



Welcome to the July 2018 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: an appreciation of Alastair Pitblado, the Mental Capacity (Amendment) Bill, the Joint Committee on Human Rights considers DoLS reform and fluctuating capacity;

(2) In the Property and Affairs Report: the OPG mediation pilot

(3) In the Practice and Procedure Report: court fees reductions and when to join;

(4) In the Wider Context Report: Lady Hale on *Cheshire West* and the CRPD, Parliamentary debates and developments and a major Council of Europe report on attorneys and advance directives;

(5) In the Scotland Report: AWI consultation responses and Sandra McDonald reflects on her time as Public Guardian;

You can find all our past issues, our case summaries, and more on our dedicated sub-site [here](#).

#### Editors

Alex Ruck Keene  
Victoria Butler-Cole  
Neil Allen  
Annabel Lee  
Nicola Kohn  
Katie Scott  
Simon Edwards (P&A)

#### Scottish Contributors

Adrian Ward  
Jill Stavert

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

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### Alastair Pitblado

*[We are very sad to report the death of Alastair Pitblado, the Official Solicitor and Public Trustee. We will publish in the next issue an appreciation of him by Jim Beck, from the office that he oversaw for over a decade, but in the meantime, we reproduce here Alex’s reflections that were published in Legal Action Magazine.]*

I last saw Alastair in the Supreme Court at the hearing of his appeal (on behalf of the patient) in the Y case. He was very sick with the illness that ultimately took him, but the fact that he had come almost directly from his hospital bed to attend the hearing was absolutely characteristic of him. He was absolutely tenacious in pursuit of the protection of the rights upon whose behalf he acted as Official Solicitor, and in defending the systems established for their protection. I hope that he would have appreciated the irony that two days after his death the Strasbourg court delivered a judgment making clear just how right he had been in *Re X* to insist on the importance of the participation in proceedings of those being deprived of their liberty.

I did not always agree with Alastair, and indeed vividly recall giving a talk at a conference about why he was wrong on a point, with him in the front row giving me the characteristically quizzical look he gave that meant that there was a lot he could say but was holding back (for now). But there was no doubting the care that he took – and instilled in all those under him to take – to ensure all the complexities had been considered before deciding what call to make on behalf of any individual “P.” No-one could ask for more of someone bearing such responsibilities, and we owe him a huge debt of thanks.

### Mental Capacity Amendment Bill

Acting considerably more quickly than many had expected to give effect to its commitment to legislate to act upon Law Commission’s Mental Capacity and Deprivation of Liberty report, the Government has introduced the Mental Capacity Amendment Bill.

This is a rather different Bill to that attached in draft to the Law Commission’s report. In particular, all the wider elements of that Bill (e.g. securing greater weight in best interests

decision-making for the person's wishes and feelings and greater safeguards in relation to steps constituting a serious interference with a person's Article 8 ECHR rights) have been stripped out, along with such elements as the codification of the concept of 'advance consent.' Instead, the Bill is narrowly focused on a variant of the Law Commission's Liberty Protection Safeguards ('LPS'). The [Explanatory Notes](#), from which some of what follows is drawn, do not give an explanation for why this course been taken; the [Impact Assessment](#) says that "*the Law Commission also proposed making some wider amendments to the Mental Capacity Act which we have decide not to legislate for at this point, as we think there are other effective levers to deliver improvement in these areas.*" We have no doubt that exactly what these levers may be and how effective they are will be probed further at second reading in the House of Lords on 16 July.

We set out the key features of the Bill below, along with some points where it differs from the Law Commission proposals. Not least because Alex is incapable of providing a detached view, we will leave consideration of its broad merits (or demerits) for others at this stage; we would, though, welcome any thoughts that people may wish to contribute in advance of our next report in September; and many may wish to see Lucy Series' initial observations [here](#) and [here](#). We are also working on further opportunities both to update people and to feed into the Parliamentary process; we will update by way of email in the interim.

The commentary here is presented on the basis that the Bill would be made law exactly as it stands.

### *Definition of deprivation of liberty*

There is no statutory definition of deprivation of liberty, so the definition remains that contained in Article 5 ECHR, as interpreted, in this context, by the Supreme Court in *Cheshire West*.

### *Interim/emergency deprivation of liberty*

Section 4B MCA will be amended so as to provide express authority for a person to take steps to deprive another person of their liberty if four conditions are met. Broadly speaking, section 4B gives authority to take steps to deprive a person of their liberty in three circumstances:

1. where a decision relevant to whether there is authority to deprive the person of liberty is being sought from the Court of Protection;
2. where steps are being taken (either by a responsible body or a care home manager) to obtain authorisation under Schedule AA1 (replacing the concept of urgent authorisations under DOLS); or
3. in an emergency (i.e. solving the problem discussed at paragraphs 45-50 of our [guidance note](#) on deprivation of liberty in the hospital setting).

### *New Schedule AA1*

This will replace DOLS with a new scheme which will be called LPS (although this name is not on the face of the Bill).

Schedule AA1 provides for the new administrative scheme for the authorisation of arrangements enabling care or treatment of a person who lacks capacity to consent to the arrangements, which give rise to a deprivation of

that person's liberty. In a change to the Law Commission's proposals, the LPS will only apply to those aged 18 and above.

Under Schedule AA1, a responsible body will be able to authorise arrangements giving rise to a deprivation of a person's liberty in any setting (or in more than one setting). The responsible body will be:

1. The "hospital manager" where the arrangements are carried out mainly in a hospital;
2. A CCG or Local Health Board in the case of arrangements carried out through NHS continuing health care (but not mainly in a hospital);
3. A local authority in all other cases, including where care is arranged by the local authority, and where care is provided to people paying for their own care (self-funders).

Before a responsible body can authorise the arrangements, it must be satisfied that three authorisation conditions are met:

1. the person who is the subject of the arrangements lacks the capacity to consent to the arrangements;
2. the person is of unsound mind; and
3. the arrangements are necessary and proportionate. Note here that, in a difference to the Law Commission proposals, there is no reference to the necessity and proportionality being judged either by

reference to the risk of harm to the person themselves or by the risk of harm to others.

A further difference to the Law Commission proposals is that the Bill does not on its face provide that at least two people have to carry out the assessments, so it would appear that all three could be carried out by a person with the suitable experience and knowledge. It may well be that this a matter addressed in the Code of Practice.

The responsible body (or, as below the care home) must also carry out consultation with the person and a range of others, in particular to try to ascertain the cared-for person's wishes or feelings in relation to the arrangements.

A person who is not involved in the day-to-day care of, or in providing any treatment to, the person must also carry out a pre-authorisation review<sup>1</sup> to determine whether it is reasonable for the responsible body to conclude that the authorisation conditions are met. In cases where the person is objecting to the proposed arrangements, an Approved Mental Capacity Professional must carry out the pre-authorisation review. In that case, the Approved Mental Capacity Professional must determine whether the authorisation conditions are met.

One major difference to the Law Commission proposals is what happens where arrangements are wholly or partly carried out in a care home. The general effect of the relevant paragraph (13) of Schedule AA1 is that the care home manager must arrange the relevant assessments and take the other necessary steps before an

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<sup>1</sup> The concept of 'pre-authorisation review' is essentially the same as that of 'independent review' proposed by the Law Commission.

authorisation can be given by the responsible body.

Once an authorisation has been given, there are a number of safeguards put in place for the person. These include regular reviews of the authorisation by the responsible body or care home, and the right to challenge the authorisation before the Court of Protection (under a new s.21ZA). Although the Bill is silent on this, we would anticipate that such challenges would attract non-means-tested legal aid as s.21A challenges do at present.

From the outset of the process of authorisation under the Schedule to the point when the authorisation comes to an end, the person is to be represented and supported either by an “appropriate person” or an IMCA.<sup>2</sup> If the person has capacity to consent to being represented by an IMCA, the person must make a request, or where they lack the capacity to consent, the responsible body must be satisfied that being represented and supported by an IMCA would be in the person’s best interests. An IMCA must be appointed unless there is an appropriate person who would be suitable to represent and support the person, consents to being appointed and is not engaged in providing care or treatment to the person in a professional role. There are also circumstances in which the appropriate person must themselves be provided with an IMCA.

Authorisations can be varied where (for instance) the responsible body changes because the location of the arrangements change. They can also be renewed, in the first

instance for 1 year, and thereafter for periods of up to 3 years.

Part 7 of Schedule AA1 sets out the interface between the LPS and the Mental Health Act 1983. This is another major area of difference to the Law Commission Bill, which would (in general) have excluded the use of the LPS in the mental health setting. Part 7, by contrast, broadly speaking maintains the current position (and also maintains much of the drafting of Schedule 1A albeit in – if this possible – even more complicated form). The effect is that patients who are detained under the Mental Health Act 1983 or who are objecting to being in hospital for mental health treatment (or to that treatment), cannot be made subject to an authorisation under Schedule AA1.<sup>3</sup> But in the community a person could be subject to an authorisation under Schedule AA1 and subject to Mental Health Act requirements, so long as the authorisation does not conflict with those requirements. Note in this context that s.16A is being repealed: the Court of Protection would not therefore be bound by the same eligibility issues in the mental health setting which led to the complexities in the *Dr A* case.

One final difference to the Law Commission Bill worth noting at this stage is that this Bill does not introduce a tort of deprivation of liberty actionable against a private care provider. In light of the continued distinction between false imprisonment and deprivation of liberty identified by the Court of Appeal in *Jollah*, discussed in the Wider Context report, it would appear that it will remain the case that a self-

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<sup>2</sup> Section 39A-D MCA 2005 will be repealed, as these advocacy provisions are tied to DOLS.

<sup>3</sup> Unless the person falls within the ‘learning disability’ exception, at which point the LPS could be used.

funder who does not meet the (tighter) test for false imprisonment would have no direct recourse against the care provider where steps are not taken to ensure that arrangements are authorised.

#### *Next steps*

Second reading of the Bill is in the House of Lords on 16 July. We do not anticipate that Royal Assent would be granted before early next year, and, given that a transition period will be required before the DoLS can be replaced by the LPS, it is likely that the amended Act would not be fully in force until 2020 at the earliest, and potentially 2021.

#### **Joint Committee on Human Rights Report: the Right to Liberty and Security**

*[On 29 June, only a matter of days before the Mental Capacity (Amendment) Bill was introduced, the Joint Committee on Human Rights published the [report](#) into its inquiry into the reform of DoLS. Whilst we recommend reading the whole report to get the Committee's full consideration of the questions of (1) whether DoLS should be reformed as a matter of urgency; (2) whether the Law Commission's proposals strike the right balance, and (3) whether there should be a statutory, definition of deprivation of liberty, we reproduce here the summary (with footnotes omitted) for those needing / wanting to cut to the chase.]*

Article 5 of the European Convention on Human Rights (ECHR) prohibits arbitrary deprivation of liberty. Consequently, it is vital to have mechanisms to ensure that the arrangements made for vulnerable people who lack mental capacity are in their best interests. It is also important that resources are, as far as possible, directed to care rather than to legal and

bureaucratic processes. This report seeks to advise the Government on how to address a serious problem that has emerged in these legal and bureaucratic processes.

The current Deprivation of Liberty Safeguards (DoLS) scheme safeguards against arbitrary detention of people who are deemed to lack capacity to consent to their care or treatment, such as older people living with dementia, people with autism and people with learning disabilities. However, the scheme is broken. The Supreme Court's decision that a person is subject to "confinement" when "under continuous supervision and control" and "not free to leave" (the 'acid test'), irrespective of their contentment, has resulted in a tenfold increase in the number of DoLS applications.

This has placed extreme pressure on Local Authority resources. Seventy percent of the almost 220,000 applications for DoLS authorisations in the past year were not authorised within the statutory time frame. Consequently, many incapacitated people continue to be deprived of their liberty unlawfully and those responsible for their care, or for obtaining authorisations, are having to work out how best to break the law.

At the Government's request, the Law Commission has produced proposals for a new system of safeguards. The Commission proposes replacing DoLS with Liberty Protection Safeguards (LPS). LPS would authorise the specific arrangements that give rise to the deprivation of liberty. They are, therefore, more targeted than DoLS, which authorise the deprivation of liberty in general. LPS would apply to wider categories of people than DoLS, as they would extend to domestic settings, persons

aged 16 and over, and persons of “unsound mind”. DoLS currently only apply to care homes and hospitals and over 18s with a mental disorder.

We support the principle that Article 5 safeguards should be applied to all those deprived of their liberty regardless of their care arrangements, but the potential expansion of the scheme into domestic settings runs the risk of creating an invasive scheme that is difficult to operate effectively. This highlights the importance of establishing more clearly the definition of “deprivation of liberty” so that such safeguards are applied to those who truly need them.

The Law Commission did not grapple with this difficult issue. We recognise that deprivation of liberty is an evolving Convention concept rooted in Article 5; the difficulty is how this is interpreted and applied in the context of mental incapacity. In our view, Parliament should provide a statutory definition of what constitutes a deprivation of liberty in the case of those who lack mental capacity in order to clarify the application of the Supreme Court’s acid test and to bring clarity for families and frontline professionals. Without such clarity there is a risk that the Law Commission’s proposals will become unworkable in the domestic sphere.

The Law Commission’s proposals for independent review of authorisations for deprivations of liberty are in our view compliant with the European Convention on Human Rights. It would be disproportionate to establish a separate review body. Nonetheless, we recommend that the Code of Practice must set out clear guidelines to deal with potential conflicts of interest.

The Law Commission’s proposals introduce the possibility of providing advance consent to care and treatment arrangements that would otherwise amount to a deprivation of liberty. This is not currently possible under the DoLS scheme. We consider that advance consent for care arrangements should be valid, as long as safeguards are in place to verify the validity of this consent.

The provision of advocacy helps to ensure that individuals can exercise their rights to challenge authorisations, as the advocate may initiate court proceedings. Unlike DoLS, which provided advocates on an ‘opt in’ basis, LPS provides advocates as of right. We support this enhancement of rights to advocacy. However, we recognize the shortage of advocates available and urge the Government to consider appropriate funding arrangements for adequate levels of advocates. We also suggest that an individual’s right to participate in court ought to be codified and that responsibility for securing the individual’s access to court should be prescribed clearly on the face of the Bill. Whilst the individual’s appropriate person and advocate should have a duty to appeal on behalf of the individual, the responsible body should be under a clear statutory duty to refer cases where others fail to do so, for example, when the individual objects or the arrangements are particularly intrusive.

The Law Commission proposes that the question of whether the Court of Protection (CoP) should retain jurisdiction to hear challenges or whether this should be transferred to the First Tier Tribunal (FTT) should be reviewed by the Lord Chancellor, the Lord Chief Justice and the Senior President of Tribunals.

We consider that a tribunal system has serious merits for consideration.

At present, the Legal Aid Agency can refuse non-means tested certificates for challenges to DoLS where there is no existing authorisation. The current system has produced arbitrary limitations on the right of access to a court. Legal aid must be available for all eligible persons challenging their deprivation of liberty, regardless of whether an authorisation is in place, particularly given the vast number of people unlawfully deprived due to systemic delays and failures.

DoLS apply to those with a mental disorder. LPS will apply to persons of “unsound mind” to reflect the wording of Article 5. We recommend that further thought be given to replacing “unsound mind” with a medically and legally appropriate term and that a clear definition is set out in the Code of Practice.

The interface between the Mental Capacity Act (MCA) and the Mental Health Act (MHA) causes particular difficulties. Deciding which regime should apply is complex, and causes the courts and practitioners difficulties. The Law Commission proposes to maintain the two legal regimes: the MHA would apply to arrangements for mental disorders; the LPS would apply to arrangements for physical disorders. Inevitably, problems will continue to arise at the interface between these two regimes. We are particularly concerned by two issues. Firstly, this proposal requires assessors to determine the primary purpose of the assessment or treatment of a mental or physical disorder—this is difficult where persons have multiple disorders. Secondly, we are concerned that there would be essentially different laws and different rights for

people lacking capacity depending upon whether their disorder is mental or physical. We consider that the rights of persons lacking capacity should be the same irrespective of whether they have mental or physical disorders.

The Law Commission’s proposals could form the basis of a better scheme for authorising deprivations of liberty, directing scrutiny to those who need it most. However, while it should be cheaper than the application of the current DoLS to all those falling within the *Cheshire West* definition, it is not cost free. We urge the Government to consider how this new scheme might be appropriately funded.

#### *Comment*

The JCHR report came too late for the Government to consider before introducing the MC Amendment Bill (although the very fact of the inquiry may, itself, been very helpful in ensuring that it introduced the Bill). It will be interesting to see whether the Government responds during the passage of the Bill to the recommendations made by the JCHR in relation to the Bill – in particular in relation to the definition of deprivation of liberty.

#### **Supreme Court news**

The Supreme Court will hear the appeal in *MM* (concerning conditional discharge and confinement) on 26 July. It will hear the appeal in *PJ* (concerning the jurisdiction of the Mental Health Tribunal over human rights issues, as well as CTOs and deprivation of liberty) on 22 October.

The Supreme Court has also just granted permission to the Official Solicitor to appeal against the decision of the Court of Appeal in *Re*

*D* [2017] EWCA Civ 1695. The hearing has been expedited and listed for 3 and 4 October. Anyone who wants to understand how the MCA 2005 is intended to interact with the Children Act 1989 will be well advised to keep a careful eye out for the judgment in due course.

We await, of course, the judgment in the *Y* case concerning the circumstances under which agreed decisions to withdraw life-sustaining treatment must be brought before the courts for sanction.

### The headache of fluctuating capacity

*RB Greenwich v CDM* [2018] EWCOP 15 (Cohen J)

*Mental capacity – assessing capacity – care – residence*

This case concerned a 63 year old woman with a diagnosis of personality disorder and poorly controlled diabetes.<sup>4</sup> While there was a dispute between the applicant local authority and the Official Solicitor (on behalf of CDM) relating to her capacity to determine her residence and manage her property and affairs, both agreed that she did have capacity to make decisions about her care and treatment or, in the alternative, had “fluctuating capacity” so to do.

CDM lived alone with her pets following the death of her husband in 2014. The couple had had a number of dogs and cats which CDM referred to as her “babies”: concern was raised after CDM allowed the condition of both herself and her home to deteriorate. CDM had a history of poorly controlled diabetes as a result of which she sustained an amputation of the right toe and

subsequently in May 2017, her lower right leg. Shortly prior to the amputation of her lower right leg, CDM fell and sustained a fracture to her hip.

Subsequent to the amputation, CDM was discharged home, but refused to engage with orthodox rehabilitation methods – she insisted on mobilising with an upside-down broom, rather than a walking stick or zimmer frame, and continued to sleep on the sofa rather than in the bedroom she had shared with her late husband. After a short period at home, she was discovered by the ambulance service sat in vomit and faeces and was taken first to hospital, and then to a nursing home. Throughout the proceedings that followed, CDM remained adamant that she wished to return home to her “babies”. Cohen J noted that she remained “fiercely independent, articulate and determined” and felt “erased” by her treatment.

The parties instructed an independent psychiatrist, Dr Series, to provide a report on CDM’s capacity, in which he concluded that there would be an “inevitable variation” in her mental state due to fluctuations in her blood glucose, both as a result of her poorly controlled diabetes, and in the context of a diagnosed personality disorder. Having concluded that the CDM had fluctuating capacity to determine where she should live, Dr Series revised this opinion in the course of his oral evidence, ultimately concluding that she lacked the requisite capacity.

Cohen J resisted the submissions of the Official Solicitor to the effect that questions of capacity have to be made prospectively in order that

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<sup>4</sup> Katie being involved in this case, she has not contributed to this report.

professionals responsible for P's care are able to make decisions in their best interests without daily capacity assessments. Rather, he held that

*50 [...] Paragraph 4.4 of the Code of Practice says that an assessment of a person's capacity must be based on their ability to make a specific decision at the time it needs to be made and not their ability to make decisions in general.*

*51. I accept that in some examples, for instance, the capacity to consent to sexual relations the capacity albeit fluctuating will be one that will either be present or not present. But management of her diabetes is a different matter. It covers a wide range of different situations which may arise frequently or infrequently. The treatment required may be of very different natures. I cannot see that this particular form of fluctuating capacity can properly be managed other than by a decision being taken at the time that the issue arises.*

Cohen J then extrapolated from this position to hold that, given that CDM's personality was regarded by Dr Series as aggravating her diabetes as it led to poor diabetic control which in turn led to the making of unwise decisions about her treatment and an inability to cooperate with professionals, *"when making appropriate decisions she has capacity but when making manifestly inappropriate decisions she lacks capacity."*

## Comment

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<sup>5</sup> Although there is at least one case we know of where the judge has made 'contingent' declarations as to the circumstances under which P would lack capacity.

This decision goes to show precisely how difficult it is for the court to deal with fluctuating capacity.<sup>5</sup> The approach taken by Cohen J was faithful to the time-specific nature of capacity but is more than a little problematic to apply in practice. In particular, it is difficult to see how professionals are left with an appropriate touchstone to decide when CDM is, and is not, making capacitous decisions about her diabetes medication.

Cohen J's decision is also one that (albeit for perhaps understandable reasons) comes very close to recasting the capacity test as an outcome-based test in a way that was expressly rejected by the Law Commission in its work leading to the MCA 2005. If the case goes further on appeal, it will be interesting to see whether the Court of Appeal sees this as a problem with the Act itself when it comes to fluctuating capacity, or a problem with the way that it was applied on the facts of this particular case.

## Capacity, Prader-Willi, and engaging with P

*Re FX* [2017] EWCOP 36 (District Judge Bell)

*Mental capacity – assessing capacity – care – residence*

## Summary

This interesting decision from last year which recently appeared on Bailii is the first reported decision where consideration has been given to questions of capacity in the context of Prader-Willi Syndrome ('PWS'). Although a decision of

a District Judge, which does not therefore have any precedent value, it is of particular interest for highlighting some of the complexities which arise in relation to this condition.

The question was whether a 32 year old man, FX, had capacity to make decisions in relation to residence and care. The man asserted throughout the s.21A proceedings (through his litigation friend) that he had capacity to make the decisions; the CCG (whom it appears must have been funding his care) asserted that he did not.

Both the BIA, SN,<sup>6</sup> and the independent psychiatric expert, Professor Tony Holland, were restricted in their ability to assess capacity by a refusal by FX to discuss matters which directly related to his PWS. DJ Bell noted that “[t]his is a subject which FX finds embarrassing to talk of and which he fears may result in a deleterious outcome from his perspective. He has also expressed frustration about the number of professionals who have undertaken assessment work with him.” DJ Bell reminded herself of a decision cited as *Re P* [2014] EWHC 119 COP<sup>7</sup> in which Cobb J considered what conclusions should be drawn when a person deliberately avoids engaging or cooperating with the mental capacity assessment process thus “it seems to me that patient’s lack of engagement or cooperation with the assessment may contribute in itself to a conclusion that a patient is unable to “understand the information relevant to the decision” (section 3(1)... a) and/or (perhaps more significantly, if the patient is shown to understand) unable to use or

*weigh that information as part of the process (section 3(1)(c))”.* DJ Bell held that she was “satisfied that his reluctance to discuss his PWS arises from embarrassment and frustration. This explanation does not, in itself, establish that he has relevant understanding.”

Unlike SN, Professor Holland found it difficult to engage with FX, DJ Bell noting that “[i]n undertaking his assessment Professor Holland considered records for FX from last year, he spoke with a senior staff member at Care Home C and met with FX on two occasions. On the first occasion for ten minutes and subsequently for forty minutes. Unfortunately, he established minimal rapport with FX and FX did not wish to engage with any discussion about his PWS.”

Professor Holland concluded that FX lacked capacity in relation to residence and care; SN “could not conclude that FX lacks capacity in respect of residence and care. She described her discussions with FX, he would not discuss his PWS but in every meeting he has discussed some of the factors of his care and treatment. She was unable to establish on the balance of probabilities that FX’s PWS (or any other mental impairment) is affecting his ability to decide on receiving care and treatment and what that care and treatment should be.”

The difficulty that Professor Holland had in engaging with FX fed into his report, discussed by DJ Bell thus (in passages that merit reproduction as demonstrating so many of the

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<sup>6</sup> Who assessed his capacity on behalf of the local authority in the context of (it appears) renewing the standard authorisation; it would appear that she must have taken a different view to whomever it was had initially assessed his capacity because, as below, she concluded that FX had capacity, which would logically

have meant that the original standard authorisation should not have been granted.

<sup>7</sup> Interestingly, this is not, as far as we can see, a reported judgment – should anyone care to provide the transcript for wider use, it would be much appreciated as this is a very useful paragraph!

issues that so often come up in our experience of capacity assessments):

*42. Professor Holland explained that the basis of his opinion was one third assessment time with FX, one third general knowledge of PWS and one third from records provided to him (over a year old at the time). He acknowledged the limitations that this placed upon his assessment and said that he would have been much more comfortable had he been able to spend more time with FX. He accepted that his opinion should be treated with a degree of caution.*

*43. There are other reasons to be cautious about the opinion of Professor Holland. In his evidence he demonstrated an obvious knowledge of PWS and great commitment to improving the lives of those who suffer from it. Unfortunately, this seems to have led Professor Holland to conflate best interests with capacity. He acknowledged that with respect to understanding of relevant information he had set the bar quite high and linked this to the consequences of uncontrolled symptoms of PWS upon sufferers and the benefits to them of a tightly controlled regime particularly with respect to food security. In addition, he failed to conduct a proper analysis of the presumption of capacity. In his analysis the burden was shifted to FX to demonstrate that he possesses capacity. He was unable to provide a satisfactory answer to Mr O'Brien's question 'what did FX say to lead you to the conclusion that he lacked capacity having regard to the test under section 3?' He did not consider whether any of FX's reported actions were unwise decisions rather than indications of lack of capacity.*

*44. There has been a lack of clarity about the particular decisions to be made by FX. Professor Holland's evidence has been relied upon to support the second respondent's assertions of lack of capacity. In his oral evidence Professor Holland was clear that FX has the capacity to decide between two environments, as that is a more "concrete" decision and one where he could decide which he prefers. However, where all options are open, in his opinion FX cannot incorporate in to his thinking an understanding of his PWS and then he does not have capacity. This echoes his opinion set out at paragraph 2 of his 2<sup>nd</sup> report:*

*'the question I asked myself is: if offered a free choice of any type of accommodation would FX be able to incorporate an understanding of the fact he had PWS into any decision he made about his residency? I conclude on the balance of probability that he would not. However, it is very likely that he would be able to form a view between two possible options both of which had food security.'*

*45. FX does not have two options to choose between (as confirmed by LB). Following LBL v RYJ a decision is not to be made by P in general or in abstract. On the basis that Professor Holland is satisfied that FX has capacity to decide between two options it must follow, as matter of logic, that he has capacity to make decisions about the place where he currently resides.*

*46. SN takes a different view. She has different qualifications to those of*

*Professor Holland and her assessment was not ordered for the purposes of these proceedings. However, she had the advantage of being able to meet more extensively with FX and was able to have more productive discussions with him. She conducted her assessment from the correct starting point of presuming that FX has capacity and applying the relevant statutory framework and guidelines.*

*47. When I consider those matters about which there is evidence of FX's understanding [...] I am satisfied that FX is able to understand, retain, use or weigh the relevant information set out in LBX v K & M and to communicate his decision. Professor Holland did not specifically address this with FX but confirmed in his oral evidence that he would expect FX to understand this. The assessment of SN reinforces this.*

*48. In addition, from the evidence of SN, I am satisfied that FX understands that he has PWS and that it is an eating disorder. He has identified that he needs support when going out in the community and that he needs support with portion control. He understands that rejecting support at Care Home A caused him to gain weight. He understands that he is overweight and that this affects his health. He knows that losing weight would improve his sleep apnoea. He wishes to lose weight and he is trying to do so. He understands that staff try to help him by suggesting healthy options when out but that sometimes he rejects advice.*

*49. I am satisfied that FX has capacity to make the relevant decisions in respect of residence and care as are required at this time. Should a situation arise where there*

*are complex decisions to be made it may be necessary to reconsider issues of capacity in light of those decisions.*

## Comment

Questions of capacity in the context of Prader-Willi can be extremely complex (as discussed in this paper prepared by the PWS Association [here](#)). On one view, the outcome in this case could be seen as coming perilously close to the somewhat problematic conclusion that “so long as FX is taking sensible decisions he has capacity” (see also in this regard *CDM* discussed here). On the other hand, the judgment stands as an object lesson in following the route map of the MCA with care: despite the superficial disparity in expertise in relation to PWS, SN's care in following the route map of the MCA meant that her evidence carried greater weight than did that of Professor Holland.

## DOLS rights – a simple guide

Tor's new simple guide to DOLS, and the rights to which authorisations gives rise can be found [here](#).

## Deprivation of liberty and participation – Strasbourg speaks

*DR v Lithuania* [2018] ECHR 548 (European Court of Human Rights (Fourth Section))

## Article 5 ECHR – DOLS authorisations

## Summary

A lady in her 60s was ordered by a court to be subject to a psychiatric assessment to consider her criminal responsibility for an alleged offence. She was taken in handcuffs by police to a court psychiatric centre around 110 kilometres away,

assessed, and released the same day. This breached Article 5(1)(b) as the court order had not authorised that deprivation of liberty.

Two months later, the District Court ordered that she be involuntarily detained for compulsory psychiatric treatment and this decision was upheld on appeal by the Regional Court. These decisions were based upon psychiatric evidence showing her to be of unsound mind, namely chronic schizo-affective disorder with a type of mania. But she was not examined in person by the court and, although legally represented, she was effectively excluded from personally participating in the proceedings:

91 ... the Court underlines that the proceedings in question concerned the assessment of the applicant's mental condition, and thus she was not only an interested party, but also the main object of the court's examination. Her participation was therefore necessary not only to enable her to present her own case, but also to allow the judge to form a personal opinion about her mental capacity... It further notes that there is no indication that at the relevant time the applicant's mental condition was of such a degree that her personal participation in the proceedings would have been meaningless ... The Court finds it particularly important to note that the applicant sent a letter to the Tauragė District Court, asking to be given an opportunity to attend the hearing in her case .... However, she did not receive any response from that court. No reasons - medical or otherwise - for disregarding the applicant's wish to participate at the hearing were provided in the Tauragė District Court's decision .... The Government were unable to provide an explanation as to why the Tauragė

*District Court had not replied to the applicant's letter ...."*

It was held that the domestic courts did not adequately demonstrate that her condition was such as to require compulsory treatment when the decisions to hospitalise her were made. There was an at best superficial judicial analysis of the criteria for detention:

95. *In this connection, the Court cannot fail to notice that the decisions of the Tauragė District Court and the Klaipėda Regional Court were each only a few pages long (see paragraphs 28 and 32 above). They essentially reiterated the conclusions of the psychiatric assessment, without providing any independent analysis of the necessity of the applicant's hospitalisation. The Court finds it especially disconcerting that the domestic courts did not in substance address any of the applicant's and her lawyer's arguments. In particular, the Klaipėda Regional Court stated that "the arguments in [the applicant's] appeal confirm[ed] that she [could not] critically assess her disorder [and did] not understand the danger posed by her mental condition, nor the need for treatment" (see paragraph 32 above). In the Court's view, such circular reasoning - according to which a person's reluctance to undergo psychiatric hospitalisation demonstrates his or her inability to appreciate his or her condition and thereby yields yet another reason for involuntary hospitalisation - is incompatible with the principle of effective protection of Convention rights (see Plesó v. Hungary, no. 41242/08, § 67, 2 October 2012)."*

As a result, the Court found that her rights under Article 5(1)(e) were also breached and she was awarded 7500 euros for the distress and frustration suffered.

### Comment

This decision emphasises the importance of enabling the person to in judicial procedures which authorise their deprivation of liberty. Not only is this necessary to enable the person to present their own case if they wish to; it also enables the judge to form their own view of the person's mental capacity. Secondly, it illustrates how important it is for the court to independently analyse the necessity – and we would suggest the proportionality – of the proposed deprivation of liberty. Perfunctory scrutiny cannot be expected to be legally valid.

What are the implications, if any, for COPDOL11/Re X process? It certainly suggests that there should be clear reasons given as to why the deprivation of liberty is required – and throws into question whether the standard recitals on the face of the orders made suffice.

We would suggest that this decision does not automatically require Court of Protection judges to personally examine P's mental capacity. But it does illustrate the importance of the consultation Annexes to Form COPDOL11. If P does wish to see the judge, or otherwise participate, this case demonstrates that P should not be excluded. Indeed, personal participation in detention proceedings would rarely, we suggest, be "meaningless". For if P wants to participate, participation has inherent meaning and the focus must be on making necessary arrangements to enable that to happen.

There is a passing reference by the court to Article 14 CRPD but nothing in the merits analysis. But what is of interest are the criticisms relating to the circular reasoning of the domestic courts. After all, how often is a person's denial of the need for treatment relied upon as a further reason to detain them? What some might call the "insight justification". Indeed, the court's reference to *Plesó* is a reference to the concept of insight, where the court previously held:

*67 ... In this refusal [to undergo hospitalisation], [the domestic courts] perceived proof of his lack of insight into his condition – rather than the exercise of his right to self-determination – which, in those courts' view, entailed the risk of his health declining. For the Court, to accept this line of reasoning would be tantamount to acquiescing in a circular argument, according to which a person reluctant to undergo psychiatric hospitalisation would thereby demonstrate his inability to appreciate his own condition and the risk of its potential worsening – which would yield yet another reason for his involuntary treatment. The Court finds that this kind of handling of such cases is incompatible with the principle of effective protection of Convention rights.*

Insight, beware.



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## Editors and Contributors



**Alex Ruck Keene:** [alex.ruckkeene@39essex.com](mailto:alex.ruckkeene@39essex.com)

Alex is recommended as a 'star junior' in Chambers & Partners for his Court of Protection work. He has been in cases involving the MCA 2005 at all levels up to and including the Supreme Court. He also writes extensively, has numerous academic affiliations, including as Wellcome Research Fellow at King's College London, and created the website [www.mentalcapacitylawandpolicy.org.uk](http://www.mentalcapacitylawandpolicy.org.uk). To view full CV click [here](#).



**Victoria Butler-Cole:** [vb@39essex.com](mailto:vb@39essex.com)

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



**Neil Allen:** [neil.allen@39essex.com](mailto:neil.allen@39essex.com)

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



**Annabel Lee:** [annabel.lee@39essex.com](mailto:annabel.lee@39essex.com)

Annabel has experience in a wide range of issues before the Court of Protection, including medical treatment, deprivation of liberty, residence, care contact, welfare, property and financial affairs, and has particular expertise in complex cross-border jurisdiction matters. She is a contributing editor to 'Court of Protection Practice' and an editor of the Court of Protection Law Reports. She sits on the London Committee of the Court of Protection Practitioners Association. To view full CV click [here](#).



**Nicola Kohn:** [nicola.kohn@39essex.com](mailto:nicola.kohn@39essex.com)

Nicola appears regularly in the Court of Protection in health and welfare matters. She is frequently instructed by the Official Solicitor as well as by local authorities, CCGs and care homes. She is a contributor to the 4<sup>th</sup> edition of the *Assessment of Mental Capacity: A Practical Guide for Doctors and Lawyers* (BMA/Law Society 2015). To view full CV click [here](#).

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## Editors and Contributors



**Katie Scott:** [katie.scott@39essex.com](mailto:katie.scott@39essex.com)

Katie advises and represents clients in all things health related, from personal injury and clinical negligence, to community care, mental health and healthcare regulation. The main focus of her practice however is in the Court of Protection where she has a particular interest in the health and welfare of incapacitated adults. She is also a qualified mediator, mediating legal and community disputes, and is chair of the London Group of the Court of Protection Practitioners Association. To view full CV click [here](#).



**Simon Edwards:** [simon.edwards@39essex.com](mailto:simon.edwards@39essex.com)

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



**Adrian Ward:** [adw@tcyoung.co.uk](mailto:adw@tcyoung.co.uk)

Adrian is a recognised national and international expert in adult incapacity law. While still practising he acted in or instructed many leading cases in the field. He has been continuously involved in law reform processes. His books include the current standard Scottish texts on the subject. His awards include an MBE for services to the mentally handicapped in Scotland; national awards for legal journalism, legal charitable work and legal scholarship; and the lifetime achievement award at the 2014 Scottish Legal Awards.



**Jill Stavert:** [j.stavert@napier.ac.uk](mailto:j.stavert@napier.ac.uk)

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

## Conferences

### Conferences of interest

#### Costs and summer drinks reception

On 26 July a training event and summer drinks reception will be hosted by London CoPPA in association with Hardwicke Chambers covering hot topics in the world of Court of Protection costs. For more details, see [here](#).

#### Towards Liberty Protection Safeguards

This conference being held on 24 September in London will look at where the law is and where it might go in relation to deprivation of liberty. For more details, and book, see [here](#).

#### 5<sup>th</sup> International conference on capacity: ageing, sexuality & human rights

Capacity Australia is hosting this fascinating-looking conference in Rome on 3 October. For more details see [here](#).

### Advertising conferences and training events

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

We are taking a summer break (from this, but not from the world of mental capacity law, which is going to be a very busy one over the next few months). Our next edition will be out in early September. Please email us with any judgments or other news items which you think should be included. If you do not wish to receive this Report in the future please contact: [marketing@39essex.com](mailto:marketing@39essex.com).

**Michael Kaplan**  
Senior Clerk  
[michael.kaplan@39essex.com](mailto:michael.kaplan@39essex.com)

**Sheraton Doyle**  
Senior Practice Manager  
[sheraton.doyle@39essex.com](mailto:sheraton.doyle@39essex.com)

**Peter Campbell**  
Senior Practice Manager  
[peter.campbell@39essex.com](mailto:peter.campbell@39essex.com)



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[clerks@39essex.com](mailto:clerks@39essex.com) • [DX: London/Chancery Lane 298](mailto:DX: London/Chancery Lane 298) • [39essex.com](http://39essex.com)

**LONDON**  
81 Chancery Lane,  
London WC2A 1DD  
Tel: +44 (0)20 7832 1111  
Fax: +44 (0)20 7353 3978

**MANCHESTER**  
82 King Street,  
Manchester M2 4WQ  
Tel: +44 (0)16 1870 0333  
Fax: +44 (0)20 7353 3978

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

**KUALA LUMPUR**  
#02-9, Bangunan Sulaiman,  
Jalan Sultan Hishamuddin  
50000 Kuala Lumpur,  
Malaysia: +(60)32 271 1085

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