



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

(1) In the Health, Welfare and Deprivation of Liberty Report: the DHSC emergency guidance on MCA and DoLS, the Court of Protection on contact and COVID-19, treatment escalation and best interests, and capacity under the microscope in three complex cases;

(2) In the Property and Affairs Report: the Golden Rule in (in)action and the OPG's 'rapid response' search facility for NHS and social care staff to access the register of deputies / attorneys;

(3) In the Practice and Procedure Report: the Court of Protection adapting to COVID-19 and an important decision on the s.48 threshold;

(4) In the Wider Context Report: COVID-19 and the MCA capacity resources, guidance on SEND, social care and the MHA 1983 post the Coronavirus Act 2020, dialysis at the intersection between the MHA and the MCA and an important report on the international protection of adults;

(5) In the Scotland Report: the response of the legal community to AWI law and practice under COVID-19, and an update from the Mental Health Law Review.

You can find our past issues, our case summaries, and more on our dedicated sub-site [here](#). Chambers has also created a dedicated COVID-19 page with resources, seminars, and more, [here](#).

If you want more information on the Convention on the Rights of Persons with Disabilities, which we frequently refer to in this Report, we suggest you go to the [Small Places](#) website run by Lucy Series of Cardiff University.

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

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HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

DHSC guidance on the MCA and DoLS

The DHSC's eagerly anticipated [emergency guidance](#) on the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) During the Coronavirus (COVID-19) Pandemic was published on 9 April 2020. The key points are reproduced below:

- *This guidance is only valid during the COVID-19 pandemic and applies to those caring for adults who lack the relevant mental capacity to consent to their care and treatment. The guidance applies until withdrawn by the Department. During the pandemic, the principles of the MCA and the safeguards provided by DoLS still apply.*
- *Decision makers in hospitals and care homes, and those acting for supervisory bodies will need to take a proportionate approach to all applications, including those made before and during the pandemic. Any decisions must be taken specifically for each person and not for groups of people.*
- *Where life-saving treatment is being provided, including for the treatment of COVID-19, then the person will not be deprived of liberty as long as the treatment is the same as would normally be given to any person without a mental disorder. The DoLS will therefore not apply. It may be necessary, for a number of reasons, to change the usual care and treatment arrangements of somebody who lacks the relevant mental capacity to consent to such changes.*
- *In most cases, changes to a person's care or treatment in these scenarios will not constitute a new deprivation of liberty, and a DoLS authorisation will not be required. Care and treatment should continue to be provided in the person's best interests.*
- *In many scenarios created or affected by the pandemic, decision makers in hospitals and care homes will need to decide:*
 - (a) *If new arrangements constitute a 'deprivation of liberty' (most will not).*
 - (b) *If the new measures do amount to a deprivation of liberty, whether a new DoLS authorisation may be required (in many cases it will not be).*
- *This guidance, particularly the flow chart at Annex A, will help decision makers to make these decisions quickly and safely, whilst keeping the person at the centre of the process.*
- *If a new authorisation is required, decision makers should follow their usual DoLS processes, including those for urgent authorisations. There is a shortened Urgent Authorisation form at Annex B*

which can be used during this emergency period.

- *Supervisory bodies who consider DoLS applications and arrange assessments should continue to prioritise DoLS cases using standard prioritisation processes first.*
- *DoLS assessors should not visit care homes or hospitals unless a face-to-face visit is essential. Previous assessments can also be considered as relevant evidence to help inform the new assessments.*

The guidance also includes the DHSC's approach to the interaction between the MCA and public health legislation:

If it is suspected or confirmed that a person who lacks the relevant mental capacity has become infected with COVID-19, it may be necessary to restrict their movements. In the first instance, those caring for the person should explore the use of the MCA as far as possible if they suspect a person has contracted COVID-19. The following principles provide a guide for which legislation is likely to be most appropriate:

- (a) The person's past and present wishes and feelings, and the views of family and those involved in the person's care should always be considered.*
- (b) If the measures are in the person's best interests then a best interest decision should be made under the MCA.*
- (c) If the person has a DoLS authorisation in place, then the authorisation may provide the legal basis for any restrictive arrangements in place around the measures taken. Testing and treatment should then be delivered following a best interest decision.*
- (d) If the reasons for the isolation are purely to prevent harm to others or the maintenance of public health, then PHO powers should be used.*
- (e) If the person's relevant capacity fluctuates, the PHO powers may be more appropriate.*

If the public health powers are more appropriate, then decision makers should contact their local health protection teams (<https://www.gov.uk/guidance/contacts-phe-health-protection-teams>).

Comment

One point of particular importance is the DHSC's statement that they consider that the *Ferreira* 'carve out' from Article 5 to apply not just to the delivery of life-sustaining treatment in hospital but also where such is being delivered in care home. Albeit that this goes beyond the position pronounced upon by the courts, one can see the logic behind this. The DHSC's view is therefore that "[t]he DoLS process will therefore not apply to the vast majority of patients who need life-saving treatment who lack the mental capacity to consent to that treatment, including treatment to prevent the deterioration of a person with

COVID-19." A very clear focus must, therefore, be kept upon how the core principles of the MCA are being applied to the decisions being made about that person's care and treatment.

Alex has done a webinar walkthrough of the guidance from his shed, including further commentary and discussion, available [here](#).

Care homes and contact – the Court of Protection pronounces

BP v Surrey County Council & Anor [2020] EWCOP 17 (Hayden J)

Article 5 ECHR – deprivation of liberty – Article 8 ECHR – contact

Summary

In this case, Hayden J had to grapple with the impact of COVID-19 in the care home setting. The urgent application arose in the context of an existing s.21A application challenging the DoLS authorisation to which the man in question, BP, was subject, as a result of a decision by the care home in question to suspend all visits from any family members to P and indeed to the others living in the home. The restriction also extended to any other visitors.

As Hayden J noted:

can be no doubt that the change to BP's quality of life from 5 o'clock on Friday 20th March 2020 was seismic. Additionally, the restriction extended to the Mental Capacity Assessor visiting. Thus, there is need for heightened vigilance to ensure that BP's fundamental rights are not eclipsed by the exigencies of the Coronavirus pandemic. Fundamental to my consideration of the issues presented by this case is Article 11 UN Convention of the Rights of Persons with Disabilities ('CRPD') which provides:

"Article 11 – Situations of risk and humanitarian emergencies

States Parties shall take, in accordance with their obligations under international law, including international humanitarian law and international human rights law, all necessary measures to ensure the protection and safety of persons with disabilities in situations of risk, including situations of armed conflict, humanitarian emergencies and the occurrence of natural disasters."

10. The COVID-19 pandemic plainly falls within the circumstances contemplated by Article 11 and signals the obligation on the Courts, in particular, and society more generally to hold fast to maintaining a human rights based approach to people with disabilities when seeking to regulate the impact of this unprecedented public health emergency.

The application brought was for the following:

a) A declaration that if, within 72 hours of SH Care Home being served with a copy of the relevant order it has failed to take steps to facilitate the attendance of Dr Babalola and to reinstate daily family visits to BP, then it is not in BP's best interests to reside in the interim at SH Care Home;

b) An order that if the above has not been complied with by SH Care Home, the order dated 6 March 2020 extending the standard authorisation be revoked and the standard authorisation shall terminate at the expiry of that 72-hour period;

c) A declaration that the total ban on visits is a disproportionate interference with BP's rights under Articles 5 and 8 (read with Article 14) of the European Convention on Human Rights;

d) An interim declaration that whilst the restrictions on visits remain in place it is in BP's best interests to return home with a package of care.

BP, who was diagnosed with Alzheimer's disease in December 2018 and was deaf, but able to communicate through a "communication board." Hayden J noted that:

On the evening of 23rd March 2020, the Prime Minister announced, during the course of a public broadcast, stricter measures by the Government relating to COVID-19. The essence of the guidance is that people should stay at home, with very limited exceptions and for very tightly constrained purposes. At his age and with his underlying health problems BP is vulnerable to the most serious impact of the Coronavirus. In my view, it is necessary to state the risk BP faces, were he to contract the virus, in uncompromising terms: there would be a very real risk to his life. Manifestly, there are powerful and competing rights and interests engaged when considering this application.

Having considered decisions of the European Court of Human Rights, the statement of principle of the Council of Europe's Committee on the Prevention of Torture relating to the treatment of individuals deprived of their liberty in consequence of the COVID-19 pandemic, and Article 25 of the CRPD (the right to health), Hayden J noted that:

The case is, in any event, listed for further directions on 3rd June 2020. Accordingly, the interim declarations relating to BP's lack of capacity to conduct these proceedings and to make decisions concerning his residence and care remain valid. The focus of the arguments is therefore on whether it remains in BP's best interest to stay in the care home. It is in this context that I must consider the relevant rights and freedoms that all agree are engaged.

Hayden J outlined the plans that were being developed to seek to secure continuing contact:

The plan advanced by FP [BP's daughter] was that her father should come and live with her. She has been self-isolating so as to prepare for his return. The arrangement is that Mrs RP would move out, in light of the safeguarding concerns I have referred to above and that FP would care for her father alone. Ideally, care support would reinforce FP's care but, all recognised that, in the present circumstances, this could not be secured. FP realistically acknowledged that her father is prone to what is termed "misadventure" and should be watched vigilantly. Though she could not quite bring herself to acknowledge it, she recognised that her offer of 24 hour per day single handed care for her

father is not, in truth, a realistic option. FP said, "everyone is a loser in this situation!". Both in and out of court, which in this case meant on or off Skype recording, efforts were made to explore the possibilities for contact. It is not necessary for me to work through them in this judgment. Their significance is that the care staff and the family, with the help of their advocates, began to absorb some of the stark realities of their present situation. A great deal of effort was made to see whether it might be possible to unlock a fire door and provide for a visit at a suitably safe distance. In the end and for a variety of reasons that was not possible. The plan that was ultimately put together provides for BP's education in to the world of Skype with creative use of a communication board and the exploration of concurrent instant messaging. Additionally, the family can, by arrangement, go to BP's bedroom window which is on the ground floor and wave to him and use the communication board. All this will require time, effort and some creativity. I am clear that there is mutual resolve by all concerned. When I asked FP what she thought her father would want if he was addressing this question objectively with his full faculties intact, she unhesitatingly told me that the last thing he would want would be to burden her or her family. Approaching this challenging situation from that perspective appeared to give FP some comfort. I am entirely satisfied that this is a balanced and proportionate way forward which respects BP's dignity and keeps his particular raft of needs at the centre of the plan. Equally, I have no doubt that this application, for all the reasons that I have alluded to, was properly brought. It has been important to recognise that in addition to his Alzheimer's BP's deafness is a separate and protected characteristic, as defined in Section 148(7) of the Equality Act 2010. As such, it requires to be identified and considered as a unique facet of BP's overall needs.

Importantly, Hayden J, reiterating guidance he had previously given on [19 March](#), considered that:

Accordingly, though I recognise the challenges, I consider that the outstanding assessment by Dr Babalola can be undertaken via Skype or facetime with BP being properly prepared and supported by staff and, to the extent that it is possible, by his family too.

Although the judgment does not expressly provide this, it is clear that the consequence was that the application was dismissed, although with clear judicial approval of the plan drawn up to seek to maintain as much contact as possible between BP and his family.

Conclusion

The outcome of the application was, not, perhaps entirely surprising, although reflective of the changes that have been wrought by COVID-19 – only a few weeks ago, a care home that sought to impose such draconian restrictions would have been the subject of fierce criticism by a court. It is perhaps important to note that the DoLS regime does not, itself, justify restrictions upon contact. The DHSC's [emergency guidance](#) on the MCA and DoLS contains a limited discussion of isolation measures where the person is suspected of having COVID-19, but does not address the basis upon which care homes can properly seek to impose restrictions upon those in BP's position without recourse to the Court of Protection.¹ Such serious interferences with the right to private and family life under Article 8 ECHR

¹ Or, indeed, another court if – as will be the case in many situations – the individual in question does not lack capacity to make decisions as to contact. The Health Protection (Coronavirus, Restrictions) (England) Regulations 2020 (discussed [here](#)) do not give the power to restrict visits.

will in very many cases be justified by the threat that would otherwise be posed to the lives of those within the care home, but, as Hayden J recognised, the stakes are indeed very high. As Hayden J also recognised – implicitly – that draconian restrictions upon contact can only be justified where all practicable steps are taken to secure the maintenance of such contact as can be achieved.

It is perhaps also important to highlight that at the point that Hayden J was deciding the application, the full extent of the ravages of COVID-19 within care homes had not yet become clear. It is not all obvious, one might think, that in a situation such as that of BP, the state's obligations under Article 2 ECHR would not dictate that the DoLS authorisation be discharged and his daughter be provided with the support required to enable her to support him at her home.

Public health restrictions, social distancing and capacity

Our [rapid response guidance note](#) on social distancing and capacity addresses some of the key dilemmas that have arisen in the context of squaring the provisions of the MCA 2005 and the requirements for social distancing. Alex's article on [public health restrictions and capacity](#) on his website addresses the underpinning public health measures in more detail.

Treatment withdrawal and remote justice

A Clinical Commissioning Group v AF [2020] EWCOP 12 (Mostyn J)

Best interests – medical treatment

Summary

This case concerned AF, a man in his mid seventies who following a stroke in May 2016 was receiving Clinically Assisted Nutrition and Hydration ('CANH') via a PEG. The case came before the court for determination of whether AF had capacity to make decisions about the continuation of CANH, and in the event that he did, whether it was in his best interests to receive such treatment.

The onset of the national COVID-19 medical emergency led the parties and the court at a telephone case management conference on the day before the start of the trial to agree that the hearing should take place by Skype:

The hearing took place over three days. There were 17 continuously active participants. 11 witnesses were heard. 2 journalists observed the proceedings. The participants and witnesses were scattered all over the country from Northumberland to Cornwall, Sussex to Lancashire.

Much of the evidence appears to have focussed on ascertaining AF's past and current wishes and feelings about CANH. The court had to balance the following evidence:

- The evidence of SJ, AF's daughter, that AF (who had worked for the NHS for thirty years and so was keenly aware of disability and death) had stated on many occasions that he that he would not want to be kept alive as a "body in a bed".
- The fact that AF had not recorded these views in writing despite consulting a solicitor following the death of his wife about the possibility of making a living will.
- The evidence that on three occasions before AF was discharged from hospital to a nursing home, he had expressed a wish to die. Mostyn J held that these views were expressed after the point at which AF had lost capacity to make decisions about taking 'the ultimate fatal step'.
- Although there were records that for a while AF resisted PEG feeding, his resistance has reduced over time and by the time of the hearing he was cooperating by lifting his top for the PEG to be connected.
- The evidence that AF derived pleasure from physical and emotional stimuli such as eating certain foods, having his back washed, listening to music and visits from pets and children.
- SJ's strong view that continuation of CANH is not what her father would have wanted, and so it was not, in her view, in his best interests.
- The views of the GP, and the Official Solicitor acting as AF's litigation friend, that continuation of CANH was in AF's best interests (the CCG and the local authority remaining neutral on the issue).

Mostyn J concluded that it was in AF's best interests to continue to receive CANH. Of particular significance in coming to this conclusion was his finding that *AF's 'oral statements to his family cannot be construed as being applicable to anything more than a descent to a vegetative or minimally conscious or equivalent state. They cannot be construed as being applied to his present condition.'*

Comment

The substantive decision in this case gives rise to some of the same almost philosophical questions as were raised in the *Briggs* case, and discussed also in this article by Alex [here](#), as to the extent to which a person pre- and post- (here) a stroke is the same person. On the face of the evidence as recorded by the judge, the decision is perhaps unsurprising given the evidence as to AF's quality of life. Mostyn J had little difficulty in concluding that AF was not just a 'body in a bed' and so his previously expressed views just did not apply to the situation in which he found himself.

The case may however best remembered, for the procedure that was adopted, thanks to the extremely powerful [blog](#) Celia Kitzinger published about the hearing. While the view from the bench was clearly that the hearing was a success – the judge stating that 'the hearing proceeded almost without a hitch' - SJ (despite being supported by Ms Kitzinger, counsel and solicitor) found the experience extremely difficult. The blog is essential reading for anyone involved in Court of Protection proceedings. It shines a spotlight on SJ's experience (echoed we have no doubt by many families caught up in these

extremely complex cases (both legally and emotionally)) at a time when the difficulties are magnified by the adjustments the court and the parties are having to make as a result of the public health crises. Quite how a litigant in person would be able to negotiate a substantive remote hearing, alone, from home, with a court hearing being beamed to them, perhaps via a mobile phone, is difficult to imagine.

Treatment escalation and best interests

University Hospitals Bristol NHS Foundation Trust v ED [2020] EWCOP 20 (Moor J)

Best interests – medical treatment

Summary²

In this case, Moor J had to consider whether treatment escalation would be in the best interests of a woman with learning disability. The decision was made in the context of the COVID-19 pandemic (and the hearing was conducted remotely in consequence), but the **reasons** why it was said that escalation (including admission to the hospital's Intensive Care Unit and attempting any form of resuscitation) would not be in her best interests were not related to the pressures placed on the hospital by the pandemic. The judgment was delivered extempore – i.e. 'live' at the end of the hearing, rather than by way of written judgment provided later.

The case concerned a 35 year old woman with quadriplegic Cerebral Palsy and severe learning difficulties. She had no verbal communication and communicated with facial expressions. The Trust's case was that she could communicate basic feelings, such as whether she was comfortable or distressed. Her mother disagreed and believed ED communicates to a higher extent than that. Her mother also believed that ED had capacity to make the relevant decisions.

ED had lived at home throughout her life with her mother in the West Country. She had had a short ICU admission when only a matter of months old, and none again until 2013. Her medical position had become more complicated since 2018, and she was in hospital in March 2020, having been admitted with pneumonia; her respiratory condition deteriorated. She was initially given non-invasive ventilation by a hospital ventilator almost 24/7. By 17 March 2020, she had improved with intravenous antibiotics and she was only, at that point, having non-invasive ventilation for approximately 3 hours per day plus at night. Nevertheless, the clinicians considered that she should have a tracheostomy (initially performed in 2013 and then removed in 2018) reestablished, but her mother was not keen. On March 2020, ED's position deteriorated again. She became ventilator dependent and antibiotics were again prescribed. The tracheostomy was then performed, and there was then a significant improvement. ED was back on the Respiratory Ward, and had improved to the extent that the ventilator was being removed for increasing periods of time.

² Note, Tor having been involved in the case, she has not contributed to this report.

There were, however, no plans for her imminent discharge from hospital, and the Trust were concerned that there might be a further deterioration in the future. It therefore brought an application to court for declarations that:

it is lawful, if there is a deterioration in the condition of the First Respondent, Ms ED, (a) not to provide CPR or any other resuscitative measure and (b) not to admit her to the ICU Unit or provide an ICU level of care, even if, absent this order, she would meet the criteria for ICU admission.

The Trust's reason for seeking the declarations were to avoid ED from undergoing extensive and potentially invasive medical treatment that the Trust considered not to be in her best interests. It submitted they would have a low prospect of success and that, if successful, would likely lead to a worse quality of life.

Moor J set out the evidence before him in considerable detail, concluding that ED did not have capacity to make the material decisions. As to best interests:

30. In her closing submissions, Ms Watson urged me to make the declarations that have been sought. She said that, in particular, it was not appropriate to put ED through the sort of ICU treatments that would involve, for example, vasoactive drugs, renal replacement therapy, ICU level ventilation, treatment that requires central venous access, or cardio-pulmonary resuscitation. She said that the Trust will continue to provide the highest level of treatment that they can give in the current Respiratory Ward, but they should not have to give treatment that is burdensome, unpleasant and painful. This should ensure that, when the time comes for ED to pass away, it should be in a dignified manner with all appropriate palliative care at that point. I accept that submission. I take the view that the Trust's position is correct. I endorse the position.

31. Mr. Patel QC for the Official Solicitor agreed and adopted the same position. He said that there was quite compelling medical evidence of the trajectory downwards. The position is diminishing episode by episode and that, at some point, a line has to be drawn. He accepted the evidence of the three doctors that the line should be drawn from now on. And that any further treatment should be in the Respiratory Ward and there was, he submitted to me, compelling medical evidence behind that position. I accept those submissions.

32. Ms Butler Cole QC asked me to take into account the other factors in ED's life. And, of course, I do so. I entirely accept that she has had a good quality of life with her mother over the years. I have read with great care of the trips to various festivals that she has made. I have seen the pictures of her with what might be described as celebrities. I understand the enjoyment that she and others have had out of her life. And of course, I as the Judge very much want her to get better from this current infection that she has had. I am pleased to have heard of her improvement in the last few days. I hope that it will be possible for her to return home. I accept entirely that she should continue to have a good level of treatment as is provided to her in the Respiratory Ward. I am quite sure that that is in her best interests.

32. What I do not agree, and I come to this with something of a heavy heart, is that it is in ED's best interests to have the far more invasive treatments that are involved usually and regularly by ICU

admission. In particular, I cannot see that it is in her interests to have CPR or such other resuscitative measures at this point of time. In the healthy, such measures are extremely painful, distressing and difficult to administer. In somebody with ED's conditions, I consider it would be quite intolerable and burdensome. And I am absolutely satisfied that I should indeed make the declaration that I have been asked to make as to CPR and any other resuscitative measures.

33. I have also come to the conclusion that I should make the declaration about future admission to an ICU Unit. I make it clear, and have already done so, that by making this order, I do not consider it to be obligatory. I am saying that it is permissive. It will be up to the doctors on the ground to decide what to do in each particular circumstance. But assuming that there has been no significant change of circumstances, I take the view that it is right that I should authorise no future such admissions. It is quite clear to me that many of the things that would be involved in that, such as the renal treatment or the treatments via the neck, are likely to be extremely burdensome to ED and to provide no significant benefit to her whatsoever.

34. It is of course sad to come to that conclusion. I very much hope that she will not get ill again and that we will not have to get to the point of needing such treatments. But I am clear that, if she does so, the treatment that she should have, all other things being equal, is on the Respiratory Ward. It will be the best possible treatment on that ward. It will include ventilation. It will include antibiotics. It will include physiotherapy. But it will not include the extra active involvements of the ICU Unit. That in my view will not assist her, will harm her and cause her pain and is likely to be entirely futile.

It appears from the judgment that Moor J had, essentially, concluded at that point, but that Counsel for ED's mother then addressed him further upon s.4(6) MCA 2005:

37. Ms Butler-Cole QC then submitted to me that I had not addressed at all the matters in relation to s4(6) of the Act concerning not just the expressed view of the person or wishes and feelings but also the beliefs and values that would be likely to influence their decision if they had capacity and the other factors they would be likely to consider. She said that those were matters that she in her submissions about the evidence or lack of it as to whether ED was the sort of person who would take a less than 10% chance of survival or not.

Moor J then responded at the hearing and subsequently:

38. This is already a very long extempore judgment, but I entirely accept that I did not deal directly with the point in relation to section 4(6). I take the view that ED would recognise that the treatment she is getting on the Respiratory Ward is excellent treatment and that for her to have to go through the additional invasive treatments of the ICU and CPR would not be in her best interests because it would be futile in the long term and it would be likely to cause her pain and suffering and not achieve any advantage. And that is the reason why I have come to the conclusion I have.

39. Although I did not make the point at the time, I add, when approving this note of the judgment, that it is not as though I am authorising only palliative care going forward. I am approving these declarations on the basis that ED will continue to get a very high level of care on the Respiratory

Ward. I take the view that this makes this case entirely different from other cases referred to by counsel and that this is something that ED would undoubtedly take into account pursuant to section 4(6).

Comment

The decision in this case – as in all decisions of the Court of Protection – intensely fact-specific, and those wishing to understand the underpinning clinical reasoning in more detail should review the evidence as set out by Moor J. However, four broad points of more general importance arise:

- (1) ICU admission will be crucial in certain cases – essentially to give the person a fighting chance – but as Moor J highlighted, it is something that carries with it its own serious traumas, and is not to be contemplated lightly in any case;
- (2) The point made at paragraph 33 is of very significant importance. Moor J was not declaring that it would be **unlawful** for ED to be admitted to ICU, i.e. barring her admission there. Rather, he was saying that, if the doctors decided at the time that her circumstances were the same as they were at the time that the case was before him, then they would not be acting unlawfully by not admitting her. This may seem a distinction without a difference to non-lawyers, but has a real significance. Just as with a DNACPR/DNR decision (which, in effect, Moor J was making by his declaration in that regard), the declaration of Moor J in relation to ICU served to guide the doctors as to their actions in the event that a particular event came to pass, not to prevent them exercising their clinical judgment at that point;
- (3) Some may think that Moor J's approach to ED's wishes, feelings, beliefs and values did not properly comply with the injunction of the Court of Appeal in *Re AB (Termination)* [2019] EWCA Civ 1215 that: "[t]he requirement is for the court to consider both wishes and feelings. The judge placed emphasis on the fact that AB's wishes were not clear and were not clearly expressed. She was entitled to do that but the fact remains that AB's feelings were, as for any person, learning disabled or not, uniquely her own and are not open to the same critique based upon cognitive or expressive ability. AB's feelings were important and should have been factored into the balancing exercise alongside consideration of her wishes." Some might think that, at a minimum, Moor J should have undertaken the exercise of considering whether there were, in fact, any reliable indicators of these factors, or whether what FD was relaying reflected her **own** (entirely legitimate) feelings – i.e. the approach taken by Hayden J in *Abertawe Bro Morgannwg University Local Health Board v RY & Anor* [2017] EWCOP 2;
- (4) It might be thought striking that the Official Solicitor agreed with the Trust's application, without reference (at least in the transcript of the judgment) as to ED's wishes, feelings, beliefs and values. This could have been on the basis that the Official Solicitor had undertaken the exercise from the *RY* case and considered that there were no reliable indicators. However, some might feel that this is an example of another case where the Official Solicitor was being asked to do the impossible, i.e.

both represent ED and provide the court with 'neutral' assistance in the resolution of what might be in her best interests. For more on this, see this article [here](#).

Capacity under the microscope

A Local Authority in Yorkshire v SF [2020] EWCOP 15 (Cobb J)

Mental capacity – assessing capacity – contact

Summary

This case concerned the decision-making capacity of AF, a 45 year old married woman with mild learning disability, type 2 diabetes, depression and frontal lobe dementia. AF had problems communicating and expressing herself as well as difficulties understanding language. Her presentation was described as very complex. SF had been married to a man called AF for nearly 25 years. AF was significantly older than her and retired. By the time the matter came on for hearing before Cobb J, AF had been discharged as a party.

The Official Solicitor and the applicant local authority had agreed that SF lacked the capacity to litigate, and make decisions about her care, residence, property and affairs, entering and terminating a tenancy, and contact with others. The matter that came for determination before Cobb J was whether she had capacity to consent to sexual relations and whether she had capacity to have contact with SF in distinction from having contact with others. It was the local authority's case that SF had capacity in respect of both of these areas. By the conclusion of the oral evidence, the Official Solicitor did not actively oppose the local authority's case.

What became clear from the evidence of the jointly instructed consultant psychiatrist, Dr Donovan, was that SF's presentation had shifted significantly in the previous year or so. While she had previously been described as funny and outgoing, AF now described her as having almost no personality at all. It was thought that this was due to her dementia.

Dr Donovan had concluded that SF lacked the capacity to make decisions about contact with third parties because she had difficulty interpreting the subtle verbal and non-verbal cues of others thus impacting on her ability to process information and appraise the appropriateness and safety of the behaviour of others in order to make a decision about her interactions with them.

However, in relation to her capacity to make decisions about her contact with her husband, Dr Donovan took a different view stating that SF retains and used her premorbid level of knowledge about her husband when making decisions about contact with him. As he noted, "[t]here is evidence in dementia that the understanding and conduct within well-established long-term relationships remain intact for some time, and this appears to be the case here'. Dr Donovan explained the difference between:

- episodic memory – this is memory derived from the personally experienced events of life and;

- semantic memory – i.e. knowledge retained irrespective of the circumstances in which it was acquired - deriving from the feeling around memory rather than the facts surrounding the memory. It is described as a *“collection of one’s experiences which moulds the way you respond.... Drawing on lots of cues in a very unconscious way.”*

Dr Donovan’s evidence was that, where her husband was concerned, SF has a semantic memory which enabled her to know *“that she has feelings for him, that she knows how he makes her feel. She is able to tell if he is in a good or a bad mood”* However with strangers she has no such memory. This was the basis upon which Dr Donovan concluded that SF had capacity to make decisions about contact with AF but not with strangers.

An additional complication in the assessment of SF’s capacity to consent to sexual relations, and one that is not uncommon, as the fact that SF was described by the judge (in his paraphrasing of the evidence before him) as a “biddable” woman ,who was happy to be led by her husband. Disentangling what was attributable to her passivity and what to her disorder of mind was complex. This was particularly so given the evidence that SF considered that that males take the lead in deciding when to have sexual relations and women do not refuse to have sex as this would negatively impact on the relationship. Dr Donovan concluded that

- SF understood that she had a choice whether to consent or not and had considered the personal consequences of consent versus refusal. While this illustrated a degree of passivity, this was not unique to her mental disorder and pre-dated the onset of her dementia. Dr Donovan further noted that it was a common view held in various relationships.
- SF had lots of information to draw on when making decisions about consenting to sex, including whether she wanted sex and whether she wanted to avoid upsetting AF if she did not want to have sex with him.

Cobb J found that SF lacked capacity to make decisions about contact with others, but that she had capacity to make decisions about consenting to sexual relations and contact with her husband.

Comment

This is a fascinating judgment, in particular because of the granular detail that Dr Donovan gave to illustrate precisely how he understood SF’s mind to work. It drew upon what is known about how dementia impacts on the mind, namely that it does not have a uniform effect on all aspects of the mind, also sought to distinguish carefully between SF’s ability to use and weigh different types of information dependent on how she has obtained it. If only all capacity assessments (and, in turn, determinations – i.e. decisions upon capacity) in difficult cases such as this could descend to this level of detail. Whether or not one agrees with the conclusion, the route by which it was reached was clearly and transparently spelled out.

We also anticipate that the difference between semantic and episodic memory is likely to be the focus of many a letter of instruction and cross examination question in the future!

Capacity and executive (dys)function

Sunderland City Council v AS and Others [2020] EWCOP 13 (Cobb J)

Mental capacity – assessing capacity – contact

Summary

This case concerned the capacity of AS, a man on a Community Treatment Order pursuant to the Mental Health Act 1983. AS had a diagnosis of mild learning disability, acquired brain injury, bipolar disorder and personality disorder traits. He exhibited what was described as challenging behaviour and as being resistant to his care plan. He resided in supported accommodation with other vulnerable service users, requiring him to be supervised at all times given the risk he posed to them.

Cobb J received a range of evidence, including a report from a jointly instructed consultant forensic and clinical psychologist Dr. Stephanie Hill, and unsworn evidence of AS given from the witness box.

Dr. Hill had initially taken the view that AS had litigation capacity while lacking subject matter capacity, and that his capacity fluctuated, in that when calm he had capacity but when aroused, lacked it. In the final analysis however Dr. Hill concluded that AS in fact lacked capacity to make decisions about litigation, residence, care and contact with others on a permanent (as opposed to fluctuating) basis.

By the end of the oral evidence, all the parties (including the Official Solicitor on behalf of AS) agreed that AS lacked capacity in all of the areas outlined in the judgment: Dr. Hill confirmed that no amount of further information would be likely to make the difference to AS's ability to exercise capacitous decision-making and that this lack of capacity was permanent. Having heard Dr. Hill's oral evidence, and her thoughtful revision of her earlier-expressed views, Cobb J was satisfied that the evidence displaced the presumption of capacity in relation to AS's decision-making on residence, contact, care and in respect of this litigation.

Cobb J also found that AS was deprived of his liberty, but that this was justified and should be authorised by way of making an order under s.16(2)(a) MCA 2005.

Comment

Cobb J accepted the submission made by the local authority that part of the relevant information AS was required to be able to process to have the capacity to make decisions about residence included the structure and routine that living in a supported living placement provided as compared to living independently in the community. While in some respects it could be said that the structure and routine is part of the care package, following the Court of Appeal case of *B v A Local Authority* [2019] EWCA Civ

913 in which the Court warned against considering capacity in silos, this is undoubtedly the correct approach.

The second notable issue raised in this decision is Dr Hill's reliance on the NICE guidance on decision making which highlights the difficulties in assessing the capacity of people with executive dysfunction, cautioning that as well as an interview style assessment, real-world observation of the person's decision making may be required to get a full picture of capacity. When incorporating this into the assessment of AS's capacity, Dr Hill moved from a conclusion that AS's capacity fluctuated (i.e. he had capacity when calm, but lacked it when aroused in the real world) to concluding that in fact he lacked decision making capacity on care and residence. Dr Hill's change of view appears to have arisen from her stepping back and considering AS's capacity on a more macro level saying about care "*When I looked at my reasoning in relation to care, I realise that I have over-emphasised his ability to look at care plans and specifics..... AS does not understand that as a concept in relation to his overall well-being. AS is very concrete in his thinking, and very focused on immediacy, and he struggles with the overarching structure*" [our emphasis].

It is suggested that by stepping back and asking whether P can process the concept and structures around residence and care, rather than focusing on the more 'micro' questions about the specifics of the care plan or the kind of accommodation, the assessor is less likely to assess interrelating issues in silos and so come to contradictory and unworkable conclusions on capacity.

Capacity, vulnerability and insight

Leicester City Council v MPZ [2019] EWCOP 64 (HHJ George)

Mental capacity – assessing capacity

Summary

This case concerns the capacity/vulnerability interface between the MCA and the inherent jurisdiction and, crucially, the role of belief when determining capacity. Mary was 31 years old and was diagnosed with a learning disability and both emotionally unstable and dependent personality disorders. She was in supported accommodation and the court was determining her capacity to conduct litigation and to make decisions about her residence, care, contact, access to social media and the internet, to enter and surrender a tenancy and to consent to sexual relations. The case focused upon the impact of her personality disorders on Mary's ability to decide.

HHJ George observed:

31. ... There is evidence of her rejecting as untrue, information given to her by professionals which is objectively true, and evidence of her accepting information from third parties as true, when it is objectively untrue. Dr Lawson said this is not a failure to understand the information, but a failure to believe it. He agreed that if Mary cannot assess the validity of information when it is given to her, she

will not be able to use that information effectively due to her personality disorder. He also accepted that if Mary makes a decision about contact for example, on the basis of incorrect information because she does not accept or believe something that is objectively true, this affects her ability to make the decision about contact because the premise upon which the decision is being made, is wrong.

32. I have been referred to the decision of MM [2007] EWHC 2003 (Fam) a decision of Munby J as he was then, in which he held that, "if one does not believe a particular piece of information then one does not, in truth, comprehend or understand it, nor can it be said that one is able to use or weigh it." In other words, the specific requirement of belief is subsumed into the more general requirements of understanding and the ability to use and weigh information.

The local authority submitted that the personality disorders were causing Mary's inability to believe relevant information which meant her decisions were on a false basis which was relevant to her capacity to make them. On behalf of Mary it was submitted that this "*can only be the case where the failure to believe is the result of a disorder of the functioning of the mind or brain. Or, put another way, a capacitous person may make a decision because he does not believe evidence put before him (that evidence being demonstrably true). The fact he made a mistake does not make his decision incapacitous.*"

Following further evaluation of the evidence, the court adopted the approach of Munby J:

34. In his report, Dr Lawson sets out how this occurs: Mary has a pathological dependence on abusive relationships which causes her to reject the truth of information given to her. This means that she cannot consider satisfactorily the merit or demerits of information given to her in balanced manner. I accept that there is a contradiction in Dr Lawson's evidence. He says Mary understands the relevant information given to her, but he also accepts that she does not always believe the relevant information. Having heard his evidence, I find that this is a difference in terminology rather than substance. The case law makes it clear that a failure to believe is a failure to understand and use or weigh in the context of the specific decision-making exercise engaged...

...

36. Taking Dr Lawson's evidence as a whole and considering how the personality disorders impact on all Mary's decision-making, I have concluded that they do so distort her perception of the world, that she lacks MCA capacity in all domains...

37. I conclude that this evidence, taken with her inability to understand relevant information in that she is not always able to believe the truth of what she is told, means the local authority has rebutted the presumption that Mary has capacity to make the range of decisions before the Court. Dr Lawson went further than saying it depended on the circumstances. His evidence was that the personality disorders are pathological and so distort her decision-making as to render her incapacitous. The evidence is that there is no room for a distinction to be made depending on who Mary is in conversation with. So pervasive and distorting are the disorders on the operation of her mind, that even with those with whom she is in a therapeutic or benign and caring relationship, her fear of

damaging that relationship is so great that her capacity to make a decision is vitiated. (emphasis added)

Specifically in relation to Mary's capacity to consent to sexual relations:

40. Relevant to this consideration is the other point the local authority submitted to the Court, namely the proposition that Mary does not understand that she can say no to having sexual relations. In other words, she does not understand that sexual relations are consensual. If that is right, then that would render her incapacitous. The local authority relies on the evidence of Ms Clarke in this regard. Dr Lawson agreed that if the Court found that Mary did not understand that she had a choice about whether or not to engage in sexual relations, then this would render her incapacitous. In his evidence, he agreed with Ms Clarke that while Mary understood as a matter of theory that a person can say no to sex, she did not understand the choice when it related to her. I agree that this is what the evidence shows.

41. I am therefore satisfied that Mary does not appreciate she has a choice as to whether or not to have sexual relations. The case law makes it clear that this must inform capacity, and so I conclude that the local authority has rebutted the presumption in this domain as well." (emphasis added)

If she was wrong in this, HHJ George observed, would have held that Mary was vulnerable and invoked the inherent jurisdiction (paragraph 38).

Comment

Although the word 'insight' is not mentioned in the judgment, the issues discussed are very relevant to it. The MCA omitted a belief requirement but the approach of Munby J subsumes it within the statutory limbs of understanding, using and weighing. It seems odd to suggest that we cannot understand anything we do not believe. For we often disbelieve things that we understand. The key is the extent to which the "thing" is capable of being an objectively-proven "fact" or "truth". The less certain the fact/truth is, the more careful we must be when determining whether the capacity assumption has been rebutted.

PROPERTY AND AFFAIRS

The Golden Rule in (in)action

Re Templeman Deceased [2020] EWHC 632 Ch High Court (Chancery Division (Fancourt J))

Mental capacity – testamentary capacity

Summary

In this case one of the children of the late Lord Templeman disputed the validity of his last will, made in 2008.

At that time, he was suffering from episodic memory problems but was otherwise mentally fit. It was contended that he had forgotten the terms of his earlier will and was operating under an illusion that two potential beneficiaries had been done a wrong that needed to be put right. This factual case was rejected (see paragraph 128 and 129 of the judgment) but the court went on to consider what the position would have been had that case been accepted.

At paragraphs 132 and 133 the court held as follows.

132. Even if I had concluded that Lord Templeman had forgotten the terms of his 2004 codicil and/or the gift of Rock Bottom by Sheila when making his new will and was acting in the belief that a wrong had been done to Jane and Sarah that needed to be put right, I would still have held that he had testamentary capacity. The argument of the Defendants was put in two different but complementary ways. First, that because Lord Templeman could not recall the arrangement that had been deliberately made and the reasons for it, he could not sufficiently comprehend and appreciate the nature and extent of the claims on his estate: he could not appreciate that Jane and Sarah did not have a legitimate and substantial claim for provision under his will, whereas his own family did have. Second, that his mind was so prejudiced by an illusory belief that a wrong had been done to Jane and Sarah that had to be put right that he lacked a just appreciation of those claims.

133. Comprehension and appreciation of the calls on a testator's bounty does not require actual knowledge of other gifts that have been made to, or the financial circumstances of, a potential object. A testator does not have to have all the facts with which to make a correct or justifiable decision; he has to have the capacity to decide for himself between competing claims. That means that he must have the ability to inform himself about those claims, to the extent that he wishes to do so, but not that he must remember the relevant facts about each of the potential objects or have correctly understood their financial circumstances. Whether Jane and Sarah had a legitimate claim on him and if so to what extent, compared with his blood relations, was a matter for Lord Templeman, as long as he had the capacity to weigh the rival claims.

The emphasis, therefore, is on the capacity to understand and it is not necessary to show that the testator had all the facts in his mind so long as he had the capacity so to do.

The result was, therefore, that the Lord Templeman's last will stood and we should all bear in mind these words from the judgment.

18. In such circumstances, Mummery LJ (with whom Patten LJ agreed) concluded in Hawes v Burgess [2013] EWCA Civ 94; [2013] WTLR 453 at [57] that it would be a "very strong thing" to conclude that a testator lacked testamentary capacity because he did not "comprehend and appreciate the claims to which he ought to give effect". Mummery LJ continued at [60]:

"My concern is that the courts should not too readily upset, on the grounds of lack of mental capacity, a will that has been drafted by an experienced independent lawyer. If, as here, an experienced lawyer has been instructed and has formed the opinion from a meeting or meetings that the testatrix understands what she is doing, the will so drafted and executed should only be set aside on the clearest evidence of lack of mental capacity. The court should be cautious about acting on the basis of evidence of lack of capacity given by a medical expert after the event, particularly when that expert has neither met nor medically examined the testatrix, and particularly in circumstances when that expert accepts that the testatrix understood that she was making a will and also understood the extent of her property"

Comment

As others have observed, it is ironic that Lord Templeman had, himself, not followed his own Golden Rule as to the obtaining medical advice in the case of an "aged testator or testator who has suffered a serious illness." It is doubly ironic that this judgment reinforces that that 'rule' is a matter of practice, as opposed to a legal requirement.

OPG guidance for attorneys and deputies

The OPG has issued guidance for attorneys and deputies as to how to discharge their roles during COVID-19, reinforcing that the obligations under the MCA imposed upon them are not relaxed. The guidance makes clear that a person cannot give up their role temporarily, but that they do not have to take steps to step down permanently simply because they cannot visit the individual in question at the moment. It also emphasises that:

Being an attorney or deputy does not mean that you can tell a health or care provider they have to use their resources to help the person. This includes resources such as care provision, particular medical equipment or a doctor's time.

OPG 'rapid response' register search process

The OPG has launched a 'rapid response' search process for NHS and social care staff to be able to obtain information quickly about whether a COVID-19 patient has an attorney or deputy. The details, and the template email to use, can be found [here](#).

OPG survey on COVID-19 and LPAs

The Office of the Public Guardian is gathering information on the impact the coronavirus outbreak is having on the process of making a lasting power of attorney (LPA).

If you are someone who helps people plan for the future, they would like to know more about how the outbreak is affecting you and your clients. Please complete this [short survey](#) which includes the opportunity to leave your contact details if you would like to discuss your responses in more detail.

PRACTICE AND PROCEDURE

The Court of Protection and COVID-19

The Court of Protection, along with wider society, is going through an extraordinarily rapid transformation to address the consequences of the pandemic.

A useful set of resources relating to the wider operation of courts (including legal aid) can be found on the Mental Health Law Online website [here](#); the Judiciary website has also collated advice and guidance [here](#). Key resources relating to the Court of Protection are the guidance letters from the Vice-President, Hayden J, as follows (in reverse chronological order):

- 31 March 2020: [Guidance on remote access to the Court of Protection](#), including a detailed protocol for remote hearings and draft order.
- 24 March 2020 [Further Guidance for Judges and Practitioners in the Court of Protection arising from Covid-19](#)
- 18 March 2020: [Additional Guidance for Judges and Practitioners arising from Covid-19](#)
- 13 March 2020: [Visits to P by Judges and Legal Advisers](#)

The Court of Protection Bar Association issued guidance (approved by Hayden J) on 7 April 2020 as to effective conduct of remote hearings in the Court of Protection, available [here](#). The experience of Rosie Scott, one of the members of the Court of Protection team, with remote hearings can be found [here](#).

Further guidance is likely to be forthcoming, and Hayden J has formed the HIVE group to meet (remotely) at regular intervals throughout the present public health crisis. The objective will be to continue to refine the approach to dealing with the Court's business and to seek to ensure that it runs as smoothly as possible. The members of the group are:

- Hayden J
- HHJ Carolyn Hilder
- Sarah Castle (the Official Solicitor)
- Vikram Sachdeva QC, Vikram.SachdevaQC@39essex.com
- Lorraine Cavanagh QC, Lorraine.Cavanagh@stjohnsbuildings.co.uk
- Nicola Mackintosh QC (Hon), nicola.mackintosh@macklaw.co.uk
- Alex Ruck Keene, alex.ruckkeene@39essex.com

- Joan Goulbourn (Ministry of Justice)
- Mary MacGregor (Office of Public Guardian)
- Kate Edwards, kate.edwards@wrigleys.co.uk

Questions for consideration by the HIVE group should be directed in the first instance to one of the members of HIVE whose email addresses are listed above.

Separately, HMCTS has issued its [family business priorities](#) for April 2020, i.e. what work must be done, what work will be done, and what work HMCTS will do its best to do. In relation to the Court of Protection, they are divided as follows:

Must be done

- Urgent applications
- Applications under Mental Capacity Act 2005, s 16A and s 21A
- Serious medical treatment cases
- Deprivation of Liberty
- Form COP1 Statutory Wills – where person is near end of life.
- Safeguarding applications via the Office of the Public Guardians

Work that will be done

- Gatekeeping and allocation referrals – care
- Gatekeeping and allocation referrals – private
- Other family care orders/documents/emails
- Court of Protection – welfare cases

Work that “we will do our best to do”

- Court of Protection – property and affairs

The s.48 threshold recalibrated

DA v DJ [2017] EWHC 3904 (Fam) (Parker J)

Practice and Procedure (Court of Protection) – other

Summary

In this case, decided in 2017, but which only appeared on Bailii in March 2020, Parker J considered in considerable detail the operation of s.48 MCA 2005: i.e. the jurisdiction of the Court of Protection to

make interim declarations and decisions.

The case concerned a wealthy woman, about whom her children were concerned, and in respect of whom they wished to bring an application to the Court of Protection. The dilemma they – and the court – faced was neatly summarised in these two paragraphs:

10. As part of the preparation for this case, the applicant and his siblings have instructed a consultant psychiatrist, a Dr Glover, who has provided a report based on the statements to which I have referred and the text messages. He has not met or even seen DJ. I recognise, as indeed does Sir Robert, the limitations of this approach. Nonetheless, in my assessment, it is not one that can be wholly discounted or disregarded. The children have taken the view that it would be impossible, ineffective, and counterproductive to ask their mother to be assessed. She expresses herself to be wholly sane and rational.

[...]

12. The proposal which is made on behalf of the applicant is, in my view, a moderate and tempered one. It is intended with the support of the Official Solicitor through his representative, Ms Hobeys-Hamsher, to introduce psychiatric expertise in the form of a psychiatrist to DJ at her home in pursuit of an assessment. In order so to do, an order is sought, after the necessary interim declaration, without which the court can make no order, and after case management directions, for disclosure to be sought from the borough in which DJ lives and from medical attendants who may have assisted her in the past.

In order to proceed, Parker J had to resolve the conflict between the decisions of HHJ Marshall in *Re F* [2009] EWHC B30 (Fam) and that of Hayden J in *Wandsworth LBC v A McC* [2017] EWHC 2435 (Fam) as to the threshold for engaging the jurisdiction. HHJ Marshall had held that what was required was "sufficient evidence to justify a reasonable belief that P may lack capacity in the relevant regard." Hayden J had rejected HHJ Marshall's approach, on the basis that "...the presumption of capacity is omnipresent in the framework of this legislation and there must be reason to believe that it has been rebutted, even at the interim stage. I do not consider, as the authors of the 'Mental Capacity Assessment' did that a 'possibility', even a 'serious one' that P might lack capacity does justification to the rigour of the interim test. Neither do I consider 'an unclear situation' which might be thought to 'suggest a serious possibility that P lacks capacity' meets that which is contemplated either by Section 48 itself or the underpinning philosophy of the Act." Hayden J held that an interim declaration had to be founded upon a "solid and well-reasoned assessment in which P's voice can be heard clearly and in circumstances where his own powers of reasoning have been given the most propitious opportunity to assert themselves."

Parker J observed that:

65. It is uncomfortable, even invidious, to be asked to disagree with the decision of another judge of equivalent status. However, I am invited to approach this case by both counsel on the basis that Judge Marshall's reasoning should be preferred to that of Mr Justice Hayden. Both Sir Robert and Mr

Rees submit that the stark and restrictive interpretation by Hayden J, with its requirement of explanation to the asserted incapacitous person and ability for his/her voice to be heard, makes the Act unworkable in practice and runs a high risk of imperilling the safety and wellbeing of those persons whom the Act and the judges are charged with protecting. Reliance is placed upon Judge Marshall's words which I have quoted at length and I am asked to approve them.

66. I regard her approach as consistent with the policy of the Act, one which makes sense on the basis of common sense and practicality as she observed. I agree that were it necessary in every case, as opposed to preferable, to defer assessment of capacity until there has been either a formal psychiatric assessment and/or engagement of P undermines the Act's purpose and unsupported, indeed is positively contradicted, by the Law Commission report and the explanatory notes after the Royal Assent which I have cited, I am satisfied that I can take into account such materials which are plainly to be regarded as travaux préparatoires and which are, in any event, consistent with a purposive construction of the Act.

67. Furthermore, to require the "voice" of P to be heard before reaching a decision as to whether the s.48 gateway is passed is not to be found within the structure of the Act itself but is, adopting the approach of Judge Marshall, one of the matters to be taken into account when considering the case in the round. I note also that on the facts of the decision in respect of J in the Wandsworth case, the only material upon which the local authority appear to have relied was what J said himself. In contrast to the case before me, there appears to have been no other extraneous observation of behaviour, of attitude, examination of written material, and so on.

68. I can see that there may be cases in these highly fact-specific areas where to hear the voice of P explaining a comment or account may be an important part of the assessment process, particularly at the final stage. I disagree that there is any compulsion for such view to be expressed. In practice whether an explanation is required will mostly be where silence in the face of something calls for an answer.

Parker J went on to:

70. [...] disagree also with Hayden J that "a possibility" and particularly "a serious one" does not fulfil the test set out in s.43. Furthermore, an "unclear situation" which might "suggest a serious possibility P lacks capacity" in my view also falls within the criteria to be considered or the circumstances to be considered under s.38.

71. I have been urged not to seek to recast the clear words of s.48 in any different language which might further confuse the law in this area. It is obvious to me that the word "reason" in s.48 means that there must be evidence upon which a belief is formed. It probably needs to be prima facie credible, not in the sense that it is believed but in the sense that it is capable of belief (for instance, something which is plainly fanciful or impossible might be capable of being disregarded), and I see no reason, indeed it seems to me axiomatic in the phraseology of s.48(a) that the court is entitled to draw inferences from the prima facie facts which are sought to be established.

On the facts of the case, and applying the “simple test in the Act,” Parker J took the view that the s.48 threshold was crossed, and made an order (the precise terms of which were not set out in the judgment) to move the case forward. She had, earlier (and importantly) noted that, if the woman was “unwilling to see the experts instructed, or the medical professionals instructed; and/or the assessment is not concluded; it is agreed that a report should be written having regard to the written material alone.”

Comment

As we noted at the time that the *Wandsworth* judgment was handed down, it was a problematic decision (in which it appeared not to have been brought to Hayden J’s attention that Charles J, his predecessor as Vice-President of the Court of Protection, had expressly endorsed HHJ Marshall’s position). With respect, we entirely agree with the approach adopted by Parker J, which avoids some of the real difficulties that the *Wandsworth* judgment caused, in particular where it has not been possible to gain access to the person to carry out a proper capacity assessment.

Short note: habitual residence and jurisdictional deadlock

In *QD (Habitual Residence) (No.2)* [2020] EWCOP 14, Cobb J gave a follow up judgment to that delivered in December 2019. In that judgment, Cobb J decided that the move of QD from Spain to England had been a wrongful act perpetrated by his children, that he remained habitually resident in Spain, and that the Court of Protection should decline primary jurisdiction in accordance with the provisions of Schedule 3 of the MCA 2005, and should yield to the jurisdiction of the Spanish Court. Cobb J had agreed that he could exercise the limited jurisdiction available to him pursuant to Schedule 3, paragraph 7(1)(d), to make a ‘protective measures’ order which provided for QD to remain at and be cared for at the care home which he was living and to continue the authorisation of the deprivation of his liberty there only until such time as the national authorities in Spain have determined what should happen next. Cobb J held that it was “*for the Spanish administrative or judicial authorities to determine the next step, which may of course be to confer jurisdiction on the English courts to make the relevant decision(s)*”

Following that decision, a Spanish lawyer (was instructed to advise on the process by which the Spanish Court could accept jurisdiction. She made clear that the Spanish proceedings could not progress whilst QD remained in England. As Cobb J noted, this gave rise to:

something of a legal ‘deadlock’ has arisen; I have found that the English Court does not have primary jurisdiction in respect of QD, as he is not habitually resident here; this does not of itself give rise to an immediate obligation to return QD to Spain. There is, currently, no order of the Spanish Court directing the return of QD which is capable of recognition and enforcement by the Court of Protection under MCA 2005 Schedule 3, paras 19 and 22. It appears that the Spanish Court will not be able to exercise its primary jurisdiction to decide where QD should live (and whether he should return to Spain) unless QD is returned to Spain; the decision of whether he

should be returned, how he should be returned, and when he should be returned, would primarily fall (unless it comes within Schedule 3, para.7(1)) to be to be considered by the Spanish Court.

Cobb J had started to take steps to seek to break the deadlock when the COVID-19 pandemic swept Europe, such that, even if it were theoretically possible to order a return at the present time, to implement would be impractical, and to do so would clearly expose QD to an unacceptable risk of infection.

The Official Solicitor invited the court to make an 'in principle' best interest decision that he be urgently returned to Spain. She was concerned that unless QD is returned to Spain, to enable the Spanish court to make the decision about QD's long-term residence, the Applicants' wrongful act would *de facto* be regularised by default. She further accepts that the direction should be stayed pending the conclusion of the pandemic.

Cobb J held as follows:

17. In spite of its limited practical effect at this stage, I felt that I should pause to reflect on the decision, particularly given the quality of the submissions made on all sides. While tempted to try to break the jurisdictional 'deadlock' at the moment, by making an 'in principle' best interests' decision, I have (somewhat reluctantly) reached the conclusion that I should simply adjourn the decision, and re-list this application for further review in three or four months' time. I have so decided for the following reasons:

i) I cannot in all conscience exercise a jurisdiction ("exercise its functions under this Act": Schedule 3 MCA 2005) based on 'urgency' under Schedule 3 para.7(1)(c), while at the same time adjourning the implementation of the order for an indefinite period, which is likely to be many months; I have already decided (see [4](iv) above) that 'urgency' means "an immediate need" for the substantive order; there would be an unacceptable dissonance between these outcomes;

ii) point which did not arise at the hearing, but which has occurred to me while considering this judgment: I would like the parties to consider whether they feel that [the Spanish lawyer] has sufficiently covered the provision raised in Schedule 3, para.11 MCA 2005: "In exercising jurisdiction under this Schedule, the court may, if it thinks that the matter has a substantial connection with a country other than England and Wales, apply the law of that other country" (my emphasis by underlining); in this regard, while I am advised that the Spanish Court would generally deploy its comprehensive legal framework with clearly prescribed 'best interests' criteria, specifically, how would the Spanish Court consider the issue of whether QD should return? If the parties, or any of them, considers that Ms Garcia has not addressed this specific question, she should/could be asked a supplementary question focused on this point;

*iii) Even if I were to make an 'in principle' decision now, such a decision would have to be subject to a further welfare review/enquiry of some kind as/when the pandemic has passed, in order that I could then be satisfied that QD remains fit for travel abroad, and that this would not be contrary to his best interests; this approach corresponds with that taken by Hedley J in relation to a related point arising under MCA 2005 Sch. 3 para 12 in the case of *Re MN* [2010] EWHC 1926 (Fam) at*

paras [35] to [36] (“It has to be said, however, that were the current stay to remain in place for an appreciable period, this court may well need an updated assessment from [the expert advising on welfare]”);

iv) It is agreed that there is, in any event, a need for some further evidence from KD about the arrangements for QD in Spain; there is no confirmed space for QD at Vista Al Mar; it is not confirmed that the staff there will cater for the needs of a person with dementia. She has agreed to furnish this further information in writing. Even if this information were available now (which it is not), given the likely delay in resolving this issue, it is likely that updated/contemporary evidence on these points would have been required in any event;

v) The Applicants have conceded that they cannot and will not take advantage of QD’s continued presence here in this country to mount a case down the line that his habitual residence is changing or has changed; I would not in any event be minded to reach such a conclusion on the facts given the extraordinary prevailing circumstances.

Looking beyond the facts of QD’s case, it is unfortunate that Cobb J was not in a position to find a way through the deadlock with which he was presented. This is not the first time that the Court of Protection has encountered the problem that a foreign court may not exercise jurisdiction over a person until physically present upon their soil – even where it is clear that they are habitually resident there. Similar problems have been encountered rather closer to home with Sheriffs’ courts in Scotland, which have led to complex, and not entirely satisfactory, steps to be taken to make urgent applications upon the person reaching Gretna Green whilst travelling under cover of an English order.

Short note: placement in England for purposes of psychiatric treatment

In *The Health Service Executive of Ireland v Moorgate* [2020] EWCOP 12, Hayden J considered in some detail the operation of the regime under Schedule 3 MCA 2005 for recognition and enforcement, in the context of a placement of a young Irish woman at an English psychiatric facility for treatment of anorexia nervosa. The placement took place under cover of an order of the Irish High Court, put forward for recognition and enforcement by the Court of Protection.

Baker J had previously had to address the complex questions of law to which this gave rise in 2015 (*The Health Service Executive of Ireland v PA & Ors* [2015] EWCOP 38). This was the first time the current Vice-President of the Court of Protection had had to consider them. His judgment provides an updated route-map for navigating the complexities, and also (as an appendix) an endorsed and detailed comparison of the domestic regimes (MHA and MCA) that would apply were a person placed under a foreign order were, in fact, to be treated under the frameworks that would apply if they were habitually resident in England & Wales.

THE WIDER CONTEXT

The MCA and COVID-19

Alex has set up a [resources page](#) on his website for the MCA and COVID-19, gathering guidance and practical resources. The resources page also includes a [link](#) to a recording of the first rapid response webinar held by the National Mental Capacity Forum on 1 April, at which Alex spoke; a second webinar will be held on 28 April 2020.

The impact of the Coronavirus Act 2020

We have produced a guidance note addressing the impact of the Act upon social care and SEND, available [here](#). We have also produced a rapid response guidance note addressing the impact of the changes to the MHA 1983 (which have yet to be brought into force), available [here](#).

Short Note: hospitals, scarce resources and human rights

In a decision handed down on 9 April 2020, Chamberlain J gave some important observations about the lawfulness of the allocation of scarce hospital resources in *University College London Hospitals NHS Foundation Trust v MB* [2020] 882 (QB).

The case arose because the Trust sought possession of a bedroom from a woman called MB in a hospital that it runs (where she had been since February 2019), on an urgent basis: “because the COVID-19 pandemic meant that the bedroom is urgently needed for other patients; and because in any event it is contrary to MB’s interests to remain in the Hospital, where she is at increased risk of contracting COVID-19.” The Trust, the claimant, contended that the woman could be safely discharged to specially adapted accommodation provided by the local authority, with a care package, which the Trust considered more than adequate to meet her clinical and other needs. Chamberlain J had to decide whether to grant the Trust an injunction on an interim basis to require MB to leave the hospital.

The facts of the case, and in particular MB’s medical history, are complex, and we do not set them out here. For present purposes, it is of importance that MB did not seek to defend the claim on the basis that it was irrational of the Trust to cease to provide her with inpatient care, and hence to require her to leave (and the judge held that any such contention would be unsustainable).

Rather, MB argued that requiring her to leave would breach her rights under Article 3 and Article 8 ECHR (read independently, and together with Article 14), as well as amounting to breaches of the Equality Act 2010. Chamberlain J started with Article 3 ECHR:

So far as Article 3 ECHR is concerned, Mr Holland’s submissions amount to this: if it can be established that, unless her concerns are addressed, discharge will precipitate suicide, self-harm or extreme distress rising to the level of severity necessary to qualify as inhuman or degrading treatment within the meaning of Article 3 ECHR, the Hospital is legally precluded from discharging her until

those concerns are met, even if her concerns are, from an objective clinical point of view, unreasonable and unwarranted. I cannot accept that proposition.

The reasons Chamberlain J gave for rejecting her contention are important, and merit setting out largely in full:

54 It is a tragic feature of MB's complex constellation of mental health difficulties that she frequently suffers from extreme distress, whether she is in hospital or not. But, if the Hospital were precluded from doing anything which might precipitate such distress, it would soon end up in a situation where it was legally precluded from taking any step other than in accordance with MB's wishes. In this case, MB would be entitled to insist on the provision of whatever she considers she needs as a condition of discharge from hospital, even if the result of her doing so were that the needs of others could not be met. That is not the law, because her needs are not the only ones that the law regards as relevant.

*55 In some circumstances, a hospital may have to decide which of two patients, A or B, has a better claim to a bed, or a better claim to a bed in a particular unit, even ceasing to provide in-patient care to one of them to leave will certainly cause extreme distress or will give rise to significant risks to that patient's health or even life. A hospital which in those circumstances determines rationally, and in accordance with a lawful policy, that A's clinical need is greater than B's, or that A would derive greater clinical benefit from the bed than B, is not precluded by Article 3 ECHR from declining to offer in-patient care to B. This is because in-patient care is a scarce resource and, as Auld LJ put it in *R v North West Lancashire Health Authority ex p. A* [2000] 1 WLR 977, at 996, "[i]t is plain... that article 3 was not designed for circumstances... where the challenge is as to a health authority's allocation of finite funds between competing demands". Decisions taken by a health authority on the basis of finite funds are, in my judgment, no different in principle from those taken by a hospital on the basis of finite resources of other kinds. In each case a choice has to be made and, in making it, it is necessary to consider the needs of more than one person.*

56 The present situation does not involve a comparison of the needs of two identified patients. But the decision to withdraw permission for MB to remain in the Hospital is still a decision about the allocation of scarce public resources. Decisions of this kind are a routine feature of the work of hospitals and local authorities, even when there is no public health emergency. The fact that we are now in the midst of the most serious public health emergency for a century is likely to accentuate the need for such decisions. The absence of evidence identifying a specific patient or patients who will be disadvantaged if MB remains where she is does not mean that such patients do not exist. It is important when considering human rights defences in cases of this sort not to lose sight of that.

*57 Analytically, the reason why a decision to require a patient to leave a hospital is unlikely to infringe Article 3 ECHR is because it is based on a prior decision not to provide in-patient care. Such a decision engages the state's positive (and limited) obligation to take steps to avoid suffering reaching a level that engages Article 3, rather than its negative (and absolute) obligation not itself to inflict such suffering. Where the decision to discontinue in-patient care involves the allocation of scarce public resources, the positive duty can only be to take reasonable steps to avoid such suffering: cf *R (Pretty) v Director of Public Prosecutions* [2002] 1 AC 800, [13]-[15] (Lord Bingham). It is difficult to conceive of a case in which it could be appropriate for a court to hold a hospital in breach of that duty by*

deciding, on the basis of an informed clinical assessment and against the background of a desperate need for beds, to discontinue in-patient care in an individual case and, accordingly, to require the patient to leave the hospital. The present is certainly not one.

In relation to Article 8:

the difficulties facing MB's argument are even more pronounced. In R (McDonald) v Royal Borough of Kensington and Chelsea [2011] UKSC 33, [2011] HRLR 36, Lord Brown said this at [16]:

"the clear and consistent jurisprudence of the Strasbourg Court establishes 'the wide margin of appreciation enjoyed by states' in striking 'the fair balance ... between the competing interests of the individual and of the community as a whole' and 'in determining the steps to be taken to ensure compliance with the Convention', and indeed that 'this margin of appreciation is even wider when ... the issues involve an assessment of the priorities in the context of the allocation of limited state resources'".

Even though the decisions to cease to provide in-patient care to MB and to require her to leave plainly interfere with MB's right to respect for private and family life, the evidence adduced by the Claimant amply demonstrates that the interference was justified in order to protect the rights of others, namely those who, unlike MB, need in-patient treatment. Bearing in mind the broad discretionary area of judgment applicable to decisions of this kind, there is no prospect that MB will establish the contrary.

Finally, in relation to Article 14:

60 Nor does reliance on Article 14, read with Article 3 or Article 8, take matters any further. The decision to decline in-patient care to MB does not discriminate against her on the ground of her disabilities. The Hospital has treated her in the same way as a patient with different disabilities or with none: it has determined whether to continue to offer her in-patient care on the basis of her clinical need for such care. To the extent that this is itself discrimination against those, like MB, whose disabilities make them perceive a need for things (such as a rainwater canopy outside the front door) for which there is in fact no objective need, the discrimination would be justified even outside the context of a public health emergency. In the context of such an emergency, there is no prospect that a challenge based on Article 14 in these circumstances could possibly succeed.

MB also relied upon the Equality Act 2010, but to no avail:

61. As for MB's arguments under the 2010 Act, these too are without merit. Compliance with the duty in s. 149 of the 2010 Act [the public sector equality duty] is a matter of substance, not form. The fact that there has been no express reference to that duty does not matter. What matters is whether the factors required to be considered have been considered, insofar as they are relevant to the function in question. Here, the function is that of deciding whether to cease to provide in-patient care to MB. That decision was taken on the basis of the careful assessment of Dr Christofi and other members of the multi-disciplinary team. The assessment paid the fullest possible attention to the complex needs arising from MB's physical and mental disabilities. The contrary is not arguable. To the extent that it is said that the decision discriminates against MB on the ground of her disabilities

contrary to s. 29 of the 2010 Act, any such discrimination is justified for the same reasons as given in relation to Article 14. To the extent that the complaint is one of failure to make reasonable adjustments, the history demonstrates that Dr Christofi and his team have made every possible reasonable adjustment. The further adjustments to the care package now sought are, for the reasons I have given, not reasonable. There is therefore no arguable claim under the 2010 Act.

It was therefore clear, the judge held, that even on an interim basis, MB had no sustainable public law challenge (and that, had she sought to judicially review the Trust's decision, he would have refused permission and certified her claim totally without merit). He therefore granted the injunction,

Comment

There is, at present, much discussion in relation to the potential for resources within hospitals to become sufficiently stretched that decisions may have to be made that clearly and expressly proceed on utilitarian grounds: i.e. expressly comparing the relative need of one patient with another for (for instance) a bed in intensive care, or a ventilator. A good overview of the ethical issues can be found in this [briefing paper](#) prepared by the Essex Autonomy Project, and a resource for considering issues in detail is [this site](#) maintained by the Centre for Law, Medicine and Life Sciences at the University of Cambridge. The legal issues that arise were also discussed in this webinar held by members of Chambers on 7 April 2020, the recording of which is available [here](#).

This judgment is a good reminder that considerations of the allocation of scarce resource are ever-present even absent the current situation. It also lays out clearly both the steps for Trusts would need to take to ensure that utilitarian decisions that may have to be made in future are lawful, and also the hurdles that will lay in the way of those who may seek to challenge such decisions.

It should, finally, be emphasised that to the extent that current concerns about the impact of COVID-19 on clinical resources are leading decisions about advance care planning to be done to, not with people, this is wrong: see Alex's video [here](#).

Dialysis, the MHA 1983 and the MCA 2005

A Healthcare, B NHS Trust v CC [2020] EWHC 574 (Fam) High Court (Queen's Bench Division) (Lieven J)

CoP jurisdiction and powers – interface with inherent jurisdiction – Mental Health Act 1983 – interface with MCA – treatment for mental disorder

Summary

This case concerned a 34-year-old man ('CC') with psychotic depression, mixed personality disorder who was deaf, had diabetes and was detained under s.3 of the Mental Health Act 1983. The main issue was whether haemodialysis was medical treatment for his personality disorder for the purposes of MHA s.63. Lieven J held that the dialysis treatment, use of light physical restraint and chemical restraint (if required), was authorised by s.63.

Medical treatment for mental disorder

The responsible clinician's view was that CC's non-compliance with dialysis treatment was a symptom or manifestation of his mental disorder and that 'at best' his decision-making capacity was fluctuating. Without dialysis he would die and, to be reasonably stable, he needed 4 hours of it, three times a week. The treating team's intention was to commence peritoneal dialysis, which involved the insertion of a catheter, enabling less burdensome overnight dialysis. But, in the meantime, haemodialysis was necessary. His acceptance of the treatment fluctuated, but there were times – including the day before the hearing – when he was clear that he wanted it, did not want to die, and would want to be restrained if necessary to receive it.

Lieven J held that the treatment fell within the scope of MHA s.63:

36. In my view this is a clear case of the treatment proposed, the dialysis, treating a manifestation of the mental disorder, namely personality disorder. The need for dialysis stems from CC's self-neglect, including in regard to diet, which has led in whole or in part to his kidney failure. The reason his diabetes has resulted in kidney failure is to a large extent because of that self-neglect, which is itself a consequence of his mental disorder...[I]t seems to me clear that the physical condition CC is now in, by which dialysis is critical to keep him alive, is properly described as a manifestation of his mental disorder. There is a very real prospect that if he was not mentally ill he would self care in a way that would have not led to the need for dialysis. Further, that CC is refusing dialysis is very obviously a manifestation of his mental disorder. When he is mentally well he agrees to dialysis. His situation is therefore highly analogous with that of the force feeding cases.

The judge rejected the argument that, to fall within s.63, the "primary purpose" of the treatment must be to treat the mental disorder:

37 ... I do not think that one can take from the words of section 145(4) a need to analyse a hierarchy of potential purposes of the treatment or causative links. It is in my view sufficient that a purpose of the proposed treatment is to alleviate a manifestation of the mental disorder. There is no suggestion in any of the caselaw that I have referred to above that the Court (or a clinician) has to go through the type of exercise Mr Lock proposes. It is therefore sufficient that the renal failure is a manifestation of the mental disorder.

Interface between ss.62, 63 and 58

The health bodies submitted that the sedation required to carry out the dialysis fell within MHA s.58 and therefore required either capacitous consent or a second opinion appointed doctor ('SOAD') to certify the sedation as appropriate. Lievien J held that s.58 was excluded because this was emergency treatment for the purposes of s.62:

46. In my view, on this second issue under the MHA 1983 Mr Lock's arguments are wrong and section 63 is the appropriate course. There is no doubt that in this case, as in most if not all the previous authorities, the treatment being proposed under section 63 is urgent, and in all those cases life-

saving. The proposed dialysis for CC is plainly extremely urgent, and without it he will undoubtedly die. In those circumstances in my view the case plainly falls within section 62(1)(a) (b) and (c) and as such section 58 is excluded. In particular, in urgent treatment cases such as this, treatment is immediately necessary to save CC's life, to prevent a serious deterioration of his condition and to alleviate serious suffering.

47. I also accept on the facts that Mr Lock's analysis would make section 63 largely, if not wholly redundant, because in most if not all cases where section 63 is relied upon, the treatment will involve some use of medication, often sedation. It makes no sense of the statute for sedation to be dealt with under one statutory route and other forms of treatment to be dealt with by a wholly different one.

48. I do accept Mr Lock's point that considerable care needs to be taken in the use of section 63 if it is not to become a way of treating detained mental patients, with or without capacity, without their consent. However, the safeguard that is in place is the requirement set out by Baker J in NHS Trust v A at [80] that in cases of uncertainty, the appropriate course is to apply to the Court."

MCA 2005

The alternative argument of the health bodies was to seek a contingent declaration under MCA s.15(1)(c). The evidence suggested that the day before the hearing, CC had capacity to make the decision but it was fluctuating. The judge would have been prepared to make the declaration but, given that the treatment fell within MHA s.63, it was not necessary to do so:

51. ... I emphasise that this is not a case of CC simply making a poor decision with which the Court and the health professionals do not agree. Mr Maguire's Attendance Note and Dr H's evidence are both clear, that when well CC does not wish to die and wishes to have dialysis. His change of position is a function of his mental state worsening, and that in turn is a function at least in part of him refusing dialysis. I therefore find that when CC refuses dialysis he does lack capacity

...

55. In some ways this case is more straightforward. CC currently has capacity and is clear that he wants to have dialysis; that he does not want to die; and that he wishes to continue to have dialysis if he loses capacity. This is therefore in practice akin to an advance decision under section 24 MCA 2005, albeit that he has not gone through the formal processes of an advance decision contained in section 25 MCA 2005 and it is an advance decision to accept treatment not refuse it. It is in those circumstances relatively easy to declare that if CC loses capacity in respect of a decision about dialysis, then it is in his best interests to have dialysis in accordance with the care and treatment plan proposed. Such a declaration undoubtedly accords with CC's wishes and feelings, both because he has said so when he has capacity, but also because he is clear that he wants to live, and if he does not have dialysis then at some point he will die very prematurely."

Accordingly, it was held that it was for the responsible clinician to decide whether to provide the dialysis treatment under s.63, in consultation with the clinicians attending to his physical health, including the consultant nephrologist, which was subject to the supervisory jurisdiction of the High Court.

Comment

This is an interesting decision for many reasons. First, and as acknowledged at paragraph 9, treatment for end stage renal failure would not normally be seen as treatment for mental disorder. As the MHA Code of Practice recognises at paragraph 16.6:

[Medical treatment] includes treatment of physical health problems only to the extent that such treatment is part of, or ancillary to, treatment for mental disorder (eg treating wounds self-inflicted as a result of mental disorder). Otherwise the Act does not regulate medical treatment for physical health problems.

For mental disorder to result in self-neglect which results in kidney damage and therefore treatment for kidney damage is treatment for mental disorder reflects a very elastic interpretation of s.63. And such elasticity is hugely significant in human rights terms, given that, controversially, s.63 neither requires consent nor a second opinion. This decision can be contrasted with *GJ v Foundation Trust* [2009] EWHC 2972 (which was not referred to in the judgment) where GJ was forgetting to take his insulin because of dementia. There it was held that diabetic treatment was physical treatment and not treatment for mental disorder.

Secondly, the arguments around s.58 were rather novel. Section 58 is the 3-month psychiatric medication rule and the safeguards apply "*if three months or more have elapsed since the first occasion in that period when medicine was administered to him by any means for his mental disorder*". It is surprising therefore that all parties accepted that sedation for dialysis (namely midazolam) was medicine administered for personality disorder. Moreover, it was not clear whether, even if it was, 3 months had elapsed since it was first administered.

Thirdly, the reference to CC's "advance decision to accept treatment" needs unpacking. An advance decision under MCA s.24 is to refuse healthcare so, in reality, his capacitous desire for treatment was an advance *statement* which has very different legal consequences to an ADRT.

Recall, available treatment and the MHA

PM v Midlands Partnership NHS Foundation Trust [2020] EWHC 574 (Fam) Upper Tribunal (AAC) (Upper Tribunal Judge Church)

Mental Health Act 1983 – treatment for mental disorder

Summary

Whilst detained under MHA s.3 with schizoaffective disorder, PM commenced long-acting depot anti-psychotic medication (Aripiprazole at a dose of 300mgs, to be administered monthly). She received two doses, the first on 17 May 2019 and the second on 21 June 2019, with the plan that she should continue on the depot on the third Friday of each month. On 5 July 2019 she was discharged onto a

community treatment order ('CTO') and, to continue the treatment, a second opinion appointed doctor ('SOAD') was required to certify it as appropriate within 3 months of it first being administered; that is, 17 August 2019. The request for a SOAD was made on 15 July 2019 but, owing to a SOAD backlog, such certification would not be made within the statutory deadline.

The tribunal hearing took place on 15 August 2019 where the patient argued that appropriate medical treatment was not available because the depot would be unlawful in two days' time and that, accordingly, PM should be discharged from the CTO. This was rejected by the tribunal which upheld the CTO and this decision was appealed to the Upper Tribunal. The main issue was "*whether the lawfulness of administering medication to a Part 4A patient is relevant to a tribunal's assessment of whether the medical treatment proposed by the responsible authority was appropriate and available, or whether such a consideration, like consent, is something that comes into play only at the later stage of deciding whether to give the treatment*" (paragraph 9.4).

Appropriateness

At first instance, the tribunal had held that the lack of a SOAD opinion was not relevant to appropriateness of medical treatment. The Upper Tribunal held that the SOAD's opinion "*may, but will not always, be relevant to the issue of appropriateness*" and it depends on the facts (paragraph 9.10). If, for example, a SOAD refused to certify, that would likely be evidence for the tribunal to consider when determining appropriateness.

Availability

In the absence of precedent as to the meaning of 'available', the judge considered the following dictionary definition to be the most suitable in the context of the MHA: "*capable of being employed with advantage or turned to account; hence, capable of being made use of, at one's disposal, within one's reach.*" So, having determined that treatment is clinically appropriate, a tribunal must also be satisfied "*that the treatment proposed is one that can be provided should consent be forthcoming*".

10.4. To consider an example, if the appropriate medical treatment relied upon is not one which the responsible authority has the resources to provide, and there is no plan to source the treatment from another provider, then it could not be said to be "available" because there would be no prospect of the treatment actually being given in practice, even were the responsible clinician to decide that the treatment should be given and should valid consent be obtained.

...

10.6 ... a legal impediment is at least capable of being relevant at the identification and classification stage to the extent that it can be said to take the treatment outside the options at the clinician's disposal or within the clinician's reach.

The fact that, at the precise moment of the tribunal, SOAD approval was not necessary for another 2 days was not fatal to the argument: the tribunal should not use a 'snapshot' approach but instead look at the whole course of treatment, past, present and future (paragraphs 10.13–10.15). In conclusion:

12.1 ... While the lawfulness of the administration of treatment is not, per se, relevant to the "appropriateness" of medical treatment it is relevant to its "availability".

Accordingly, the tribunal erred in law but, as PM had already been discharged from the CTO before the Upper Tribunal's decision, the first instance decision need not be set aside.

Comment

This is a significant decision in the context of the MHA. Appropriate medical treatment is not available if it requires SOAD-certification and has not been so certified. This of course does not mean that a patient would be denied treatment they require as, for example, there may still be a nurse available to administer the depot. But what it does mean is that the patient would not be on the CTO to receive it. The Coronavirus Act 2020 provides a means to not require SOAD certification if getting a second opinion would be impractical or involve undesirable delay. However, that amendment has not yet been implemented.

The linking of legal impediments with the concept of availability may be relevant in relation to other aspects of the MHA. The appropriate medical treatment being available requirement is present in many other aspects of the MHA, so the linking of legal impediments with the concept of availability may have a broader application. The Code already states that "*medical treatment must actually be available to the patient. It is not sufficient that appropriate treatment could theoretically be provided*" (paragraph 23.14). Introducing the legality of such treatment into the equation, at least insofar as non-compliance with the treatment safeguards are concerned, may therefore give rise to further legal arguments in this area.

The Protection of Adults in International Situations

The European Law Institute has published a report on the protection of international adults (to which both Adrian and Alex contributed).

The ELI project began in 2017, under the leadership of Pietro Franzina and Richard Frimston, and was successfully approved by ELI's Membership in March 2020. The Report encourages the European Union to consider both external action and the enactment of legislation in the field of protection of adults. It provides analysis on the protection of adults in international situations. Where appropriate, it includes proposals regarding such protection as well as further issues surrounding the application of the Hague Convention of 13 January 2000 on the International Protection of Adults. It addresses the following issues: (a) the bases and scope of the Union's competences as regards the protection of adults in international situations; (b) the strategies that the Union should consider following in order to enhance the protection of adults in the relations between Member States; and (c) further

improvements that the Union may promote with respect to the Hague Convention of 13 January 2000 on the International Protection of Adults without making use of its external competence or its legislative powers. Finally, the Report sets forth a checklist to encourage the development of private mandates within the ambit of the substantive laws of the Member States.

The Report has been already presented to Members of the European Parliament and brought to the attention of national authorities and relevant stakeholders, and strides will continue to be taken in this regard.

It should also, in this regard, be noted that during the course of the Second Reading of the Private International Law (Implementation of Agreements) Bill in the House of Lords on 17 March 2020, the question of why the 2000 Convention had not been ratified in respect of England & Wales was raised by Lord Wallace of Tankerness. For the Government, Lord Keen responded:

The noble and learned Lord, Lord Wallace of Tankerness, raised [the 2000 Convention]. Hague, unlike Lugano, for example, can be entered into by a state, but can be ratified and applied in respect of only one jurisdiction within the state. It so happens that [the 2000 Convention] was implemented in respect of Scotland, but not of England and Wales, nor, I believe, Northern Ireland. I am not able to explain why it has been in abeyance for a number of years with respect to those other jurisdictions, but I can say that since the noble and learned Lord raised the point with me I have spoken to officials who are addressing that matter. Certainly, our recommendation would be that it should be applied in respect of England and Wales as well.

We await developments as the Bill progresses through Parliament.

Short note: information disclosure and the rights of others

In *ABC v St George's Healthcare NHS Trust* [2020] EWHC 455 (QB) Yip J dismissed a claim brought by the daughter of a man with Huntington's disease for negligence and Article 8 ECHR in circumstances where the claimant's father had instructed the NHS Trust not to share his diagnosis with his daughter and the NHS Trust complied with his instruction.

The court accepted the claimant's submission that the NHS Trust owed her a duty of care to balance her interest in being alerted to the genetic risk posed by her father's condition against the interest of her father in having his confidentiality protected and the public interest in maintaining confidentiality. However, Yip J stressed that the duty would only rarely give rise to a cause of action because: the standard of care would be measured by reference to professional guidelines where non-disclosure is the default option; decisions supported by a responsible body of medical opinion would not be considered negligent; and, the courts would grant considerable latitude to clinicians making difficulty decisions.

On the facts of the case the duty had not been breached because the clinician in question had considered his patient's safety, taken advice from a geneticist and heard competing arguments before

making what was a difficult decision in respect of which there was a reasonable range of professional opinion.

The CQC and Whorlton Hall

On 18 March 2020 the Care Quality Commission (“CQC”) published the findings of an independent review into its regulation of Whorlton Hall between 2015 and 2019. The review was undertaken by Professor Glynis Murphy and was tasked with examining whether abuse of patients at Whorlton Hall should have been identified earlier by the CQC. In summary, the review concludes that the CQC followed its procedures but makes six recommendations for the improvement of the CQC’s inspection and regulatory approach:

- displaying data for services in a user-friendly way to help inform inspections
- changing inspection methodology to include more unannounced and evening weekend inspections, more regular “Provider Information Requests” (PIRs) and the quicker publication of inspection reports
- improving the response to allegations of abuse, safeguarding alerts and whistleblowing
- prioritising gathering the views and experiences of people using services and their families on inspection
- adopting a more flexible inspection approach when information about a service indicates that it is at risk of failing its service users
- not registering isolated, unsuitable or outdated services or allowing them to expand.

Many of these improvements are presumably going to have to wait until the CQC is able to resume business as normal.

RESEARCH CORNER

We highlight here recent research articles of interest to practitioners. If you want your article highlighted in a future edition, do please let us know – the only criterion is that it must be open access, both because many readers will not have access to material hidden behind paywalls, and on principle. This month, we highlight the article by Alex on ‘Capacity in the time of Coronavirus’ now available (in pre-print) in the International Journal of Law and Psychiatry’s Special Issue: “Mental health, mental capacity, ethics and the law in the context of Covid-19 (coronavirus).” The article examines the impact of the Coronavirus Act on health and social care outside hospital; public health restrictions; the MCA under strain; the Court of Protection; medical decision-making, the MCA and scarce resource; and mental health law. It is also available in pre-print via ResearchGate here.

SCOTLAND

AWI law and practice: the co-operative response of the legal community

“The law is one of the caring professions”

(Retired) Sheriff Brian T Kearney

“We need to stick together and help each other in times like these”

Fiona Brown, Public Guardian

Lawyers are unlikely to be able to save a single life in the current emergency. Collectively, they can provide support to those in the front line, help to meet the needs and anxieties of the general public, and make proactive and inventive contributions towards responding to the crisis in ways that nevertheless safeguard as far as possible our society's core values of respect for human rights, due process, and the rule of law. The collective response of the legal community, largely in an atmosphere of complete cooperation, openness and mutual trust, and at quite astonishing speeds, has been massive. The Centre for Mental Health and Capacity Law at Edinburgh Napier University, led by Jill, has played a full role in that intensive effort, not only in contributing directly to many processes underway, but in preparing and publishing overviews, explanation and comments. More narrowly, this piece narrates some of the work of the Law Society of Scotland, through both its in-house staff and the army of those (not limited to professional lawyers) who contribute voluntarily to the Society's work, within the areas of legal practice covered by this Report. “In-house” has become a rather outmoded technicality, as – like most other firms and organisations – in the midst of this intense activity the Society had to manage the transfer of all its staff to home working.

The particular threads followed in this article must be seen in the context of broader issues, with many difficult and critical aspects, across a range including the administration of justice in the criminal courts, the operation of the civil courts, and the operation of the whole conveyancing system. While these aspects of the emergency have dominated, all of the “normal” responsibilities of the Society have remained. Even in “normal” times, these are sufficient to occupy fully the fit and lean in-house structure of the Society.

Practice updates from the Law Society can be found at <https://www.lawscot.org.uk/news-and-events/law-society-news/coronavirus-updates/>. Practitioners should continue to check regularly, particularly for updates relevant to their own areas of practice. For each item, the date of the most recent update is entered. It is clear that the profession generally is engaging carefully with these. Some updating has resulted from thoughtful consideration by a practitioner of a previous version of a particular item. Where particular items are referred to in this article, the date of the most recent update when accessed for preparation of this article is shown in brackets. Of particular relevance to adult incapacity are general items on “Court: criminal and civil” (updated 18 April), “Non face-to-face identification and verification” (updated 14 April), and “Non face-to-face ID where electronic verification

fails or is not possible" (updated 14 April). Most private client practitioners will also wish to pay particular attention to the "Wills guidance" (updated 25 March).

Of direct relevance to adults with incapacity practice is the guidance on "Power of attorney" (updated 08 April). Typically of the progress of such matters in these times, I was asked by the Professional Practice Department of the Law Society to join at short notice a conference call following upon receipt by the Society of enquiries from practising firms as to whether the "statutory interview" requiring to be carried out by the prospective certifier of a power of attorney document, immediately before execution, could be done remotely. Fortunately, I was able to advise that I had once done precisely that, with the full knowledge and agreement of Sandra McDonald, then Public Guardian. A UK citizen habitually resident overseas, fortunately in a country that had ratified Hague Convention 35 on the International Protection of Adults, wished to grant a Scottish power of attorney. He had been habitually resident in Scotland, and still had property in Scotland. Thus he was able to apply to his power of attorney the law of Scotland, rather than the law of his current habitual residence, because he qualified to do so under all three of the criteria listed in paragraph 4(2) of Schedule 3 to the Adults with Incapacity (Scotland) Act 2000, substantially replicating relevant provisions of Hague 35. Having consulted with the Public Guardian, I sent the document to him and interviewed him by Skype. He introduced me to a neighbour who had called round to witness the document. I conducted the interview in the usual way. He held up the print of the document that he had received from me, showing that it had not yet been executed. He executed it, and the witness signed. He held it up again to show that it had now been executed, and then mailed it back to me. I could thus properly certify that I had "interviewed the granter immediately before the granter subscribed the document" (sections 15(3)(c)(i) and 16(3)(c)(i) of the 2000 Act) and that I could otherwise properly sign the certificate. I did so, and – accompanied by confirmation that this methodology had been followed – the application for registration was submitted and registration in due course completed. In effect, that experience was transferred into the first edition of the power of attorney guidance.

Issue of the original guidance resulted in two further developments. Firstly, a practitioner contacted the Society with a well-reasoned request as to whether interview by telephone might sometimes be possible. That was carefully considered, and resulted in the additional text in the guidance advising that the procedure recommended in it does not necessarily preclude a solicitor as certifier being satisfied by other means that the solicitor can properly certify, in circumstances carefully circumscribed in the updated guidance, and with the reminder that certifying solicitors must be satisfied in every individual case that they can properly certify, and that the decision to do so can be robustly justified if that should subsequently become necessary. It is typical of many of the accommodating adjustments to law and practice guidance that they place enhanced reliance upon practitioners acting carefully with full professional responsibility for what they do. Practitioners will not need to be reminded of the potential "with benefit of hindsight" issues that could arise if whether they have done so is subsequently challenged.

The second consequence was that the flow of applications to the Office of the Public Guardian did not reduce. As everywhere, available OPG staff were diminished by consequences of the crisis, and transferred to home working. Careful management of systems and resources meant that OPG staff were still able to give priority to applications identified by them as urgent. However, solicitors had come under pressure from clients responding to publicity, and items from sources such as their own GP practices, urging the importance of putting in place anticipatory measures such as powers of attorney and advance directives so that they could be used at very short notice in circumstances of medical emergency. No-one granting powers of attorney in these circumstances was interested in an explanation that the document could not come into force until after it had been registered, that registration would be deferred indefinitely, but in the event of urgency the attorney could contact the solicitor acting in the application, who in turn could contact OPG to explain the urgency, following upon which OPG would process the application rapidly and then issue the certificate of registration. Emergency situations would be likely to require a much quicker response than that. Meeting these needs, in the reality of the present situation including the resources available to OPG, is being addressed as rapidly as possible by the Society, but is more challenging. In the meantime, it is counter-productive for solicitors to bombard hard-working members of OPG staff by passing on their clients' anxieties and frustrations, except only when genuine urgency can be demonstrated. The quotation from the Public Guardian at the head of this article accurately reflects the prompt and helpful cooperation and understanding given by her and her staff throughout. That must be reciprocated.

There have been two rounds of proposed "temporary modifications" to relevant legislation in the UK and Scottish Coronavirus Bills, both of which have now become law (as to the latter, see the comments of the Centre for Mental Health and Capacity Law [here](#) and [here](#)). That is not necessarily the end of the story. The Society's work continues. An update will be provided in the May issue.

Adrian D Ward

Scottish Mental Health Law Review and COVID-19: we are continuing!

Everyone has been affected by the COVID-19 pandemic but what does this mean for the Scottish Mental Health Law Review chaired by John Scott QC?

Firstly, conscious of the importance of the Review it will continue and has not been paused albeit there have been some temporary adaptations to take account of the crisis. There is a great deal of work that can still be done despite the restrictions that are likely to be in place for at least the foreseeable future. Such work includes gathering information on experiences of the operation of the law and developing various themed workstreams to complement the work of the Communications and Engagement and Compulsion Advisory Groups which have already been established. The Review Executive Team will continue to meet online and the existing advisory groups will be kept fully informed.

Whilst face to face meetings and public engagements are not possible at the moment – and although we hope to resume these in the not too distant future – the consultation is still 'live'. As many persons

as possible with professional or lived experience of our Scottish mental health, incapacity and adult support and protection are therefore encouraged to respond to the consultation online and its deadline has been extended to 29 May 2020. However, if it is not possible to respond to the consultation before 29 May 2020 there will still be many opportunities beyond this date. It is the Review's intention to speak to as many people as possible throughout its duration which will extend beyond the end of May 2020.

Secondly, the Review will still publish a short interim report at the end of May 2020. Bearing in mind that the current pandemic has inevitably affected information gathering this report will provide an update of the Review's progress, reflect, in general terms, on the information collected at that stage and set out its proposed next steps.

More information on the Review and consultation can be found at www.mentalhealthlawreview.scot/

*Jill Stavert**

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Katherine has a broad public law and human rights practice, with a particular interest in the fields of community care and health law, including mental capacity law. She appears regularly in the Court of Protection and has acted for the Official Solicitor, individuals, local authorities and NHS bodies. Her CV is available here: To view full CV click [here](#).



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

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Conferences

At present, most externally conferences are being postponed, cancelled, or moved online. Members of the Court of Protection team are regularly presenting at webinars arranged both by Chambers and by others.

Advertising conferences and training events

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

Our next edition will be out in May 2020. Please email us with any judgments or other news items which you think should be included. If you do not wish to receive this Report in the future please contact: marketing@39essex.com.

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