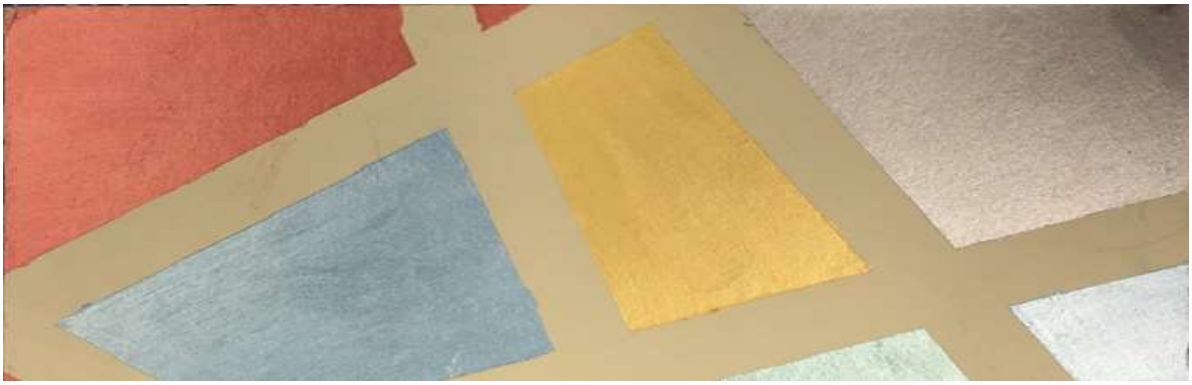
MENTAL CAPACITY REPORT:
HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

April 2020 | Issue 103



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.

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

Scottish Contributors
Adrian Ward
Jill Stavert

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

Contents

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 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:

[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.

- 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

Summary[2]

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.

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

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

> *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 permissory. 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.

Editors and Contributors

Alex Ruck Keene: alex.ruckkeene@39essex.com

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

Victoria Butler-Cole QC: vb@39essex.com

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

Neil Allen: neil.allen@39essex.com

Neil has particular interests in ECHR/CRPD human rights, mental health and incapacity law and mainly practises in the Court of Protection and Upper Tribunal. Also a Senior Lecturer at Manchester University and Clinical Lead of its Legal Advice Centre, he teaches students in these fields, and trains health, social care and legal professionals. When time permits, Neil publishes in academic books and journals. To view full CV click here.

Annabel Lee: annabel.lee@39essex.com

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

Nicola Kohn: nicola.kohn@39essex.com

Nicola appears regularly in the Court of Protection in health and welfare matters. She is frequently instructed by the Official Solicitor as well as by local authorities, CCGs and care homes. She is a contributor to the 5th edition of the *Assessment of Mental Capacity: A Practical Guide for Doctors and Lawyers* (BMA/Law Society 2019). To view full CV click here.

Editors and Contributors

Katie Scott: katie.scott@39essex.com

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

Katherine Barnes: Katherine.barnes@39essex.com

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.

Simon Edwards: simon.edwards@39essex.com

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

Adrian Ward: adw@tcyoung.co.uk

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.

Jill Stavert: j.stavert@napier.ac.uk

Jill Stavert is Professor of Law, Director of the Centre for Mental Health and Capacity Law and Director of Research, The Business School, Edinburgh Napier University. Jill is also a member of the Law Society for Scotland's Mental Health and Disability Sub-Committee. She has undertaken work for the Mental Welfare Commission for Scotland (including its 2015 updated guidance on Deprivation of Liberty). To view full CV click here.

Conferences

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. 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.

Michael Kaplan
Senior Clerk
michael.kaplan@39essex.com

Sheraton Doyle
Senior Practice Manager
sheraton.doyle@39essex.com

Peter Campbell
Senior Practice Manager
peter.campbell@39essex.com

Chambers UK Bar
Court of Protection: Health & Welfare
Leading Set

The Legal 500 UK
Court of Protection and Community Care
Top Tier Set

clerks@39essex.com • DX: London/Chancery Lane 298 • 39essex.com

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

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

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

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