness of self-funding social care

In recent years, there has been much talk in the media about pensions and retirement planning, which has helped to raise awareness of this topic among the wider public.

Yet when it comes to possible future care needs, most people have not made any plans at all for how they will pay for adult social care in older age. Given that the likelihood of needing some form of care is around one in four, it is worth asking why such a lack of planning for care costs persists.

In October 2018, a national public poll[1] by the Local Government Association shed some light on this when it revealed that nearly half of English adults (48%) surveyed said that they had little to no understanding of what the term 'social care' meant.

Alarmingly, 5% of people had never heard of the term 'social care' at all. Of those that had, 44% thought that social care was provided by the NHS, and 28% thought that it was free.

The future of care

i. Demographic trends

Expenditure on care in England is projected[2] by the Department of Health and Social Care to double from £10 billion in 2018 to reach £21.2 billion by 2038. Increases in private care expenditure are growing at a faster rate than social service spend. This trend will likely accelerate as care providers confront rising wage and energy costs.

The number of older people is growing. In the UK in 2019, there were 1.6 million people aged over 85. Age UK projections[3] indicate there will be 3.2 million people over 85 in the next 22 years, with one in five reaching their 100th birthday. Across the UK, the fastest demographic growth is the post-85 age cohort.

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[1] Majority of people unprepared for adult social care costs - Local Government Association, *https://www.local.gov.uk/about/news/majority-people-unprepared-adult-social-care-costs*

[2] The adult social care market in England, *https://www.nao.org.uk/wp-content/uploads/2021/03/The-adult-social-care-market-in-England.pdf*

[3] *https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/later_life_uk_factsheet.pdf*

ii. The means test

In contrast to the NHS, social care services operate on a means-tested basis, where individuals with lower savings or fewer assets qualify for publicly funded assistance. It's noteworthy that since the financial year 2010/11, central government has not adjusted the means test thresholds to accommodate inflation.[4]

The freezing of financial thresholds has excluded more people from publicly funded social care.

The upper bands have been frozen for 12 years in England and Northern Ireland at £23,250, while increasing to £32,750 in Scotland and £50,000 in Wales.

iii. Longevity and long-term care funding

With life expectancy increasing, people can expect to live in retirement for over 30 years.

Pension reforms have allowed more freedom and choice with pension funds. Retirees now make choices that they would not previously have been able to do, such as flexible access to pension funds via drawdown instead of opting for lifetime secure income via annuitisation.

Risks persist for many who eagerly embraced the additional flexibility created through pension reforms, as they may find in the future that they've run out of money.

Assuming the average residential care cost is around £30,000 per annum, if you enter care at 85 and live for a further five years, the cost will be around £150,000. If you live to 100, the total cost would be more than £450,000 in today's money, with no allowance for likely fee increases. This is based on an average of £30,000, and yet many will be spending significantly more than that for higher charging homes.

The issue of how long one individual will live for is difficult to assess, especially as we get older. If an individual has care needs that are costing up to £1,000 per week or more, and the care they are receiving is of good quality, with nutritious food and plenty of cognitive activity, it's impossible to know how long they'll live and what the eventual total cost will be.

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[4] *https://www.kingsfund.org.uk/sites/default/files/2020-05/Social%20care%20360%202020%20PDF_0.pdf*

Another problem in assessing life expectancy is that the longer we live, the longer we can be expected to live. Some statistics on life expectancy from the Office for National Statistics ('ONS') are available[5].

iv. Concerns on deprivation

Care funding advisers will likely face scenarios whereby intended actions could constitute deliberate deprivation.

Individuals requiring long term care typically bear the cost, unless they can demonstrate to their Health Trust/Local Authority that their financial resources are below the current means tested threshold of £23,250.

Care funding advisers must consider deprivation rules carefully. If a resident is found to have intentionally reduced their assets to qualify for state financial aid in covering care expenses, anti-avoidance measures may be invoked to recover assets from those who have benefited. Consequently, clients are advised to approach future planning with caution.

Some will hesitate to support family financially due to uncertainty over how such a gift could be challenged. This may be a retired couple with no inheritance tax (IHT) liabilities who hesitate when considering a gift to family. Or it may be the fit, healthy, and active individual with no foreseeable care need yet who fears any gift will attract scrutiny should their circumstances change in the future. Prudent forward planning when an individual does not have an obvious care need mitigates against the insertion of deprivation.

Methods of care funding

In this section we look at the different ways that care might be funded, the pros and cons of each and the suitability of these options.

i. Property

As a property is often the major asset owed by those navigating funding, it is helpful to consider the main options available when retaining and selling property.

Retaining property

Renting out the property

Letting out property could provide a regular income to support the payment of care bills.

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[5] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/lifeexpectancies/articles/howhaslifeexpectancychangedovertime/2015-09-09

Pros	Cons
• Makes the asset work • Keeps property in the estate • Benefits from any increase in value • Property is occupied • Tenants pay bills • Can prevent having to sell in a falling property market	• There may be periods with no tenant • Maintenance or tenant problems • Being a landlord requires adherence to strict safety rules • Rental income may not be sufficient to meet shortfall • Potential tax liability • Time-consuming • Management /agent fees may apply

Equity release

For those aged 55 or over who own and live in their own home and wish to fund their care at home, equity release could be an option. Such schemes allow borrowers to release some of the value of their home which does not normally need to be repaid until they (or the last borrower if borrowing jointly) die or move permanently into long-term care.

Pros	Cons
• Makes capital available • Lump sum or income • Possibly no repayments • Fixed interest rate possible (+No Negative Equity Guarantee ('NNEG')) • Benefit from increase in property value • Keeps property in estate (for now)	• More difficult if going into care home • Interest payable plus set-up costs • Debt accrual /compounding • Open-ended • Maintenance issues • May affect benefits • Legal & arrangement fees may apply

Restrictions of the equity release contract, higher interest rates and compounding interest make equity release a marginal option for most considering long-term care funding.

Deferred payment agreement

Pros	Cons
• Keeps property in estate (for now) • Low interest rate • Gives time and flexibility to sell at time of one's choosing • Benefit from any increase in value • Can rent out property • Stay in more expensive home	• Not available in Northern Ireland • Must meet criteria • Open ended, debt grows • Repayment of debt • Property maintenance/ insurance • Drop in value • May affect benefit entitlement

<u>Selling property</u>

Cash

Pros	Cons
• No investment risk • Accessible • Gradual reduction in capital • Higher interest rates available from 2022	• Deposit protection against bank failure subject to FSCS limits, currently £85,000 • Interest rates can vary over time • Inflation impacts spending power • Capital depreciation, see below • Legal and estate agent fees may apply

Cash held at bank, simple calculation:

- Assets £250,000
- Care fee shortfall £30,000 p/a
- 5% fee increases
- Nil interest, current account

Year	Annual Fees	Running Total
1	£30,000	£30,000
2	£31,500	£61,500
3	£33,075	£94,575
4	£34,729	£129,304
5	£36,465	£165,769
6	£38,288	£204,057
7	£40,203	£244,260

With the above scenario the asset balance reduces to state funding levels between year 6 and 7.

In practice, with recent increases in interest rates, a fixed term account paying higher interest can be considered for some of the capital.

Investments

Using investments to fund care fees has the potential for more growth than using cash, albeit with greater risk. These risks include investment growth not keeping up with care fees and available funds depleting (faster than if held in cash) due to poor investment conditions.

Pros	Cons
• Makes capital work harder • Potential higher income than cash • Gradual reduction in capital	• Returns are variable • Risk of loss • Pound cost ravaging[6] • Can add uncertainty to care funding • Financial advice fees if applicable[7]

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[6] Pound cost ravaging is a combination of volatility drag and sequencing risk, compounded by regular withdrawals. It can deplete investment funds quicker than expected. Poor investment performance in the early years of drawing income can quickly reduce the value of a fund. For example, if a care recipient needs to maintain a fixed level of withdrawal sufficient to cover fees during a market downturn, they may find the fund runs out quicker than anticipated. In some such situations, it may be exceedingly difficult for the fund to recover.

[7] The Financial Conduct Authority (FCA) says advisers charge an average of 2.4% of the amount invested for initial advice and 0.8% a year for ongoing advice. See *https://www.which.co.uk/money/investing/financial-advice/how-much-financial-advice-costs-aODa70J6nYs7* for more detail.

Immediate care plan

An immediate care plan ('ICP') is currently the only product that guarantees to cover the cost of care fees at a selected level for life. There is no investment risk involved.

Pros	Cons
• Helps to cap cost of care • Helps to protect remaining capital • Invest balance for estate regeneration • Tax-free income • No investment risk • Fully protected by the FSCS	• Risk to capital in event of early death if no capital protection selected • May not match fee increases • May not cover cost of increased care need • May affect benefits • Financial advice fees

ICPs are created by insurance companies and work on a mortality cross-subsidy basis, which is in effect a spread of risk. Those who die early will be cross-subsidising those who live longer. The providers of such plans have, in a way, the comfort of this spread of risk. The higher the volume of plans written, the greater the spread of risk. However, individuals and the families of those who live to the ripe old ages in care do not have such a spread of risk.

When funding significant care costs, if life expectancy assumptions by the individual in care, their families, or their advisers are underestimated, it can be disastrous. With care providers under ongoing financial pressure, many cannot sustain residents at local authority rates, which could ultimately mean being moved if the money runs out - a potentially unpleasant situation for all concerned.

An ICP is generally recommended for the following reasons:

- It provides peace of mind when funding long term care costs;
- The plan does not rely on investment returns; and
- The plan provides a higher income compared to a conventional annuity

A lump sum payment ICP works on a similar basis to an annuity and pays a guaranteed income each month/year for the rest of the recipient’s life. Once the plan has been set up, all income payments will be made directly to the care provider. This has the benefit of it not being classified as personal income, and therefore, there is no liability for income tax.

It should be noted that in the event of death, the plan will cease paying income and will not have a cash value. This means that in the event of an early death, the income payments may not equal the amount paid into the plan. However, applicants can include an option for capital protection, which will pay a cash sum equal to the amount paid, less any income paid, on death. The cost of adding this option reduces the level of income.

All care plans are individually written and based on the personal circumstances of each applicant. This means that the cost may vary considerably from case to case. For this reason, it is essential that a fully underwritten quotation is obtained for every care funding need.

However, to provide a broad estimate of the cost of a care plan, one provider[8] has calculated the average cost of providing an initial income of £20,000 per annum at various ages. This calculation has been based on the average health condition of a person entering either a Residential or Nursing care home, where conditions such as dementia, heart disease, and stroke commonly feature.

	Escalation 0%		**Escalation 5%**	
Age	**Residential**	**Nursing**	**Residential**	**Nursing**
75	£107,103	£100,486	£126,196	£117,513
80	£99,144	£91,882	£114,687	£105,434
85	£89,960	£83,225	£101,893	£93,558
90	£74,389	£70,399	£81,813	£77,216
95	£63,014	£56,361	£67,993	£60,467
100	£57,881	£56,982	£61,949	£60,836

Case study examples

This section will look at how an ICP can help fund care.

These case studies do not represent real people and are for illustrative purposes only.

i. Helen's story

Helen is 87, widowed and lives alone. She has become concerned about her ability to continue living in her home without assistance.

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[8] *https://www.justadviser.com/products/care-funding/how-much-does-it-cost/*

She now struggles to manage the stairs in her house and finds it hard to get up in the morning. She has difficulty getting out and about to see her friends as much as she used to, and she misses the company of others.

Helen has three children who take it in turns to provide care at home, but they find it difficult to juggle with their young families and work.

She is not eligible for any assistance from the state and will have to pay for her own care.

Helen would like:

- To move into a care home so she has more support and to improve her social life.
- To secure the majority of her care costs so they are guaranteed to be paid for the rest of her life and for this monthly payment to increase over time to help pay for any increase in care costs.
- To be able to leave an inheritance for her children and grandchildren.
- To mitigate the risk of ongoing care home fees eroding her assets.

Helen's home is valued at £1.1 million, with investments of £250,000 and cash savings of £50,000. Her total annual income from pensions and attendance allowance benefit is £16,800 after tax. The care home she likes costs £52,000 per year, and she wishes to have a weekly allowance of around £30 for personal expenses.

Suggested actions

Helen will keep £27.75 a week from her annual income and use £15,357 to pay the first part of the care home costs. She can fund the ICP from her savings and investments, or from the proceeds from selling her house, should she decide to sell it.

Helen decides to sell her house and use £163,042 to purchase an ICP to receive £36,643 a year to be paid to the care home for the rest of her life, increasing each year by 5%.

Existing annual income pays £15,537 towards her care costs. With one year care home costs of £52,000 this leaves a shortfall of £36,643 which can be made up by the ICP payments.

Satisfied that the majority of her care home costs are guaranteed for life, Helen leaves the rest of her assets, £1,236,958 invested for the purpose of leaving to her children and grandchildren as inheritance.

Based on national averages, the financial advice fee for this service would total c.£3,913.

Under current tax rules, the cost of her ICP will be taken out of Helen's estate's future value, helping to manage inheritance tax liability. Any death benefits will be paid out as part of the estate.

For someone of her age, the average life expectancy, according to the Office for National Statistics longevity calculator, is 93 years old, six years from now. It will take her just over four years to have recouped the initial amount she paid for her Care Plan.

Under current tax legislation, no income tax should be due on payments we make to a UK registered care provider.

Because Helen has selected to have the ICP payments increase by 5% a year, this may go some way to help pay for any future increases in the care home costs.

Helen and her adviser choose to place the remaining assets in suitable investments as she is reassured there is an amount of money already ringfenced to pay for her care costs.

ii. Mary's story

Mary is 90, widowed, and lives alone. She has dementia and a heart condition. Her husband passed away a number of years ago, but she has two daughters who live locally; they support her with regular visits and help around the home.

Mary's family has recently become increasingly concerned with her ability to cope in her own home, so they made the decision to move Mary into a care home in the local area.

When Mary was first diagnosed with dementia, she set up an Enduring Power of Attorney, so her daughters are able to manage her affairs for her. Mary is not eligible for any assistance from the state and will have to pay for her own care.

Mary and her family would like:

- Peace of mind that Mary is receiving the full-time care that she needs.

- The security of knowing that the majority of care costs are guaranteed to be paid for the rest of her life.
- To mitigate the risk of ongoing care home costs eroding her assets.

Mary's home is valued at £225,000, with cash savings of £25,000. Her total annual income from the state pension and attendance allowance benefit is £12,181. Mary has found a care home that she likes near her family, and it costs £40,000 a year. She also wishes to have a weekly allowance of around £30 for personal expenses.

Suggested actions

Based on Mary's circumstances, her adviser suggests that her annual State Pension and benefits income will cover £12,181 of her annual care home costs.

The shortfall could be covered by selling the home, and in exchange for an upfront premium of £92,000 an ICP could pay £29,262 a year to the care home for the rest of her life.

Her adviser included approximately £1,443 a year within the calculation to cover any personal expenses.

Annual pension and benefit income pays £12,181 towards care costs. Year one care home costs and personal expenses are £41,443. This leaves a shortfall of £29,262 which can be made up by the ICP payments.

Happy that the majority of her care home costs are guaranteed for life Mary's daughters place the rest of her £158,000 in cash. This amount can comfortably cover future increases to care costs and additional personal expenses.

Based on national averages, the financial advice fee for this service would total c.£2,208.

The benefits for Mary include:

- Peace of mind that a guaranteed amount of her care home costs will be paid each month until Mary dies.
- In just over three years Mary will have recouped the initial amount she paid for her ICP.
- Under current tax legislation, no income tax should be due on payments made to a UK registered care provider.
- Reassurance for Mary's family that she is in a care home with access to the support and facilities she needs.

Why specialist financial advice is needed

The complexities of the decisions some clients may need to face in later life when looking at issues such as care funding matters or whether equity release is the right thing for them, need careful and considered advice.

The Society of Later Life Advisers ('SOLLA') helps such people and their families in finding trusted financial advice by signposting to qualified and accredited advisers who understand financial needs in later life.

Seeking specialist advice is essential when considering this option of funding long-term care due to the complexity of this area for many individuals.

Annuities, in particular, can be challenging to understand and evaluate without professional guidance. Making poor choices regarding annuities can have long-lasting consequences, as these decisions are often irreversible.

Furthermore, there is a wide difference in pricing and features among providers, making it crucial to compare and select the most suitable option. The example below from March 2023 illustrates the range of costing across four providers. This is a real-life example for a 95-year-old entering care with a £3,387 per month shortfall.

Income per year (level)	**Purchase price**
£40,644	£123,499
£40,644	£127,435
£40,644	£119,396
£40,644	£89,401

The above figures are comparing plan benefits on a like-for-like basis, with variations in underwriting approaches reflecting in the purchase price. Notably, the £38,034 difference between the lowest and highest prices represents a significant 42% variance.

This highlights the importance of careful consideration when evaluating long-term care funding annuities. Through taking advice, individuals and families can navigate this complex landscape effectively, ensuring they secure the most favourable pricing while obtaining the desired plan benefits for their long-term care needs.

Process to cost an ICP

With only four providers offering such plans in the UK- Just, Legal & General, Aviva, and National Friendly - a fully underwritten offer should be obtained from each company. This process is facilitated through Medicals Direct Group (MDG), which collects the necessary information to ensure a comprehensive assessment.

The first step is to complete a Care Fees Plan Questionnaire. If the care recipient has a legal representative through a Power of Attorney or the Court of Protection, they should be involved along with proof of their right to act on the person's behalf.

An experienced nurse employed by MDG will conduct a tele-interview to obtain medical information from the care provider. An interview transcript will be completed, quality-checked, and sent to the insurance companies.
If it's not possible to arrange a tele-interview, a Care Manager's Report will be sent via email for the care provider to complete. In some circumstances, they may need more medical information and will request a GP report.

Once all the required information is received and underwritten, they provide a quote pack containing product Key Facts, T&C's, Acceptance Form, and Care Provider Declaration.

Process to arrange an ICP

Care funding plans can only be arranged through an FCA authorised financial adviser holding the CF8 qualification. The adviser will discuss the terms offered with an appointed attorney.

The adviser completes an application form with any attorney appointed using a valid Power of Attorney applying on behalf of their relative. This gives details of:

- Care costs;
- Optional benefits; and
- Other details relating to the care plan.

The adviser will send the premium and application documents to set up the care plan. The insurance company set up the care plan and issue policy documents.

The importance of considering pension funds

Personally held pension funds are worth mentioning as they become increasingly relevant in considering care funding, especially in light of changes in pension regulations.

The trend of retaining pension assets for estate planning purposes has gained momentum, and this is set to accelerate following the 2023 Spring Budget. The budget abolished the Lifetime Allowance tax and increased the Annual Allowance, Money Purchase Annual Allowance, and Tapered Annual Allowance, reducing previous constraints on accumulating assets in pension schemes.

As a result, we can expect to see a higher occurrence of significant fund values remaining in pension drawdown arrangements among individuals aged over 80.

This shift underscores the importance of personal pension funds in addressing the financial challenges of paying for care.

The tax treatment of pensions on death is generous – pensions escape inheritance tax while other types of assets do not, and where death occurs before the age of 75 there is no income tax to pay.

These benefits were the subject of a recent report from the Institute of Fiscal Studies ('IFS'), which highlighted that such treatment may lead to behaviour where some accumulate significant value in pensions and leave them untouched while drawing down on other assets.

According to the report in 2010-12, defined contribution pension pots comprised 15% of the wealth of those aged 45–59 whose total wealth exceeded £500,000 (in 2021 terms).

By 2018-20 this figure had increased substantially to 24%. This reflects a fall in their average level of non-pension wealth rather than an increase in the average size of pension pot among this group.

This could indicate that wealthier people are favouring their pensions over other savings vehicles.

The IFS report gives an example of a couple being able to pass on an estate of well over £3m IHT-free through the current system if they utilised current pension rules and made full use of their inheritance thresholds in the 2022/23 year.

With the 2023 Spring Budget abolishing Pension Lifetime Allowance taxation, the above couple are now notionally uncapped. This is likely to draw legislative scrutiny on a fertile area of estate planning, potentially resulting in changes to the IHT treatment of pension funds.

It is notable that the IFS had proposed that pensions are included in estates for IHT purposes, well before the 2023 Spring Budget announcements.[8]

Treatment of pension funds when self-funding care costs

Upon the introduction of pension freedoms legislation, initial fears that a pension fund held in drawdown could be assessed as capital during a means test were not realised. Yet if an individual withdrew all monies from the pension and placed into cash/investments, this may be the case:

> *'If a person has removed the funds and placed them in another product or savings account, they should be treated according to the rules for that product'* [9]

For unused funds held in drawdown there is no requirement to 'cash in' the pension, instead this fund will be treated as notional income. The notional level is determined by annuity rates. Notably these are general rates offered on single life level annuity basis – not the enhanced rates for impaired life, which pay at higher levels:

> *'If person is only drawing a minimal income, or choosing not to draw income, then a local authority can apply notional income. This must be the maximum income that could be drawn under an annuity product…'* [10]

If an individual is taking a higher level of income from drawdown than would otherwise be paid by an annuity, the full income is considered:

> *"If a person is drawing down an income that is higher than the maximum available under an annuity product, the actual income that is being drawn down should be taken into account'* [11]

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[8] https://ifs.org.uk/publications/blueprint-better-tax-treatment-pensions

[9] *Department of Health and Social Care, Statutory Guidance: Care and Support Statutory Guidance, Annex C s 26(a) https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#AnnexC*

[10] *Ibid, s 26(b)*

[11] *Ibid, s 26(c)*

Awareness regarding deliberate deprivation of pension funds to be noted:

> *'If you deliberately spend or give away money [….] from your pension pot to get or increase help with care costs […] they might treat you as still having that money.'*[12]

I am unsure how this would be policed or enforced, considering drawdown arrangements are intended to give choice and control when accessing pension benefits. We have yet to see an example in practice and suspect authorities will apply similar standards to other deprivations and look at motivations behind the pension withdrawal gifts.

Conclusion

This article has considered the current environment surrounding long-term care funding, particularly focusing on self-funders who lack sufficient income to cover the costs entirely. It has highlighted the complexity that the general public faces when navigating the emotionally-charged issue of care funding. Additionally, the article has drawn attention to the low national awareness of the existing care funding rules, which further compounds the challenges faced by individuals seeking appropriate financial arrangements.

With increasing demands due to demographic changes, reduced state support, longevity uncertainty, and the vulnerability of those impacted, it is crucial to explore all viable options for financing long-term care.

The use of care annuities has been highlighted as one approach to address the financial challenges faced by individuals in need of care. Moreover, the growing relevance of pensions in care funding considerations reflects an established trend for retaining pension wealth into later life.

It is crucial for policymakers, advisers, and consumer bodies to recognise the significance of these issues and work towards increasing awareness of care funding rules, promoting access to suitable financial advice, and implementing supportive measures to ensure the long-term care needs of individuals are met. By addressing these challenges, we can strive to create a more equitable and sustainable system that upholds the dignity and well-being of those requiring long-term care.

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[12] *https://www.moneyhelper.org.uk/en/family-and-care/long-term-care/how-your-pensions-can-affect-social-care-costs*

Substantial unclaimed discounts on rates and local council tax. Are your clients with severe mental impairment losing out?

Linda Johnston, Solicitor (retired), TEP (retired)

Introduction

England, Scotland, Wales, and Northern Ireland have similar, but different, regimes allowing a discount of 20-25% on annual rates/ council tax bills where a pensioner lives with an occupant who is suffering severe mental impairment, such as dementia. In Northern Ireland local rates are managed through Land & Property Services and the details of this allowance are obscurely found under the Lone Pensioner Allowance (LPA) provisions[1], which, despite the name, are not restricted to lone pensioners.

Good guidance on the provisions for England, Scotland and Wales can be found on the websites of a number of charities including Age UK, Dementia UK and the Alzheimer's Society. Northern Ireland is not so well-served. Consequently, practitioners have a valuable role to play in signposting their clients. These notes focus on the allowance available in Northern Ireland.

LPA in Northern Ireland

A 20% discount on the on a rate bill is a significant saving which repeats annually. The allowance is not means-tested, is not dependent on receiving a State benefit, and applies to owner-occupiers and tenants.

LPA is available to ratepayers aged 70 plus, living with a person suffering from a severe mental impairment (SMI) such as dementia or Parkinson's. Many other mental health conditions may apply. Under the regulations a person is deemed to be severely mentally impaired if he has a severe impairment of intelligence or social functioning (however caused) which appears to be permanent.

Clients should be guided to apply by completing the straightforward four-page Lone Pensioner Allowance application form (LPA)[2]. If the claim relies on

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[1] The Rate Relief (Lone Pensioner Allowance) Regulations (Northern Ireland) 2008.

[2] *https://www.nidirect.gov.uk/sites/default/files/2023-05/lone-pensioner-allowance-application-form.pdf*

the SMI of an occupier, the application will generate a medical form to be completed by a GP detailing the nature and date of the diagnosis. If a fee is charged by the doctor, there is provision for such cost to be covered, and also provision for backdating the allowance, potentially to the date of diagnosis.

The office of the Commissioner for Older People recently made a Freedom of Information request to assess the uptake of this allowance, using the SMI limb. The response gave a breakdown of households in NI by Council areas, with active awards as at 1st January 2023:[3]

Council	**No of active awards**
Antrim and Newtownabbey	22
Ards and North Down	40
Armagh City, Banbridge and Craigavon	19
Belfast	26
Causeway Coast and Glens	10
Derry City and Strabane	5
Fermanagh and Omagh	7
Lisburn and Castlereagh	14
Mid Ulster	6
Mid and East Antrim	19
Newry, Mourne and Down	23
Totals	**191**

The statistics are revealing and concerning given it is estimated over 20,000 adults in NI have a dementia diagnosis.[4]

It is apparent that many households are losing out on valuable financial assistance with only 191 households across NI having active LPA awards in January 2023, of which five are in City of Derry and Strabane, and 21 in Belfast.

Conclusion

Evidently there is significant scope to urge a greater uptake of LPA based on SMI. Legal, medical and social care practitioners are well-placed to inform and encourage those likely to succeed in applications. Urging Land and Property Services in Northern Ireland to rename the discount provision with an unambiguous label would also help considerably.

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[3] *https://www.finance-ni.gov.uk/sites/default/files/publications/dfp/DOF%202022-0510%20FOI%20Response.pdf*

[4] *https://www.northerntrust.hscni.net/health-and-wellbeing/older-peoples-health/dementia/*

Casenotes

Andrew Kirkpatrick
(TEP, Solicitor, Murray Kelly Moore)

Continuing Healthcare in Northern Ireland

In the matter of an application by Robin McMinnis and the Commissioner for Older People for Northern Ireland for Judicial Review
***And in the matter of decisions of the Belfast Health and Social Care Trust and the Department of Health* [2023] NIKB 72**
High Court of Justice in Northern Ireland – Scoffield J – Judgment delivered 30th June 2023
Jurisdiction: Northern Ireland

The application related to the concept of continuing healthcare (CHC) in Northern Ireland. The first applicant, Mr McMinnis, applied for CHC but was refused by the Belfast Health and Social Care Trust (the Trust). The second applicant is the Commissioner for Older People for Northern Ireland (COPNI) who principally challenged a decision of the Department of Health (the Department) to introduce a new policy in relation to CHC in 2021. The 2021 policy moved the test for CHC to one single eligibility question, namely: *"Can your care needs be met properly in any setting other than a hospital?"*. If the answer to that question was yes, then CHC would be denied.

There were two policies relating to CHC in Northern Ireland at issue in the hearing - a 2010 Department policy and the new 2021 policy. Mr McMinnis's application related to the 2010 policy.

Mr McMinnis suffers from multiple sclerosis. His health is progressively degenerating, he is essentially paralysed, retaining physical function in his head and eyes only. He requires specialist care with every physical aspect of his life but retains full cognitive function. He uses technology to type through the use of his eyes and can speak with the aid of a voice amplifier. He has resided in a nursing home since 2016. Mr McMinnis applied for CHC in 2017 considering that he met the requirement of a primary healthcare need. After difficulties around the assessment process, an assessment was eventually carried out in 2021 which concluded that he was not eligible for CHC as his needs were not sufficiently severe to qualify and that he should therefore have to pay for his care. Mr McMinnis considered that the procedure (and ultimately the decision) had been unfair because of a lack of a clearly defined test governing CHC leaving the panel to have to develop its own methodology. As part of deciding upon the methodology, the panel asked Mr McMinnis for his input as to what should be considered.

COPNI's application relates to the difficulties and inconsistencies caused by the 2010 policy and it challenged the 2021 policy. The challenge to the 2021 policy was on two grounds. Firstly, that it authorised and approved unlawful conduct by the Department in permitting the levying of charges on those whose primary need is healthcare whenever they are resident outside a hospital. Secondly, that it was in breach of the obligations under Section 75 of the Northern Ireland Act 1998 which requires the promotion of equality of opportunity between persons with particular protected characteristics, including persons of different age.

HELD

Scoffield J quashed the Trust's decision which determined that Mr McMinnis was not eligible for CHC on the basis that it was procedurally unfair to him.

The Judge also quashed the decision of the Department to adopt the 2021 policy on the basis that it was adopted in breach of its obligation to have due regard to the need to promote equality of opportunity between persons of different age under s 75 of the Northern Ireland Act 1998.

Scoffield J directed that clearer methodology must be set out for making a decision on CHC applications in accordance with the requirement for procedural fairness so that an applicant should be able to understand the methodology involved to decide whether the overarching criterion is met.

The Judge also noted that, although it fell primarily to the Trust to rectify the issues in Mr McMinnis's case, a declaration was granted that, in failing to provide guidance to the Trust, the Department acted unlawfully.

At the time of going to press, it is understood that this case has been appealed. Further updates will follow in due course.

Deprivation of Liberty

***A Health and Social Care Trust v JU* [2023] NIFam 12**
High Court of Justice in Northern Ireland – McFarland J – Judgment delivered 7th August 2023
Jurisdiction: Northern Ireland

In this case the Trust sought an order under the inherent jurisdiction of the High Court to deprive JU of her liberty.

JU is a lady in her early seventies and resides under a guardianship order in a private nursing home. She suffers from longstanding mental health problems and has diagnoses of persistent delusional disorder, emotionally unstable personality traits and recurrent depressive disorder. Over the years she has had a number of hospital admissions, the last of which was in September 2019 and she remained in hospital until July 2021 when she was transferred to the nursing home. She became the subject of the guardianship order in March 2022.

The Trust was seeking an order to deprive JU of her liberty because it considered that it may require powers in the future to ensure her safe management should her condition deteriorate and that it would be unable to intervene at a suitable level to prevent her causing harm to herself. The measures sought by the Trust included placing her under significant or constant monitoring and supervision, preventing her from leaving the place of residence, returning her to her place of residence, and taking such other measures as may be necessary to restrict or deprive her of her liberty as may be reasonable and appropriate. The order sought was under the inherent jurisdiction of the Court and was on an anticipatory and contingent basis.

It was agreed that JU did not lack capacity, despite being vulnerable, and therefore the Judge considered that the DOL provisions of the Mental Capacity Act (NI) 2016 could not apply due to her still having capacity.

The relevant medical history was that JU's mental health had begun to deteriorate in the mid-1990s. She overdosed in 2007, 2008 and 2017 and was admitted to an acute mental health hospital each time. On the 2017 occasion, she had a period of leave away from the hospital and was travelling with her husband when they stopped at a motorway service station when she jumped from a bridge and sustained serious injuries in her attempt to commit suicide. She was then in and out of hospital a number of times until in September 2019 she set fire to the family home and was found unconscious in a nearby field suffering from hypothermia. She was then detained under an assessment order and a subsequent hospital order for further treatment. She has resided in the current nursing home since July 2021 and despite periodic dips in her mental health since then, she was generally considered to be well-settled in the home without any significant issues of potential harm having occurred.

The Judge analysed the questions before the Court as being:

(a) Does the Trust owe an operational article 2 ECHR duty of care to JU?;
(b) If so, is that duty currently engaged?;
(c) If not currently engaged, in the event of deterioration in JU's mental health and the duty becomes engaged, are the existing statutory powers sufficient for the Trust to take lawful steps to fulfil its duty?;
(d) If the existing statutory powers are insufficient, is the inherent jurisdiction of the Court available to permit the deprivation of liberty of JU?; and
(e) If the inherent jurisdiction is available, should the Court exercise its discretion and grant the Trust, and others, the powers the Trust seeks and on what terms?

HELD

The Judge held that in relation to the operational article 2 ECHR duty at (a) above, despite JU having capacity, the Trust and the guardian do exercise control over JU and as such do owe an operational article 2 ECHR duty to her. The Judge did note that the duty must be seen in the light of JU's current presentation and specifically the risk of harm that she is currently presenting to herself and others which was considered by the Judge to be relatively low. This assessment was on the basis that the suicide attempt and fire occurred some time ago and JU had been successfully treated in the aftermath of both incidents with no suggestion of any recent reoccurrence.

In relation to the question (b) above, the Judge held that the article 2 ECHR duty was not currently engaged as the evidence was that JU's condition, whilst fluctuating from time to time, was being well-managed and there were no current red flags.

On question (c) above, the Judge noted that the Trust was not seeking to exercise such powers now but only in the event of a deterioration of JU's mental health. It was held that the Trust does have sufficiently adequate powers to fulfil its article 2 ECHR duty should JU's condition deteriorate. The Judge considered that the statutory provisions were enough.

On question (d), the Judge considered that the inherent jurisdiction of the Court should only be invoked when there are gaps in the legislation that require the Court to fill those gaps so as to protect a person. Given the finding at (c) above, the Judge considered the legislative provisions to be sufficient and therefore the inherent jurisdiction of the Court was not required to be invoked. The Judge also went further in holding that the inherent jurisdiction of the Court is not available in making DOL orders for vulnerable but capacitous adults.

Question (e) was therefore not required to be answered.

The application of the Trust was therefore refused.

Casenotes

Rachel Sullivan, BL

Serious medical treatment; best interests; interim declarations

***Barnet Enfield and Haringey Mental Health NHS Trust & Anor v Mr K & Ors* [2023] EWCOP 35**
Court of Protection - Judgment delivered 15th August 2023
Jurisdiction: England and Wales

Mr K was a 60-year-old man who suffered from chronic bilateral venous leg ulcers. He lived in a care home where he was deprived of his liberty, having previously spent five years living in a mental health facility. He suffered from persistent delusions and paranoia. He had previously treated his ulcers himself, but the evidence suggested that he needed urgent assessment of, and treatment for, them: a member of staff at the care home had noted that he could see into the wound, which was described as *'severely infected and malodorous'.* There was concern that without treatment the infection might progress to the extent that amputation of both legs below the knee would be indicated.

However, Mr K was resistant to having any such treatment, and refused to engage with professionals. Due to an existing heart condition, treatment against his will was fraught with difficulty. The court had evidence from cardiologists and anaesthesiologists that the use of chemical and physical restraint to transfer Mr K to hospital would pose significant risks. The risks of prolonged chemical sedation were also significant, should he require longer term sedation while at hospital in order to effectively administer treatment.

The court held that there was reason to believe that Mr K lacked capacity to make decisions about medical treatment, noting:

"[…] the language of section 48 needs no gloss and that the court need not be satisfied, on the evidence available to it, that the person lacks capacity on the balance of probabilities, but rather a lower test is applied. Belief is different from proof" (at [57]).

The court made an interim declaration in those terms. Having considered the approach taken in *DP v London Borough of Hillingdon*[1] to the effect that there was no power to make interim declarations under s 48 MCA 2005, the court held that it did have such a power under s 47 MCA 2005. Section 47 provides that the Court of Protection has *'the same powers, rights, privileges and authorities as the High Court'* in connection with its jurisdiction, and the High Court has power to make interim declarations. It was desirable that the court should retain the power to make such interim declarations:

"A determination that there is reason to believe P lacks capacity in relation to the matter, is an important step which establishes the court has jurisdiction to make best interests orders in respect of P, if additionally the section 48 (c) test of 'without delay' is met. The declaration should be precisely worded to make clear the matters in respect of which the court has jurisdiction. A finding is a less precise basis upon which to exercise the court's jurisdiction" (at [102]).

As regards best interests, there were four options available:

(a) Await further evidence;
(b) Make an order permitting urgent investigation, assessment and treatment insofar as possible at the care home;
(c) Make an order authorising Mr K's transfer to hospital, and assessment and treatment there;
(d) Seek to persuade Mr K to attend hospital.

The judgment provides a useful working through of the options, and the application of the 'least restrictive' principle. The first option was not viable in light of the urgency of the case. Although finely balanced, given the evidence before the court that some inpatient care would be needed, the third option was also not currently in Mr K's best interests. At present it was too risky, although it was likely the court might have to deal with how to strike that balance in future. The court directed that there should be urgent exploration of whether persuasion might be effective, but if not, the court endorsed assessment and treatment to take place at the care home, including with the use of chemical and physical restraint as a last resort, prior to a further hearing to consider the next steps.

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[1] [2020] EWCOP 45.

Serious medical treatment; best interests; palliative care

***Northern Care Alliance v KT* [2023] EWCOP 46**
Court of Protection – Hayden J- Judgment delivered 25th August 2023
Jurisdiction: England and Wales

KT was undergoing dialysis for end-stage kidney failure when, at the age of 53, he suffered a large left-parietal intercranial haemorrhage which left him in a prolonged disorder of consciousness. Prior to his diagnosis in 2017, he had been a pastor in the Netherlands and had always been very committed to his Pentecostal faith.

The hospital Trust applied for declarations that it was lawful and in KT's best interests to receive palliative care only, which it was acknowledged would mean he would die as a result of renal failure within a couple of weeks. The application was opposed by his family who shared his faith and felt that he would have wished for his life to be sustained for as long as possible, in whatever circumstances and whatever the challenges.

The court set out the well-known dicta of Baroness Hale in *Aintree University Hospital NHS Trust v Bland*[1] that:

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

The court recognised that KT's human rights under Article 2 (right to life) and Article 3 (right not to be subject to inhumane or degrading treatment) were engaged, and that the presumption of domestic law is strongly in favour of prolonging life where possible (*Burke v UK*).[2]

Reviewing the medical evidence, the court noted that KT's consultant in neurorehabilitation considered that he was in a prolonged disorder of consciousness with no awareness or scope for rehabilitation. He was also

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[1] [2013] UKSC 67.
[2] (2006) ECHR 1212.

suffering progressive brain atrophy, which raised the spectre of impact on the brain stem and compromise of breathing and swallowing, leading to *"a potentially awful death".* It was likely that dialysis would become impossible within the next year. The Trust had sought a second opinion from Professor Wade, who agreed that there was no prospect of significant, sustained improvement and that continuing active medical treatment was not in KT's best interests.

On the other hand, KT's family gave vivid evidence as to his beliefs and the court accepted that:

'[…] KT's attitude to his faith, the way it drove his life and its uncompromising nature, as has been identified, leads me to have confidence in the family's view that he would not have wished his life to be brought to an end in the circumstances the Trust consider meet his best interests. He would rather suffer and hold out for the will of God.' (at [31]).

The court had no hesitation in finding this. However, the court accepted that while an individual's wishes and feelings weigh heavily in evaluating the question of their best interests, they are not determinative. The court weighed against its clear findings as to KT's wishes and feelings the fact that continuing treatment was both burdensome and futile, and his progressive cerebral atrophy and the risks that entailed made continuing treatment *'grotesque to his dignity as a human being'* (at [42]). Ultimately the court therefore acceded to the Trust's application and held it was in KT's best interests to receive palliative care.

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