The good, the bad, and the 'vulnerable older adult'

Abstract: Recent declarations by the Court of Appeal indicate that the inherent jurisdiction has survived the implementation of the Mental Capacity Act 2005 for adults considered 'vulnerable' and whose decision-making is threatened by reasons other than mental impairment – such occasions may include instances of elder abuse. In this paper I argue, however, that the post-Mental Capacity Act courts have adopted a confused and outmoded concept of the vulnerable older adult, in particular where decision-making is threatened by abusive interpersonal relationships experienced by an older individual. This has particular implications in terms of the types of remedies imposed by the courts on older adults in such circumstances. In this article I suggest that by being more cognisant of recent more nuanced understandings of vulnerability, the courts may be better suited to identifying, and responding to perceived sources of vulnerability in a way that is more empowering for the older adult.

Keywords: capacity; decision-making; elder abuse; inherent jurisdiction; older adults; vulnerability

Introduction

The mistreatment of older adults, sometimes termed 'elder abuse' is frequently defined as 'a single or repeated act or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person' (World Health Organisation, 2002, p. 3; see also Dixon et al., 2010) and encompasses a broad spectrum of abuse such as psychological, physical, financial and sexual. Recent studies (O'Keeffe et al., 2007) place the prevalence of such abuse as between 2.6%-4%. The impact such abuse has on an older individual, and particularly an older adult's decision making ability, is becoming an increasing concern for policy-makers and academics alike, with emphasis being placed on how such abuse may engender a fear of reprisals in its victims, as well as affecting their self-esteem and self-worth (Joint Committee on Human Rights, 2007, ch. 8; Mowlam, Tennant, Dixon & McCreadie, 2007, ch. 5-6; Pritchard-Jones, 2014). Before 1 April 2015, identifying and responding to the domestic abuse of older persons was a matter left to local authorities, under the *No Secrets* (Department of Health, 2000) guidance

published in 2000. This minimal approach to safeguarding has been heavily criticised; in 2011 the Law Commission reported that '[t]he existing legal framework for adult protection is "neither systematic nor coordinated, reflecting the sporadic development of safeguarding policy over the last 25 years"' (Law Commission, 2011, para. 2.1). As a consequence, calls were made for a comprehensive statutory safeguarding scheme (Herring, 2012; Williams, 2008), which the Care Act 2014 now aims (but as shown below, fails) to achieve by placing an obligation on local authorities to make enquiries where an adult who, by virtue of their 'needs' is considered at risk (s.42 Care Act 2014).[1]

At the same time, it is now beyond doubt that the High Court's inherent jurisdiction has survived the implementation of the Mental Capacity Act (*KC v Westminster City Council* [2008] EWCA Civ 198; *DL v A Local Authority* [2012] EWCA Civ 253), and exists alongside the Act to protect those whose decision-making is threatened by reasons other than an 'impairment of, or disturbance in the functioning of the mind, or brain' (Mental Capacity Act 2005 s.2(1)), or to authorise a detention of those who do not come within the deprivation of liberty safeguards under the Mental Capacity Act 2005 (*An NHS Trust v Dr A* [2013] EWHC 2442 (COP)). According to Munby J:

> …the inherent jurisdiction can be exercised in relation to a vulnerable adult who, even if not incapacitated by mental disorder or mental illness, is, or is reasonably believed to be, either (i) under constraint or (ii) subject to coercion or undue influence or (iii) for some other reason deprived of the capacity to make the relevant decision, or disabled from making a free choice, or incapacitated or disabled from giving or

> expressing a real and genuine consent. (*Re SA (Vulnerable Adult with Capacity: Marriage)* [2005] EWHC 2942 (Fam) at para. 77)

Central to the more recent interpretations of the inherent jurisdiction, then, is this notion of the 'vulnerable adult' and despite the long history of this term in law and policy, it is only recently that the philosophical literature has begun to grapple with what it means to be 'vulnerable', and question its predominant construction in this context. The recent arguments put forward are that vulnerability is both universal *and* particular (Fineman, 2008; Fineman & Grear, 2013); a feature that is inherent in *all* persons by virtue of our embodiment albeit experienced differently by each individual, rather than a term to denote certain sub-groups of the population such as the elderly or those with physical or cognitive impairments.

If existing safeguarding law and policy fails to make sufficient attempt at providing a comprehensive statutory framework for tackling such abuse, and its effect on decision-making, as commentators have noted (Clements, 2015; Collingbourne, 2014), then it may well be that the inherent jurisdiction is increasingly resorted to by local authorities and the courts to safeguard those older adults who experience abusive interpersonal relationships that affect their decision-making, and who do not fall within the scope of the Mental Capacity Act. Indeed the Court of Appeal has recently noted as such; '[t]here is, in my view, a sound and strong public policy justification for [the retention of the inherent jurisdiction alongside the Mental Capacity Act]. The existence of 'elder abuse'… is sadly all too easy to contemplate' (*DL v A Local Authority* [2012] EWCA Civ 253 at para. 63). In light of this it is important for the courts invoking the inherent jurisdiction have a clear and consistent approach as to who it considers a 'vulnerable older adult'. This paper builds upon

recent literature applying the 'new' vulnerability analysis in other domains (Clough, 2014; Mackenzie & Rogers, 2013; Peroni & Timmer, 2013; Stychin, 2012), as well as existing critiques of the inherent jurisdiction (Dunn, Clare & Holland, 2008; Herring, 2009), by exploring recent case law involving older adults, and in particular by focusing on three key cases[2]; *DL* ([2011] EWHC 1022 (Fam); [2012] EWCA Civ 253)*, London Borough of Redbridge v G* ([2014] EWCOP 17; [2014] EWCOP 485; [2014] EWCOP 959; [2014] EWCOP 1361) and *NCC v PB and TB* ([2014] EWCOP 14). By focusing on these cases I argue that the courts are using an outmoded and confused concept of vulnerability in relation to older adults, and that this, given the 'theoretically limitless' (*Re B (Secure accommodation: Inherent jurisdiction) (No. 1)* [2013] EWHC 4654 (Fam) at para. 20) remedies available under the jurisdiction, is problematic in terms of the responses it envisages for instances of such abuse. By adopting a more nuanced and consistent account of vulnerability, the courts may be better suited to identifying the complex nature of decision-making for older adults[3] who experience abuse, and will therefore be able to respond more appropriately in such instances.

The legal context of the vulnerable adult

The historical background

In 1990 the House of Lords, asserting the inherent jurisdiction, held that treatment on a mentally incapacitated adult would be lawful as long as it was necessary, and it was to be deemed necessary if it was in her best interests (*Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1). Subsequently, there followed a number of cases authorising (or authorising the withdrawal of) medical treatment under the inherent jurisdiction for individuals who were considered unable to give valid consent by

reason of mental incapacity (*Airedale NHS Trust v Bland* (1993) AC 789; *Re MB (Medical Treatment)* [1997] 2 FLR 426; *Re Y (Mental Patient: Bone Marrow Donation)* [1997] Fam 110;) or because of coercion or undue influence (*Re T (Adult: Refusal of Treatment)* (1992) EWCA Civ 18). That the use of the jurisdiction was confined only to medical treatment seemed beyond doubt in 1995 by Hale J (as she then was) in *Cambridgeshire County Council v R (An Adult)* ([1995] 1 FLR 50). In this case, the local authority sought declarations in respect of the family of a 21-year-old woman in its care that, *inter alia*, it would be lawful to prevent her family contacting her. Hale J held that the declaratory jurisdiction could only be invoked to protect a legal right, and not to limit an individual's freedom of association[4]. Since then, however, the scope of the jurisdiction has been extended further by the courts in two marked directions. Firstly, following *Re F* ([2000] EWCA Civ 192), where the Court of Appeal upheld declarations sought by the local authority to restrict the contact of an abused young woman who had a low intellectual age with her natural family, the jurisdiction *has* been extended to cover decisions other than medical treatment, such as deprivations of liberty[5] (*R v Bournewood Community and Mental Health NHS Trust, ex parte L* [1999] 1 AC 458; *An NHS Trust v Dr A* [2013] EWHC 2442 (COP)), contact (*Re G* [2004] EWHC 2222 (Fam); *Re S* [2002] EWHC 2278 (Fam)), residence (*Re F* [2000] EWCA Civ 192; *Re S* [2003] EWHC 1909 (Fam)), marriage (*Re SK* [2004] EWHC 3202 (Fam); *Re SA* [2005] EWHC 2942 (Fam)) and publication restraint (*Local Authority v Health Authority* [2004] 1 All ER 480).

Moreover - and particularly important now that the Mental Capacity Act 2005 provides the legislative framework for decision-making for those who are deemed to lack capacity 'because of an impairment of, or a disturbance in the functioning of, the

mind or brain' (S.2(1)) - the scope of the jurisdiction has seemingly affirmed the early decision of the Court of Appeal in *Re T* (1992) EWCA Civ 18, and has been extended to adults who are deemed unable to make decisions for reasons other than mental impairment; more recently called 'vulnerable adults'. In *Re G* (*Re G* [2004] EWHC 2222 (Fam)) for example, the court was asked to determine whether the jurisdiction could be used to make residence and contact orders for a 29 year old woman, G, who had a history of mental illness and had previously been subjected to a guardianship order under section 7 of the Mental Health Act 1983. The court held, notwithstanding the fact that at the time of the hearing G had regained mental capacity as to her contact and residence, that the inherent jurisdiction could still be used to grant the declarations sought – a failure to do so would mean that G's condition would almost certainly deteriorate and she would lack capacity again. Similarly, in *Re SA* (*Re SA* [2005] EWHC 2942 (Fam)) the question for the Family Division was whether the jurisdiction could be invoked to protect an 18 year old who suffered from profound communication difficulties from an unsuitable arranged marriage in Pakistan, notwithstanding the fact that she had capacity to marry. In finding that it could be invoked, Munby J held that:

> A vulnerable adult who does not suffer from any kind of mental incapacity may nonetheless be entitled to the protection of the inherent jurisdiction if he is, or is reasonably believed to be, incapacitated from making the relevant decision by reason of such things as constraint, coercion, undue influence or other vitiating factors. (*Re SA* at para. 79)

Who is the 'vulnerable' adult?

So whom does the law have in mind when it speaks of 'vulnerable'? Central to the notion of vulnerability deployed by the courts, is the notion of an inherent characteristic meeting a risk of harm. According to Munby J in *Re SA,* an adult is deemed to be vulnerable if he or she is 'unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation, or who is deaf, blind, or dumb, or who is substantially handicapped by illness, injury or congenital deformity' (*Re SA* at para. 82) [6]. In light of this, Munby J goes on to say that 'SA is plainly a vulnerable adult. She is substantially handicapped by her disabilities. And, particularly because she is deaf and dumb, she may well be unable to take care of herself and protect herself against significant harm or exploitation…' (*Re SA* at para. 120). The approach adopted by Munby J in *Re SA* has been cited with approval by subsequent courts grappling with cases involving older adults (*City of Sunderland v PS and CA* [2007] EWHC 623 (Fam); *DL v A Local Authority & Ors* [2012] EWCA Civ 253), and is one that is not uncommon more generally in the case law. In *LBL v RYJ* (*LBL v RYJ & Anor* [2010] EWHC 2665 (COP)) for example, which involved capacity determinations in respect of a young woman who had suffered brain damage at birth and had significant learning difficulties, the court cites a report prepared by the educational psychologist which states that '"[the individual] has an extremely low IQ, unlikely to be capable of leading a fully independent adult life and in this respect will need help, support and care for the foreseeable future. Her limitations make her vulnerable' (*LBL v RYJ* at para. 38). Similarly, in *Local Authority X v MM and KM* (*Local Authority X v MM and KM* [2007] EWHC 2003 (Fam)), the issue was whether MM, who suffered from paranoid schizophrenia and a moderate learning disability, had decision-making capacity with regard to, *inter alia*, residence, contact, and marriage. In his decision, Munby J again ties vulnerability to

being at risk of abuse and states that 'the appropriate role of the law here is to protect the vulnerable, who as such may become easy targets for abuse or who may find themselves in exploitative contexts…' (*Local Authority X v MM and KM* at para. 130). In doing so, he refers to the case of *Dudgeon v UK* (*Dudgeon v UK* (1981) 4 EHRR 149). Albeit a case that involved the criminalisation of homosexuality, the European Court of Human Rights in *Dudgeon* offers an illustrative account of vulnerability as deriving from an inherent characteristic, which is cited with approval by Munby J:

> There can be no denial that some degree of regulation…can be justified as "necessary in a democratic society"…"to provide sufficient safeguards against exploitation and corruption of others, particularly those who are specially vulnerable because they are young, weak in body or mind, inexperienced, or in a state of special physical, official or economic dependence." (*Dudgeon v UK* (1981) 4 EHRR 149 at para. 49)[7]

Moreover, Munby J's approach in *Local Authority X v MM and KM* automatically ties being 'elderly' in with being 'vulnerable' – in paragraph 120 alone he links being 'elderly' with being 'vulnerable' together three times.

This approach to vulnerability – the presence of an inherent characteristic found in an individual such as their old age or a cognitive impairment, which is deemed to bring with it a risk of harm - is also one that arises in other legal contexts involving older adults. In *Watts v UK* (*Watts v UK* (2010) 51 EHRR SE5) for example, which involved a challenge by a 106-year old woman to the proposed closure of her care home, the court states that:

> [T]he presence of cognitive impairments…makes the individual particularly vulnerable, for no matter how much work is done to explain the situation and to help them come to terms with the situation, all that work may be lost because of the failure to register and to remember…these vulnerability factors increase the risk of adverse reactions to the relocation stress... (*Watts v UK* (2010) 51 EHRR SE5 at para. 53)[8]

In *LLBC v TH, JG and KR* (*LLBC v TG, JG and KR* [2007] EWHC 2640 (Fam)), a case concerning the residence of TG, a 78 year old gentleman with dementia, vulnerability is linked to the fact that TG is 'elderly' and 'infirm' (*LLBC v TG, JG and KR* at para. 40). This idea that a vulnerable adult is someone who is unable to protect herself because of an inherent characteristic, such as age or cognitive impairment, is also one that appears in adult safeguarding policy more generally. *No Secrets,* the safeguarding policy framework recently superseded by the Care Act 2014, defined a vulnerable adult as:

> [S]omeone who is or may be in need of community care services by reason of mental or other disability, *age* or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation (emphasis added). (Department of Health, 2000, para. 2.3)[9]

Similarly, section 42 of the Care Act 2014 now places a statutory obligation on local authorities to make enquiries where it has reasonable cause to suspect that an adult is *in need of care and support*, is experiencing or is at risk of experiencing abuse or neglect, and the needs that the individual has render him or her unable to protect him or herself from the abuse or neglect (S.42(1)(a)-(c) Care Act 2014).[10] Both the

approach taken to vulnerability by the inherent jurisdiction cases (and the broader cases) then, as well as the policy and statutory provisions surveyed here, present vulnerability as being at risk *because of* an inherent characteristic – or, more recently under the Care Act 2014, because of something that renders them 'in need' of care and support – an impairment, so to speak. In effect, vulnerability depends first and foremost on the existence of an inherent characteristic, which then renders an adult at risk of harm[11].

(Re)-conceptualising vulnerability

This idea of 'vulnerability' (or 'adult at risk') promulgated both by the courts and safeguarding law and policy more generally, then, is two dimensional – the meeting of an inherent characteristic, such as disability or age, with a risk of being subjected to some form of harm. In essence, an individual must be vulnerable *because of* something (an internal characteristic), *to* something (risk of abuse or neglect). The problems with this approach to vulnerability, particularly for older people, are multiple. If part of what renders an older person vulnerable is her age, or the impairments that are associated with advanced age such as frailty, or an illness like dementia, as has been alluded to in *Watts v UK, LLBC v TH, JG and KR* and *Local Authority X v MM and KM*, and cited with approval in *DL*, then it seems to follow that simply belonging to a group with that particular characteristic (i.e. old age, frailty, dementia) indicates that the individual is 'vulnerable'. While an older person, or a person with dementia, may experience a level of vulnerability that a younger person, or a person without dementia does not experience, the approach outlined above fails to make reference to exactly *what it is* about old age, or dementia, for example, that impacts on the ways in which an older adult experiences vulnerability[12]. For example,

an older woman with late-stage dementia who resides with her abusive husband in a rural area with limited access to medical treatment and facilities, and who is cared for by a series of different carers provided by a private care agency, will experience vulnerability in a different way to an older man with early stage dementia but who lives with his lovingly devoted wife who cares for him well, and with many high quality medical facilities nearby. In the first scenario, the woman's experience of vulnerability may be compounded because of the different intersecting layers: her gender, the abuse she suffers from her husband, the lack of continuity of care, her geographic location and lack of facilities. The dementia *of itself* does not necessarily render her vulnerable. In other words, the current two dimensional approach criticised above fails to recognise the multiple sources of an older individual's particular experience of vulnerability, and may therefore place the older person at risk of an inadequate response to 'perceived' sources of vulnerability. In essence, internal characteristics *themselves* do not generate vulnerability; it is inadequate support mechanisms that generate the experience of vulnerability.

Furthermore, the approach currently promulgated by law and policy is grounded in, and reinforces the essentialising and stigmatising properties of both vulnerability (Peroni and Timmer, 2013), and old age. Tying vulnerability to an internal characteristic such as old age, or a cognitive impairment such as dementia for example, which are themselves loaded with negative connotations (See, for example: Isaksen, 2002; Johnstone, 2013; Martens, Goldenberg & Greenberg, 2005; Snyder & Miene, 1994), reinforces the idea that being vulnerable (or being at risk) is a 'bad thing', a weakness, a fault or something to be feared, as old age, and features or conditions associated with old age have come to be seen. This approach was perhaps

most obviously adopted in a recent judgment by Newton J, who stated that, 'the Court of Protection is concerned with the *weak and the vulnerable*' (emphasis added) (*A Healthcare NHS Trust v P & Q* [2015] EWCOP 15 at para. 7). Empirical research in fact mirrors the recent theoretical literature on vulnerability, and suggests that many of those tasked with caring for older adults envisage vulnerability as a positive state of being (Steinbock-Hult & Sarvimäki, 2011) – a state that gives rise to opportunities for growth and care. At the same time, the association between 'traditional' vulnerability and old age, also mutually reinforces the stereotypical view of old age itself, as well as the need for care and support in old age, as something to be feared, something 'bad', or as a negative state of being. This outmoded approach to vulnerability, as Luna (2009, p. 124) argues, is a 'simplistic answer to a complicated problem'; it belies the universal nature of what it is to be vulnerable, that is, vulnerability exists in each individual, not just those with certain characteristics. If vulnerability is being at risk of a particular harm or threat, then it exists in every individual by virtue of our embodiment and corporeality, which renders us susceptible to any physical and emotional harm (Butler, 2004; Butler, 2010; Gilson, 2014). It exists because of our interdependence - our relationships with others, and even because of the ways in which the society we inhabit may be structured – for example, certain power imbalances may render us susceptible to being harmed. It is this particular feature of vulnerability, the idea that in order to be vulnerable you must be susceptible *to* something, that Fineman (2008) argues, in fact makes the concept a universal one – one that inheres in all of us, not just certain individuals based on a certain characteristic. This idea of vulnerability as universal, or as a quality associated with human corporeality, again is not purely theoretical or abstract. Recent empirical research suggests that this alternative conceptualisation of vulnerability in fact has

some practical weight - that in relation to older people, vulnerability is characterised by those tasked with caring for older people as simply 'being human', and furthermore is not *only* experienced by the older person as previous constructions of vulnerability would indicate, but is also experienced by caregivers for older adults (Steinbock-Hult & Sarvimäki, 2011; Sarvimäki & Steinbock-Hult, 2014).

Vulnerability and the older adult

The most recent cases that give an indication of the courts' current approach to the vulnerable older adult (and vulnerability more generally) are the three cases that form the analysis for this paper; *A Local Authority v DL*, *London Borough of Redbridge v G* and *NCC v PB*. *DL* concerned the treatment of an elderly couple (ML, 90 and GRL, 80) by their son, DL, with whom they lived. There had been concern by the Local Authority since 2005 of physical assaults, verbal threats, and controlling behaviour by DL, which included controlling the visits by care professionals to his mother, ML, as well as concerns of financial abuse (*A Local Authority v DL, ML, GRL and JP* [2011] EWHC 1022 at para. 6). It was agreed by the Local Authority that neither ML nor her husband, GRL, lacked capacity as to residence and contact with their son under the Mental Capacity Act (although by the time proceedings reached the High Court it was agreed that GRL did lack capacity: *A Local Authority v DL & Others* [2011] EWHC 1022 (Fam) at para. 2), and proceedings were therefore commenced under the inherent jurisdiction. The issue for the courts to determine was a legal one; had the inherent jurisdiction survived the implementation of the Mental Capacity Act 2005? In a unanimous decision the Court of Appeal held that it had.

Since *DL*, two cases in particular involving older adults have arisen where applications were lodged, in part, under the inherent jurisdiction on the basis of the older adult's vulnerability. *London Borough of Redbridge v G* concerned a lady of 94, G, who lived with C, and C's husband, F, to whom she had been introduced through membership of her local church. There had been concerns over G's welfare for a number of years following allegations that C was acting in an overbearing and verbally abusive manner, as well as allegations of possible financial abuse, resulting in five safeguarding referrals between March 2011 and May 2013. The issues that fell to the Court of Protection to be determined were multiple, over a series of judgments, and included, *inter alia*, whether G had capacity as to litigation, her financial affairs, contact with C and F and contact with the press. Following a determination by Russell J that she lacked capacity as to these issues (*London Borough of Redbridge v G* [2014] EWCOP 485), it was subsequently held that it would be in her best interests to place restrictions on her contact with both C and F and the press (*London Borough of Redbridge v G* [2014] EWCOP 17) and orders were granted requiring C and F to move out of G's property.

NCC v PB and TB concerned an application, again lodged under both the Mental Capacity Act and the inherent jurisdiction (in the event that PB was deemed not to lack capacity under the Mental Capacity Act), concerning, *inter alia*, the residence[13] of PB, a 79-year old woman, who had been married to TB for a number of years. There were concerns over PB's lifestyle with TB, which included unsanitary living conditions, being abandoned on 'road trips' and abusive behaviour by TB towards PB. The issue to be determined by the Court was whether she lacked capacity to decide where to live under the Mental Capacity Act or whether her

decision-making was fatally impaired because of the nature of her relationship with TB, thereby invoking the inherent jurisdiction. Parker J, sitting in the Court of Protection, found that she lacked capacity under the Mental Capacity Act, and authorised her residence in a care home based on this finding. Both *London Borough of Redbridge v G* and *PB* then, concerned individuals with what was deemed to be an impairment or disturbance in the functioning or the mind or brain; G was deemed to have dementia, whilst PB was deemed to have residual schizophrenia or schizo-affective disorder, a diagnosis on which the two experts could not agree (*NCC v PB* [2014] EWCOP 14 at para. 59), which led the Court of Protection in both cases to hold that they were not capable of satisfying the remainder of the functional test for capacity (s.3 Mental Capacity Act 2005).

Outdated vulnerability

At first glance, the outcome of these cases may seem intuitively appealing – the facts of the cases are highly emotive, and the decisions represent a desire to safeguard older adults from what appear to be abusive relationships, where there are unequal power relations at play, and as shall be shown later, recent accounts of vulnerability do not necessarily require the courts to take a back-seat or non-interventionist stance. However, the heavy reliance on outdated conceptualisations of vulnerability by the courts in these cases indicates that the judiciary has not made huge strides forward in their understanding of the vulnerable older adult. The use of the term vulnerability as a descriptor in these cases illustrates this point well. 'Vulnerability' in *London Borough of Redbridge v G*, for example, is frequently deployed as a descriptor alongside 'old', 'frail', 'elderly' and 'incapacitous'. In the capacity hearing, Russell J describes G as an 'old, vulnerable lady' (*London Borough of Redbridge v G* [2014]

EWCOP 17 at para. 12). In discussing the reporting restrictions, Russell J states that 'I have done so to protect the privacy of G who is *old, frail* and *vulnerable*' (emphasis added) (*London Borough of Redbridge v G* [2014] EWCOP 485 at para. 50). In a later hearing, Cobb J holds that 'There is…a legitimate public interest in the reporting of proceedings in the Court of Protection concerning *our vulnerable, elderly and incapacitous*. There is a separate legitimate public interest in the court protecting the *vulnerable, elderly, and the incapacitous* from public invasion into their lives' (emphasis added) (*London Borough of Redbridge v G* (No. 2) [2014] EWCOP 959 at para. 19). This, again, mirrors similar descriptive approaches taken by earlier decisions involving older adults, outlined above.[14] The association of vulnerability with old age, and certain corporeal or cognitive impairments associated with old age such as frailty or incapacity (this point will be returned to in a short while), indicates that the courts are deploying the term as a concept that attaches to those who demonstrate such characteristics. In effect, a return to the status or characteristic-based vulnerability criticised above.

This approach to vulnerability is perhaps most starkly (and worryingly) illustrated in *PB* where, in discussing whether she could have invoked the inherent jurisdiction if PB had not lacked capacity under the Mental Capacity Act, Parker J states that:

> "Unsoundness of mind" is not the same as "incapacity". PB has a diagnosed psychiatric condition which compromises her decision making. If it is not established that she lacks capacity this would be on the narrowest interpretation of MCA 2005 ("because of") and *would not impinge upon her diagnosis or her vulnerability, which results from her*

psychiatric condition. (emphasis added) (*NCC v PB and TB* [2014] EWCOP 14 at para. 119)

Although *obiter,* given that PB *was* deemed to lack capacity under the Mental Capacity Act, Parker J's approach here is firmly rooted in the idea that vulnerability stems from PB's psychiatric condition and is again reminiscent of the status based approach to vulnerability. Parker J's assertions indicate that the jurisdiction retains a role in respect of those who do suffer from psychiatric conditions but where their impairment does not mean they lack capacity under s.2(1) of the Mental Capacity Act[15]. This, combined with the approach in *London Borough of Redbridge v G*, where vulnerability status was linked to G's age and physical or cognitive characteristics, indicates that the courts in these cases continue to view vulnerability as resulting from an inherent characteristic, such as age, or as Parker J specifically states, a psychiatric condition. Tying vulnerability to an individual's inherent characteristic, such as dementia in *London Borough of Redbridge v G*, or her schizo-affective disorder in *PB*, presents the court with a far easier task than having to engage with the messy reality of the various intertwined factors that contribute to their experience of being vulnerable at an individual level, such as PB's attitudes towards marriage and her husband, or the fact that G's reluctance to have C and F removed as her carers may be because she believes her home will be taken from her and she will be placed in her care home (*London Borough of Redbridge v G* [2014] EWCOP 485 at para. 33). For the courts, it is far easier to attribute vulnerability to something concrete, or medical, such as their age or their psychiatric condition, than it is to try and navigate through a more complex set of circumstances that these two adults find themselves in – it is Luna's (2009) simplistic answer to a complicated problem in a very practical setting. The Court of Appeal itself in *DL* even acknowledges that it is

easier to identify internal characteristics that generate vulnerabilities, with MacFarlane LJ stating that 'it is not easy to define and delineate this group of vulnerable adults, as, in contrast, it is when the yardstick of vulnerability relates to an impairment or disturbance in the functioning of the mind or brain' (*DL v A Local Authority* [2012] EWCA Civ 253 at para. 64).[16]

In addition to this, another feature of these particular cases that demonstrate their steadfastness to a status or characteristic approach to vulnerability is in the way they characterise the relationship between 'vulnerability' and 'incapacity'. As noted earlier, prior to the implementation of the Mental Capacity Act, the inherent jurisdiction had developed to protect those whose decision-making was impaired because of mental incapacity. Following *Re G* and Munby J's decision in *Re SA*, however, it is obvious that *mental* incapacity is not the only basis on which to invoke the jurisdiction, or upon which a person can be vulnerable. According to Munby J in *Re SA*:

> [I]t can be seen that the inherent jurisdiction is no longer correctly to be understood as confined to cases where a vulnerable adult is disabled by *mental* incapacity from making his own decision about the matter in hand…[t]he jurisdiction, in my judgment, extends to a wider class of vulnerable adults. (Emphasis added) (*Re SA* at para. 76)

Munby J's approach, quoted here, is explicitly endorsed by both the High Court and the Court of Appeal in *DL* (*A Local Authority v DL* [2011] EWHC 1022 (Fam) at para. 53(4); *A Local Authority v DL* [2010] EWHC 2675 (Fam) at para. 19; *DL v A Local Authority* [2012] EWCA Civ 253 at para. 53).[17] Although 'the confluence of

mental impairment and undue influence is not all that unusual' (*Re BKR* [2015] SGCA 26 at para. 88), as the Singaporean Court of Appeal recently noted, in the cases discussed here, however, the judiciary has a tendency to exhibit semantic confusion as to the distinction between experiencing vulnerability, particularly when experience abusive relationships in old age, and being incapacitated (or lacking capacity). In the very first paragraph of the capacity judgment in *London Borough of Redbridge v G,* Russell J phrases the issue to be determined as whether G's lack of capacity 'is because of mental impairment within the meaning of the MCA sections 2 and 3 or if not whether she is a vulnerable adult *deprived of capacity* by constraint, coercion or undue influence…' (emphasis added) (*London Borough of Redbridge* [2014] EWCOP 485 at para. 1). This idea of lacking *capacity* because of undue influence reappears during Russell J's summary of the expert psychiatric and social worker evidence; '[b]oth [the social worker] and Dr Barker…share the view that G's *capacity* to reach decisions is undermined by the influence and presence of C and F' (emphasis added) (*London Borough of Redbridge v G* [2014] EWCOP 485 at para. 1). Russell J, however, is not alone in adopting this confused approach. A similar confusion is present in the arguments made by the Local Authority in *DL:*

> [Counsel's] submissions have therefore been to delineate the extent of the jurisdiction so that it only covers those cases where it is necessary for the court to act because *a person's capacity to make decisions for themselves has been overborne by circumstances other than those covered by the MCA 2005.* (Emphasis added) (*A Local Authority v DL* [2011] EWHC 1022 (Fam) at para. 50)

This argument is also one accepted by the Lord Justices in *DL*, with MacFarlane LJ stating that '[n]othing in the MCA 2005 makes express provision with respect to

individuals who may *lack capacity for a reason other than an impairment of, or disturbance in the functioning of, the mind or brain'* (emphasis added) (*DL v A Local Authority* [2012] EWCA Civ 253 at para. 58).[18]

This approach is also implicit in *PB*. In her summary of the expert evidence regarding PB's capacity Parker J states '…Dr Barker is not certain about the extent to which PB's decisions may be based on her beliefs about marriage, and to what extent TB's influence leads her to be *incapacitous* all the time' (emphasis added) (*NCC v PB and TB* [2014] EWCOP 14 at para. 63). To suggest that a vulnerable person can retain capacity under the Mental Capacity Act but can nevertheless be 'incapacitated' (and furthermore, incapacitated 'all the time') because of their vulnerability is disingenuous for a number of reasons. First, from a legal standpoint it risks bringing in the best interests standard found under the Mental Capacity Act, with none of the safeguards contained therein[19] into the court's remit of responses in these cases (discussed in more detail below)[20] - as Ruck Keene (2014) notes of the decision in *PB*, 'how is such an approach to be distinguished from taking a decision on behalf of such an adult?' It is, furthermore, worrying from an ethical standpoint. Using the term 'incapacitated', even in its non-legal sense, shifts the ultimate reason, or even the 'blame', for not being able to make an autonomous decision back to the individual who has been abused. Saying that an individual may be 'incapacitated' because of external forces such as coercion or undue influence indicates that it is a failure on their behalf that they are unable to make the decision – a defect within that individual's abilities to resist external pressure, so to speak, and as we shall see later, risks inviting inappropriate responses, directed towards the individual who has been abused rather than the abuser. In a more recent decision, *Re DM* (*Re DM* [2014]

EWHC 3119 (Fam)), Hayden J in fact stresses the separateness of the two concepts; 'I emphasise that "vulnerable" is not to be conflated with the concept of incapacitous' (*Re DM* at para. 5), and later (*Re DM* at para. 10) is keen to keep separate the remedies available under the Mental Capacity Act 2005, from the remedies available under the declaratory jurisdiction for those who are vulnerable.

How does the characterisation of the relationship between capacity (or incapacity) and vulnerability presented in *DL, London Borough of Redbridge v G* and *PB* support the argument presented here, namely that the courts still view vulnerability in relation to older people as being derived from an inherent characteristic? As noted earlier, in light of the Mental Capacity Act, 'lacking capacity' in one sense is now to be understood legally as stemming from a disturbance in the functioning in the mind or brain according to s.2(1) of the Act. Clear examples of such things as will be considered sufficient to fulfill this criteria are given in the Code of Practice to the Act, and include medical conditions such as dementia (Department for Constitutional Affairs, 2007, para. 4.12). It is clear then, that lacking capacity in its most common legal usage is now linked to a medical condition or cognitive impairment, something that, as noted earlier, recent vulnerability literature seeks to move away from. Characterising vulnerability as being incapacitated, as the courts do here, is reminiscent of the Mental Capacity Act approach, and risks linking an individual's vulnerability to an internal, often medical characteristic (i.e. their dementia, for example) – or reflects a 'defect' in an older individual's ability to resist external undue influence. Indeed such an approach was clearly articulated in the recent Singaporean case of *Re BKR* (*Re BKR* [2015] SGCA 26), involving the capacity of an older woman to make decisions over her property

and affairs and who was alleged have both a mental impairment and have been subjected to undue influence. The Singapore Court of Appeal held that only where there was no material question of the mental impairment causing the incapacity that the court would have no jurisdiction under the Singaporean Mental Capacity Act (*Re BKR* [2015] SGCA 26 at para. 124). In other words, wherever there is any suspicion that the mental impairment was just one of the causes of the incapacity then the issue will be determined under the Act. As I shall argue in the next section, this approach may invite inappropriate responses by the courts to perceived vulnerability.

Inappropriate remedies for older adults.

In order to assess the implications for older people if the courts are committed to retaining an inherent characteristic, or status-based approach to vulnerability, it is important to contextualise the courts' responses within the critiques and approaches to remedies derived from the theoretical literature. Recent theoretical stances on vulnerability do not assert that interventions or responses by the state or other individuals are unwanted, they in fact seek to move away from a non-interventionist stance (Fineman, 2004). Indeed the recent House of Lords post-legislative scrutiny report on the Mental Capacity Act notes on several occasions that a lack of response can entrench the experience of vulnerability just as much as improper responses[21]. What the recent vulnerability literature does seek to achieve, however, is to highlight the role that others, and, particularly for Fineman (2008; 2012) the role that the state plays in reducing the effects of external sources of vulnerability for older people – the so-called 'responsive state'. Mackenzie (2014) and Kohn (2014) however, go further than Fineman, and draw attention to the fact that in being 'responsive', the state can in itself constitute an additional source of vulnerability or further entrench an older

person's experiences of vulnerability. It has the potential for creating what Mackenzie terms a 'pathogenic' (Mackenzie, 2014, p. 39) source of vulnerability. This refers to the idea that socio-political or legal responses to the perceived 'vulnerability' of older adults may exacerbate them, or add an additional layer of vulnerability to an individual's experience. It is this feature of vulnerability that Clough (2014) notes is especially important, 'as it invites a deeper analysis of the impact of laws and policies – their ability to achieve their stated aims and, more importantly, to foster resilience in those rendered vulnerable' (Clough, 2014, p.373). In the context of this paper, these two aspects of the more recent vulnerability literature (the responsive state, and being circumspect of pathogenic vulnerability) are especially important as they indicate a need to consider the types of remedies imposed in these particular cases, and an analysis of whether such responses constitute pathogenic sources of vulnerability in themselves – in other words, do they entrench the older person's vulnerability more than no response or an alternative response? This is especially pertinent to explore, in light of other recent inherent jurisdiction decisions which envisage its task as being 'facilitative' rather than 'dictatorial'[22], an approach that may perhaps be more in line with recent conceptualisations of how best to respond to vulnerability in older adults and mitigating 'pathogenic' vulnerability.

Firstly, as argued earlier, the courts' current approach attributes an older adult's vulnerability to an inherent characteristic, and suggests that the inherent jurisdiction retains a role for those who suffer from psychiatric conditions but where the condition does not mean they lack capacity under the Mental Capacity Act (see also *An NHS Trust v Dr A* [2013] EWHC 2442 (COP)). A review of the statistics concerning the presence of psychiatric conditions in old age reveals why the implications of this

position may be extensive for older adults. It is well recorded that the number of older adults with cognitive or mental impairments is increasing in England and Wales; the number of adults with dementia in the UK currently stands at around 800,000 and is expected to rise to over 1 million in 2025, and nearly 2 million in 2051 (Alzheimer's Society, 2014, p. viii). Furthermore, it is predicted that in those over the age of 85, one in five will be diagnosed with dementia (Alzheimer's Society, 2014b). Although perhaps the most obvious, dementia, however is not the only psychiatric condition that affects older adults. Recent studies indicate that severe depression, anxiety disorders and lifetime alcohol disorders are also common in those over the age of 65 (Büchtemann, Luppa, Bramesfeld, & Riedel-Heller, 2012; Skoog, 2011; Volkert, Schulz, Härter, Wlodarczyk, & Andreas, 2013). As a result of this we can expect increased legal activity as to their decision-making over the coming years, and as has been noted recently in Deprivation of Liberty Safeguard applications (Gordon, Goldberg & Harwood, 2015; Health and Social Care Information Centre, 2014). Whilst the majority of this activity may well, at present, be dealt with under the Mental Capacity Act, the approach of the courts in these cases indicate that even if those with psychiatric conditions are not necessarily found to lack capacity under the Mental Capacity Act, they still remain 'vulnerable' based on the presence of a psychiatric condition and could be subject to orders under the inherent jurisdiction regardless of the fact that they legally still have capacity. From a purely statistical perspective, attributing vulnerability for the purposes of the inherent jurisdiction to an internal characteristic such as a psychiatric condition has potentially significant implications for older adults – and may mean that, if they are at risk of harm, their decision-making may be more readily and easily scrutinised by the courts, a position already advanced by Munby J.[23]

Secondly, in *A Local Authority v A*, which involved the decision-making ability as to contraception of a woman with serious learning difficulties who was also in a seemingly overbearing marriage, as well as in *LBL v RYJ*, the courts held that the purpose of the inherent jurisdiction was 'to facilitate the process of unencumbered decision-making' (*LBL v RYJ* at para. 62), and to 'create a situation where…she can receive outside help free of coercion to enable…her to weigh things up and decide freely what…she wishes to do' (*A Local Authority v A* at para. 79). However the result of the reasoning by Parker J, outlined above, is to the effect of stating that a residence order could still have been placed on PB by virtue of the fact that she had a psychiatric condition, even if she had not lacked capacity under the Mental Capacity Act:[24]

> In my view the inherent jurisdiction does extend to orders for residence at a particular place…Assuming that it would not constitute an unlawful deprivation of liberty in my view I would be entitled to make an order for placement against her will pursuant to the inherent jurisdiction. There are serious risks to PB if she is not properly cared for or if she is not protected against TB. (*NCC v PB and TB* at paras. 121-122)

Given the confusion the courts have between vulnerability and incapacity demonstrated above, this approach (stating that a decision made in PB's best interests under the Mental Capacity Act could also be authorised by invoking the inherent jurisdiction) is perhaps unsurprising. Ethically, however, it is problematic as a remedy imposed on PB does little to highlight and respond to the external features that may compromise her decision-making – preferring to respond to a threat that is based on her perceived inherent vulnerability, i.e. her cognitive impairment. This is, again, not

only at odds with remedies provided in cases such as *DL*, where injunctions were granted against the son (as opposed to the parents), but even *London Borough of Redbridge v G*, where injunctions were granted against C and F, not G, but it is even incompatible with previous cases such as *A Local Authority v A,* where undertakings were directed towards enabling Mrs A to make a decision as to contraception away from the influence of her husband. Authorising PB's detention in a care home based on her 'inherent' source of vulnerability may in fact render her susceptible to other (pathogenic) sources of vulnerability. Given the value she places on her marriage, she may feel disempowered or exposed based on not being able to reside with her husband, or in her own home – an aspect of moving to care homes that is frequently reported by older people in empirical research (Biedenharn & Normoyle, 1991; Gott, Seymour, Bellamy, Clark & Ahmedzai, 2004; Lee, 1997; Lloyd, Calnan, Cameron, Seymour & Smith, 2014) or she may even develop negative relationships with staff in the care home, even more likely given her original reluctance to live there.

Finally, and as touched upon earlier, the approach taken by Parker J may also be seen as envisaging a 'best interests' approach for the inherent jurisdiction. Apart from being paternalistic, a criticism often levied at any 'best interests' standard (Dunn, Clare, Holland & Gunn, 2007; Fennell, 2008; Szerletics, 2012)[25], this type of approach is problematic both legally[26], and theoretically, in light of the aims of the recent vulnerability literature on a number of counts, particularly for older people. If *A Local Authority v A* and *LBL v RYJ* are correct, then 'the goal of the jurisdiction is to safeguard decision making, rather than to safeguard well-being *per se*' (Keywood, 2011, p.331). If this is indeed the case, then the proper remit of the jurisdiction is to *facilitate* maximally autonomous decision-making for older adults and a 'best interests

approach' does not necessarily sit comfortably with the aims of vulnerability theory for older people, which emphasise empowerment and self-development, and therefore recognising effective ways in which we can promote such responses among the older population, as opposed to taking decision-making out of their hands (Fineman, 2012; Hall, 2014). A more nuanced vulnerability approach for older individuals focuses our attention on the 'conditions necessary for developing and maintaining [a specific set of] capacities' (Dodds, 2007, p.504). The decision in *PB*, however, arguably fails to recognise this in a way that is empowering for PB herself, by stating that whilst the inherent jurisdiction 'exists to protect, liberate and enhance personal autonomy…[t]o be maintained in optimum health, safe, warm, free from physical indignity and cared for is in itself an enhancement of autonomy' (*NCC v PB and TB* at para. 113). While it may be argued that this is correct from an *objective* standpoint, the way someone *should* want to make a decision objectively is irrelevant, the relevant issue framed by more nuanced accounts of vulnerability is how PB *herself* wants to make a decision, and calls for a legal response that supports this decision-making process. In particular the approach demonstrated by the courts explicitly derides the value she places on her marriage and her ability to reside with her husband, notwithstanding his controlling behaviour, and arguable lack of understanding of her medical needs. At paragraph 63, cited earlier, for example, Parker suggests that she is uncertain as 'to what extent TB's influence leads her to be *incapacitous all the time'* (emphasis added), and at other points indicates that she needs 'protection' from her husband because she is at risk (*NCC v PB* at para. 71). In the context of the inherent jurisdiction, a responsive vulnerability theory requires a consideration of the subjective experiences of the older adult - it does not necessarily seek to escape value judgments or interference, but recommends that legal responses make such judgments from the subjective point of

view of the older adult at the heart of the proceedings, rather than from an objective stance. This point becomes particularly salient when we reflect upon the multiplicity and diversity of factors that older people take into consideration when making decisions about their care (Brown, 2011; Cicirelli, 1998; Fried & Bradley, 2004; Pritchard-Jones, 2014). Comparing these three cases highlights this particular point well. In *PB,* PB is an individual that clearly values her interdependence and marriage to her husband over and above many other factors. In contrast, G, in *London Borough of Redbridge v G* values her *independence* – as well as her interdependence from the relationship with her fellow churchgoers. In *DL* it was uncertain, even doubtful, that any of the three parties concerned wanted the litigation. ML at the very least did not want proceedings brought in respect of her relationship with her son, and whilst it was not so certain that this was the case for her husband, GRL, it *was* uncertain how much he would want to go against his wife's wishes.

So what types of remedies *would* a responsive vulnerability analysis have envisaged? How could the courts have reacted more appropriately in the cases critiqued in this article? To put this question bluntly, how could the courts have responded to the situation encountered by GRL and ML, G and PB, in a more 'vulnerability-friendly' manner? One suggestion that emerges from this analysis would be to simply remove the requirement under the Mental Capacity Act that incapacity must be because of an impairment or disturbance in the functioning of the mind or the brain (Mental Capacity Act s.2(1)).[27] This would have the benefit of retaining the safeguards contained in the Act itself for such cases, and the aspects of the Act that the House of Lords post-legislative scrutiny were in favour of, but removing the association between incapacity and impairment, thereby making the Act itself applicable to

situations where an individual's decision-making is threatened by elder abuse. This would mean that cases such as these could be decided under the Act, but without the artificiality of having to establish the causal nexus between the diagnostic element and the functional element of lacking capacity – thereby potentially encompassing *DL*-type facts. Even at first glance, however, there are potentially a number of problems with this suggestion. Firstly, removing this requirement from the Act does not itself automatically render the Act relevant to instances of elder abuse – the question remains 'at what point does the state intervene in such cases'? Removing this aspect of the Act simply requires us to establish an alternative threshold over and above which the state will consider it necessary to intervene. As such, if this is a viable option, then more work must be done on how to establish what would then be the necessary boundaries of the Mental Capacity Act, or even whether such boundaries are legally realisable. Neither does such an approach conquer the problems that are encountered when faced with 'best interests' decision-making – it would continue to take decision-making out of an older person's hands and place it in the hands of the state – an approach rejected by the recent vulnerability literature. Moreover, neither does such an approach adequately address the concerns raised earlier regarding the ethical implications of conflating external threats to decision-making such as abuse, with perceived internal 'failures', such as impaired functional capabilities.

Finally, given that the Mental Capacity Act 'is concerned with enabling the court to do for the patient what he could do for himself if of full capacity, but it goes no further…the court has no greater powers than the patient would have if he were of full capacity' (*Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67, at para. 18), an alternative suggestion would be to retain the inherent

jurisdiction for cases such as these, but make greater use of the breadth of remedies available under the jurisdiction. In *London Borough of Redbridge v G*, it is welcoming to note the local authority's assurances of home-care for G, given her fears about moving to a care home (*London Borough of Redbridge v G* [2014] EWCOP 17 at para. 43), and the Court's emphasis on re-integrating G with her church community (*London Borough of Redbridge v G* [2014] EWCOP 17 at para. 83), as well as the removal of C and F from G's home. However given the clearly detrimental effect both C's conduct and the legal proceedings had on G, and the court's rejection of her consistently expressed wishes for C and F to remain in her home, perhaps the court could also have explicitly considered the possibility of offering ongoing emotional support and advice, such as counselling, to the extent that G would have been willing and able to accept such offers, and to the extent that these are not already provided within the care package available to G. Similarly in *PB*, rather than simply authorising her residence in a care home with limited supervised contact with her husband (*NCC v PB* at para. 123), the court could potentially have explored alternative options such as providing secure community living arrangements and an appropriate care package, as well as less restricted contact with TB. These suggestions may be, in principle, more sensitive to the 'responsive state' envisaged by Fineman. In light of the recent decision in *Re MN* (*Re MN* [2015] EWCA Civ 411), however, where the Court of Appeal held that the Court of Protection '…has no more power, just because it is acting on behalf of an adult who lacks capacity, to obtain resources or facilities from a third party…than the adult if he had capacity would be able to obtain himself' (*Re MN* [2015] EWCA Civ 411 at para. 80), it may be that the courts are progressively moving in the opposite direction, at least where an individual lacks capacity under the Mental Capacity Act. It remains to be seen whether the court would take this line if faced with

a similar case under the inherent jurisdiction, and if it did, then this would also indicate that the jurisdiction's remedies are not 'theoretically limitless', after all.

Concluding remarks

'Society must guard against excesses that might ironically deny the elderly their autonomy by forcing it upon them' (Kapp, 1989, p.5). This was the warning issued by Marshall Kapp in 1989. Following *DL* there does seem to be a clear commitment to retain the inherent jurisdiction to safeguard the decision-making of older adults, particularly for those who have been the victims of 'elder abuse', but the argument presented in this paper is that the court's approach to the vulnerable older adult is confused, and remains grounded in historical and outdated ideas of what it means to be 'vulnerable'. Moving forward in developing the jurisdiction for the vulnerable older adult who may be the victim of 'elder abuse', the courts may be wise to heed Kapp's warning. In turn, this paper suggests that the retention of the jurisdiction is not necessarily unwelcome[28] and may well be more flexible than the Mental Capacity Act in responding to compromised decision-making for older adults who experience abuse, but in order to be that responsive a more nuanced understanding of what it means to be vulnerable, and in particular what it means to be a vulnerable older person is required. Given the fledgling nature of the post-Mental Capacity Act cases on the scope of the inherent jurisdiction, the arguments put forward here are tentative, but in turn serve to highlight broader ethical and legal issues for further research. What is the interplay between the jurisdiction, vulnerability and human rights principles? Can the inherent jurisdiction provide a better, more appropriate way of thinking about cases of 'fluctuating capacity', such as dementia? Unfortunately only when the courts begin to engage the jurisdiction rather than forcing such cases under

the Mental Capacity Act will these areas open up for discussion, and will we be able to envisage a more responsive judiciary. At present, however, we will have to wait and see just how 'responsive', and in what way, the courts are willing to become.

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[1] The Serious Crime Act 2015 has also recently received Royal Assent, and criminalises coercive or controlling behaviour in intimate or family relationships (S. 76, Serious Crime Act 2015). Given that this is yet to be enacted, it remains to be seen to what extent this provision will also support the obligations incumbent on local authorities by virtue of the Care Act.

[2] It is worth noting at the outset that only *DL* was in fact decided using the jurisdiction. *London Borough of Redbridge v G* and *PB* were decided under the Mental Capacity Act, but nevertheless *PB* contained lengthy discussion of the jurisdiction before its ultimate rejection, and *London Borough of Redbridge v G* provided interesting comments on vulnerability. This point, and the difficulty it presents in blurring the legal boundaries of 'capacity' and 'vulnerability' will also be discussed further in this paper.

[3] Whilst aim of the paper is to examine the construction of the 'vulnerable older adult' in these cases, and examine the broader legal implications of this for the development of the inherent jurisdiction more generally, the arguments presented may apply to other 'groups' traditionally considered vulnerable, and how these particular cases interplay with other inherent jurisdiction cases will form a key feature of the analysis.

[4] Hale J held that the declaratory jurisdiction could only be invoked to protect a legal right and not to limit an individual's freedom of association. To this effect, Hale J explains a legal right in the context of this particular case by stating that 'It is access, or freedom *of* association, rather than harassment, or freedom *from* association, which is protected under English law' (emphasis in original): *Cambridgeshire County Council v R (An Adult*) ([1995] 1 FLR 50 at p.52). She goes on to say that '[i]t is clear…from the troubling circumstances of this case that there exists no wholly appropriate legal mechanism for examining whether or not W should be free to make her own decisions in the vital matter of her relationship with her family… it is a sad state of affairs that the law is unable to provide suitable protection in such a situation': *Cambridgeshire County Council v R (An Adult*) ([1995] 1 FLR 50 at p.56).

[5] *R v Bournewood Community and Mental Health NHS Trust, ex parte L* ([1999] 1 AC 458) was subsequently ruled unlawful by the European Court of Human Rights in *HL v UK* ([2004] ECHR 471), which led to the Deprivation of Liberty Safeguards being inserted into the Mental Capacity Act 2005 by the Mental Health Act 2007. More recently, however, see *An NHS Trust v Dr A* [2013] EWHC 2442 (COP).

[6] This approach was endorsed by the Court of Appeal in *DL*. It is also important to note the broad brush that Munby J takes to this idea of vulnerability, though. Despite this definition, he also states that it is difficult to delineate the group he considers vulnerable (*Re SA* at para. 77), he also said that the definition he's given is 'descriptive, not definitive; indicative rather than prescriptive' (*Re SA* at para. 82). The particular wording used by Munby J also mirrors the statutory approach under s.29(1) of the National Assistance Act 1948, although the Act does not use the term 'vulnerability' explicitly, section 29(1) states that '[a] local authority shall have power to make arrangements for promoting the welfare of persons…who are blind, deaf or dumb, and other persons who are substantially and permanently handicapped by illness, injury, or congenital deformity or such other disabilities as may be prescribed by the Minister.' I would like to thank Kirsty Keywood for bringing this point to my attention.

[7] Adopting the language of the Wolfenden Report; (Committee on Homosexual Offences and Prostitution, 1957) cited by Munby J in *Local Authority X v MM and KM* [2007] EWHC 2003 (Fam) at [128].

[8] The language used by the Court is adopted from the Jolley (2003) Report.

[9] This approach itself was adopted from *Who Decides* (Lord Chancellor's Department, 1997), the green paper on decision-making for mentally incapacitated adults, which ultimately led to the enactment of the Mental Capacity Act 2005.

[10] What exactly the Act means by 'enquiries', however, is left unexplained; the guidance for implementation simply refers to 'whatever enquiries [the local authority] thinks necessary to decide what if any action needs to be taken and by whom' (Department of Health, 2014, para. 14.57) and explains that 'enquiry' could mean any number of things from an informal chat with the individual in question, right through to a 'much more formal multi-agency plan or course of action' (Department of Health, 2014, para. 14.64). Secondly, the Act repeals s.47 of the National Assistance Act 1948, which provided local authorities with a power of removal of a vulnerable adult, but does not replace this with any other provisions such as a power of entry. In this respect the Care Act arguably falls short in comparison with the provisions in both the Scottish (Adult Support and Protection (Scotland) Act 2007) and Welsh (Social Services and Well-being (Wales) Act 2014) legislation: (Fitzgerald and Ruck Keene, 2014).

[11] The approach to vulnerability based on the presence of internal characteristics is not one that is peculiar to social welfare law and policy, though. For example, the current offences of willful neglect or ill-treatment found in section 44 of the Mental Capacity Act and s.127 of the Mental Health Act 1983 are ones that apply when a person lacks capacity, or the perpetrator reasonably believed that person lacked capacity (i.e. because of an impairment of, or a disturbance in the functioning of, the mind or brain according to section 2(1)), or when an individual is being treated for a mental health disorder. This remains the legal position until sections 20 and 21 of the Criminal Justice and Courts Act 2015, which provide for general offences of willful neglect or ill-treatment by health care workers or health care providers, enter in to force. For a critique of the scope of the current offences, as well as their utility, see: Alghrani, Brazier, Farrell, Griffiths and Allen, (2011); House of Lords Select Committee on the Mental Capacity Act 2005 Report of Session 2013-14, (2014) at paras. 301-309; Hansard, HL Deb 10 March 2015, Vol 760, Col 631. Similarly, the offence of causing or allowing the death of a vulnerable adult under section 5 of the Domestic Violence Crime and Victims Act 2004 applies only to an adult who is 'vulnerable' under its terms; 'a person aged 16 or over whose ability to protect himself from violence, abuse or neglect is significantly impaired through physical or mental disability or illness, through old age or otherwise' (S.5(6)). Likewise a similar definition is to be found in the Safeguarding Vulnerable Groups Act 2006 section 56(9) which states that an individual may be vulnerable if, *inter alia*, he has 'particular needs because of his age', 'has any form of disability' or 'has a physical or mental health problem' (S.56(9)(a)-(c)). Dunn et al. (2008) also note the use of this

characterisation of vulnerability not only in relation to the inherent jurisdiction but also to 'vulnerable witnesses' in the criminal justice system.

[12] The use of the phrase 'experience vulnerability' as opposed to 'be vulnerable' is important here. On the account of vulnerability presented here, it is important to distinguish between the two. More recent vulnerability theory, which emphasises the role of external factors, align more to an understanding of vulnerability as being experienced, however an account of vulnerability that looks at an internal characteristic (which more recent accounts, including the one advanced here) gives the overwhelming impression that vulnerable is something an individual can 'be'. It is the former understanding of vulnerability that this article adheres to and as such the term 'experience vulnerability' is deliberately used here.

[13] There was also a question over PB's refusal of an endoscopy, however this was not ultimately an issue to be decided by the court as PB voluntarily underwent the procedure (*NCC v PB and TB* at para. 124).

[14] See in particular the judgment of Munby J in *Local Authority X v MM and KM* at para. 120: 'The fact is that all life involves risk, and the young, the elderly and the vulnerable, are exposed to additional risks and to risks they are less well equipped than others to cope with.'

[15] If this the case, then we could question whether it is accurate, from an administrative point of view, as counsel for *DL* did on appeal (*DL v A Local Authority* (2012) EWCA Civ 253 at paras. 36-39), but which was rejected by the Lord Justices (*DL v A Local Authority* (2012) EWCA Civ 253 at para. 57-63)

[16] This functional approach has also been heavily criticised by the Committee on the Rights of Persons with Disabilities: 'it presumes to be able to accurately assess the inner-workings of the human mind and, when the person does not pass the assessment, it then denies him or her a core human right': UN Committee on the Rights of Persons with Disabilities, General Comment 1, CRPD/C/GC/1 at para. 15.

[17] It is precisely because vulnerability differs from mental incapacity that the courts in both *Re G* and *Re SA* felt the need to make the declarations it did; neither G nor SA lacked *mental* capacity, but both were at risk of harm. In G's case it was the risk of losing her capacity again should she have unrestricted contact with her father, and for SA it was the risk of harm if she was forced to enter in to a marriage.

[18] This is despite earlier references to vulnerability that MacFarlane LJ makes, which align vulnerability to autonomy, rather than capacity: 'The jurisdiction…is in part aimed at enhancing or liberating the autonomy of a vulnerable adult whose *autonomy* has been compromised by a reason other than mental incapacity…' (*DL v A Local Authority* [2012] EWCA Civ 253 at para. 54). This latter conceptualisation of vulnerability as pertaining to autonomy may be more in line with recent theoretical accounts.

[19] For example, the decision made must be carried out in the least restrictive way (Mental Capacity Act S1(6)), or the list of relevant factors to be considered when making the decision (S.4(6)).

[20] The legal consequences of this approach were argued forcefully by counsel for DL (*DL v A Local Authority* [2012] EWCA Civ 253 at paras. 36-41), although this argument was not accepted by the Lord Justices. See also Hewson (2013).

[21] House of Lords Select Committee on the Mental Capacity Act 2005 Report of Session 2013-14, (2014) at paras. 3, 16 and 60.

[22] In particular I discuss the difference between the approach of the courts in the cases that form the focus of this paper, in comparison with the approach in *LBL v RYJ* and *A Local Authority v A* ([2010] EWHC 1549 (Fam)). It is also important to note, however, that the arguments put forward here do not advocate for a non-interventionist approach i.e. a reinforcement of the public-private divide. What this article seeks to highlight is that intrusion may be welcome, but vulnerability theory has the potential for illustrating *more appropriate* types of remedies.

[23] '[A]n adult who is vulnerable is more likely to fall into the category of the incapacitated in relation to whom the inherent jurisdiction is exercisable than an adult who is not vulnerable. So it is likely to be easier to persuade the court that there is a case calling for investigation where the adult is apparently vulnerable than where the adult is not on the face of it vulnerable' (*Re SA* at para. 83).

[24] And, furthermore, would still have been compliant with article 5 of the European Convention on Human Rights. Her reference to 'unsound mind' is in light of the requirements of article 5(1)(e) of the European Convention, which stipulates that a person may be deprived of their liberty in accordance with a procedure prescribed by law if they are of unsound mind. We can question how wide the court in *PB* envisages the term 'unsoundness of mind' and whether this would, then, extend beyond those who have psychiatric conditions to also include those who have been subjected to coercion or undue influence - an analysis of how broad 'unsoundness of mind' may be framed is beyond the scope of this paper, however it is worth noting that the *Winterwerp* criteria require someone of unsound mind to be suffering from a 'true medical disorder' established by 'objective medical expertise' (*Winterwerp v The Netherlands* [1979] 2 EHRR 387 at para. 39).

[25] Despite these criticisms, the recent House of Lords Select Committee post-legislative scrutiny report was generally supportive of the Mental Capacity Act, and the best interests principle: House of Lords Select Committee on the Mental Capacity Act 2005 Report of Session 2013-14 (2014) at paras. 90-101

[26] Although outside the scope of this article, it is important to note that without any provision of review for PB's detention, this approach subverts the current procedural requirements that exist under the Deprivation of Liberty Safeguards and may also therefore be unlawful under the European Court of Human Rights ruling in *HL v UK* ([2004] ECHR 471). *Had* this case been decided under the inherent jurisdiction, however, and Parker J had put in place measures for the court to review her detention (as happened in *An NHS Trust v Dr. A*, then this approach, being more stringent procedurally than the review mechanisms found in the Deprivation of Liberty Safeguards, may in fact be more human rights compliant. I would like to thanks Beverley Clough for drawing my attention to this last point.

[27] I would like to thank Paul Skowron for highlighting this possibility.

[28] Indeed abandoning the inherent jurisdiction as a means of safeguarding decision-making for older people could potentially be in violation of state obligations under article 8 of the European Convention, as the Court of Appeal held in *DL* ([2012] EWCA Civ 253 at para. 66). For an argument that the jurisdiction may certainly be better equipped for dealing with the capacity of adults with mental impairments to consent to sexual relations see Clough (2014).

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