



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

(1) In the Health, Welfare and Deprivation of Liberty Report: LPS delayed to April 2022; alcohol dependence and other capacity conundrums; stem cell donation and altruism, and when to come to court in medical treatment cases;

(2) In the Property and Affairs Report: updated OPG guidance on making LPAs under light-touch lockdown and a face-off between potential professional deputies;

(3) In the Practice and Procedure Report: a basic guide to the CoP; litigation capacity and litigation friends and observations about intermediaries and lay advocates;

(4) In the Wider Context Report: capacity and the Mental Health Tribunal, a change of approach to s.117 aftercare and lessons learned from a close encounter with triage;

(5) In the Scotland Report: the Scott Review summary of responses to its initial survey and a response from the Chair to the critique in our last issue.

You can find our past issues, our case summaries, and more on our dedicated sub-site [here](#), where you can also find updated versions of both our capacity and best interests guides. We have taken a deliberate decision not to cover all the host of COVID-19 related matters that might have a tangential impact upon mental capacity in the Report, not least because the picture continues to change relatively rapidly. Chambers has created a dedicated COVID-19 page with resources, seminars, and more, [here](#); Alex maintains a resources page for MCA and COVID-19 [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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### LPS delayed to April 2022

The Government announced on 16 July 2020 that LPS would not be coming into force on 1 October 2020, but instead in April 2022.

It has been clear for some time that 1 October was not just ambitious but impossible, so this clarification is very welcome. In a [written statement](#), the Care Minister, Helen Whately, told Parliament that, whilst the intention had been to bring them into force on 1 October 2020:

*It is now clear that successful implementation is not possible by this October. We now aim for full implementation of LPS by April 2022. Some provisions, covering new roles and training, will come into force ahead of that date. I will continue to update the sector and stakeholders on timings.*

*The Government will undertake a public consultation on the draft regulations and Code of Practice for LPS. That will run for 12 weeks, allowing sufficient time for*

*those that are affected, including those with learning disabilities, to engage properly.*

*The sector will need time following the publication of the final Code to prepare for implementation. We will give the sector sufficient time to prepare for the new system to ensure successful implementation. I am considering a period of approximately six months for this.*

*After we have considered responses to the consultation, the updated Code and regulations will need to be laid in Parliament to allow for proper scrutiny. This needs to happen well in advance of the target implementation date, first to allow for that scrutiny and second because some of the regulations need to come into force earlier.*

*Health and social care has been at the frontline of the nation's response to COVID-19, with social care providers looking after many of the most vulnerable*

*in society. We have received representations from public and private bodies from across the sector over the last few months, outlining the pressures they face if they were to implement by October 2020.*

*My overall objective remains to ensure implementation of an effective system in particular for those whose lives will be most affected by this legislation.*

*The forthcoming draft Code of Practice and regulations will also offer more detailed information about how LPS will operate in practice. I will provide a further update on the progress of implementation in due course. I hope that the additional time announced today provides reassurance to the sector.*

This announcement is very timely: as the CQC has identified in its third "[Covid Insight](#)" published on 15 July 2020:

*... our inspectors have seen that, with providers increasingly looking towards the introduction of the Liberty Protection Safeguards (LPS), providers' focus on DoLS has waned and training in some areas has stagnated. Poor understanding of DoLS has remained a fundamental issue. This together with the delays and uncertainty over the progress of LPS may mean there is an increasing risk of people being deprived of their liberty without the proper authorisation.*

It will be very important to make clear that, with nearly 2 years left until LPS comes fully into force, training on DoLS must continue; when the revised timeline promised by the Care Minister is published, thought will need to be given as to how that training can start to move towards LPS

implementation. Similarly, DoLS (and also community DoL applications) must continue to be deployed where necessary, and insofar as possible.

It is also important to flag that it is already possible for work required by DoLS and (equally, if not more importantly), community Deprivation of Liberty applications to be done in such a way as to build towards LPS implementation. By way of example, a community DoL application (on a COPDOL11 form) already contains, in essence, all of the materials that would be required for consideration of the position under LPS.

## Alcohol dependence and the Court of Protection

*London Borough of Tower Hamlets v PB* [2020] EWCOP 34 (Hayden J)

*Mental capacity – assessing capacity*

### Summary

This decision deals with the thorny question of capacity in the context of alcohol dependence. The central issue was whether PB, a 52 year old man with a history of serious alcohol misuse, had capacity to make decisions about his care and residence.

### *The facts*

PB suffered from alcohol-related brain damage and had been diagnosed with a dissocial personality disorder. In addition, he had diagnoses of chronic obstructive pulmonary disease, hepatitis C and HIV. He had become homeless and was then accommodated by the local authority in a supported living placement with a care package designed to prevent him from accessing alcohol (for example, PB was not

allowed to leave the placement without an escort). The resulting deprivation of liberty was authorised, but PB objected to it. Specifically, PB asserted that he wished to stay at the placement but to be able to drink alcohol in moderation. However, a trial period of PB being allowed to drink broke down when PB returned drunk on various occasions and was abusive to staff.

#### *The evidence*

Expert evidence from a consultant psychiatrist initially found that PB had capacity to make decisions about his residence and care. In short, this conclusion was reached on the basis that, although PB seriously underestimated his ability to keep his alcohol dependence under control (recognised to be a common tendency of those suffering from substance abuse), he was able to explain coherently why he thought drinking in moderation would be possible (with the support of a stable placement and not being around other alcoholics) and, crucially, PB understood and accepted the risks to his health and well-being that would result from continued heavy drinking. This included an appreciation of the fact that he could die.

However, the expert subsequently changed his view, finding that in fact PB lacked capacity to make decisions about his care and residence. The rationale for this was that in weighing up information, PB was unable to appreciate that he did not have control over this drinking.

#### *The court's approach*

Hayden J rejected the expert's approach, and instead returned to first principles in his assessment of capacity. In so doing, he restated the provisions in s.1 and s.3 of the MCA 2005 and reviewed the case law on capacity. In light of

this, Hayden J explained: "*at the core of the Act is a central distinction between the inability to make a decision and the making of a decision which, objectively, would be regarded by others as unwise*" (paragraph 5). Further:

*14. Even where an individual fails to give appropriate weight to features of a decision that professionals might consider to be determinative, this will not in itself justify a conclusion that P lacks capacity. Smoking, for example is demonstrably injurious to health and potentially a risk to life. Objectively, these facts would logically indicate that nobody should smoke. Nonetheless, many still do. In Kings College NHS Foundation Trust v C and V [2015] EWCOP 80 at [38] MacDonald J stated:*

*"It is important to note that s 3(1)(c) is engaged where a person is unable to use and weigh the relevant information as part of the process of making the decision. What is required is that the person is able to employ the relevant information in the decision-making process and determine what weight to give it relative to other information required to make the decision. Where a court is satisfied that a person is able to use and weigh the relevant information, the weight to be attached to that information in the decision-making process is a matter for the decision maker. Thus, where a person is able to use and weigh the relevant information but chooses to give that information no weight when reaching the decision in question, the element of the functional test comprised by s 3(1)(c) will not be satisfied. Within this context, a person cannot be considered to be unable to use and weigh information simply on*

*the basis that he or she has applied his or her own values or outlook to that information in making the decision in question and chosen to attach no weight to that information in the decision making process."*

Hayden J went on to explain that the relevant question for determination here was not, in fact, whether PB had the capacity to make decisions upon alcohol. Rather, it was, as the local authority proposed, "*whether PB has the capacity to decide on where he should live and the care to be provided from him. That assessment requirements consideration of many of the factors identified by Theis J in LBX v K, L and M [...] It also requires an evaluation of whether PB understands the impact on his residence of care arrangements of his continuing to drink, potentially to excess*" (paragraph 41). Hayden J went on to answer this question in the affirmative, noting PB's various statements in which he recognised the likely risks and consequences of continued heavy drinking (including the risk of death). Hayden J noted that:

*42. Whilst I agree entirely with the Local Authority's structured approach to the test to be applied, I do not agree with its conclusion on the evidence. On the contrary, PB's analyses his dependency on alcohol in a way which is both articulate and rational. He is also clear as to the dire consequences of his drinking to excess. He makes the association between the consequences of drinking to excess and the impact on his care arrangement. He reconciles the two in his own mind by his conclusion that he should stay where he is but moderate his drinking to reasonable limits. There is within his plan an inherent recognition that drinking to excess and the*

*sustainability of the placement are irreconcilable. There is much evidence from PB's history that he is unlikely to be able to achieve this, but the potential gulf between his aspiration to moderation and the likely reality, does not negate the thought processes underpinning his reasoning. In any event I do not consider that there is evidence here which is sufficiently choate to rebut the presumption of capacity. The plan that PB identifies may not be sustainable long term but that does not permit an inference that he is unable to foresee the consequences of drinking to excess on the sustainability of the placement.*

Hayden J declined to provide general guidance applicable to all substance abuse cases on the basis that each case must be carefully considered on its facts. He also declined to give guidance on the second issue that DJ Eldergill had identified, namely, "*[w]hether or in what circumstances the Mental Capacity Act 2005 (MCA) should be used coercively to prevent people who are alcohol dependent from gaining access to alcohol.*" However, he noted that he was:

*50. [...] uncomfortable with the terminology used in the order. [...] Coercion has pejorative implications, it implies persuasion by use of force or threats. As such it has no place in the Court of Protection and jars entirely with the applicable principles of the MCA. Moreover, the question only arises when the issue of capacity has been determined. If P has capacity then manifestly the Act does not apply. If P lacks capacity, facilitating compliance with a regime to which he is opposed will always involve the lightest possible touch, the minimal level of restraint or restriction and for the shortest period of*

time.

Hayden J concluded at paragraph 51 with a statement of general principles, including the useful reminder that, "[w]hatever factual similarities may arise in the case law, the Court will always be concerned to evaluate the particular decision faced by the individual (P) in every case. The framework of the Mental Capacity Act 2005 establishes a uniquely fact sensitive jurisdiction," and that "[t]he criteria by which capacity is evaluated on any particular issue should not be confined within artificial or conceptual silos but applied in a way which is sensitive to the particular circumstances of the case and the individual involved, see *London Borough of Tower Hamlets v NB (consent to sex)* [2019] EWCOP 27. The professional instinct to achieve that which is objectively in P's best interests should never influence the formulation of the criteria on which capacity is assessed."

### Comment

On the facts of the case before Hayden J, it appears that the conclusion that PB had capacity to make decisions about his residence and care arrangements would have no actual impact, because, as Hayden J noted, he was "*perfectly happy to remain where he was,*" and it appears that, albeit rather by default than by design, he was able to leave the placement and drink. Oddly, therefore, it might be said PB's case was rather easier than the majority of cases in which alcohol dependence is in play, where the consequence of a conclusion that, notwithstanding the impact of that dependence, the person retains the capacity to make decisions about their residence and care arrangements is that the relevant public bodies feel that they are required to watch a vulnerable

individual self-destruct, seemingly powerless to protect them from themselves.

Although Hayden J declined to give general guidance, the approach that he took to the question of alcohol dependence highlights two key points.

The first is that questions of capacity do not arise in isolation: in most situations the question of whether or not a person has capacity to make decisions about drinking is not, in and of itself, likely to be of critical importance. Rather, it is the impact of their potential drinking upon their capacity to make other relevant decisions (here, as often about matters relating to residence and care) that is going to be of significance. In other words, the proper approach will be to consider whether P is able to understand, retain, use and weigh relevant information for purposes of another decision, the consequences of their alcohol dependence (for instance breakdown of the placement, homelessness or even death) being part of that relevant information.

In some cases, it may be that (1) P cannot understand, retain, use or weigh those risks; and (2) the reason why they cannot do so is because of the impact of sustained alcohol and/or drug abuse. In such a case, it can logically be said that that P's alcohol dependence means that they do not have capacity to make decisions about their residence and care arrangements. In other cases, this being one, if P can understand those risks (and there is no other relevant information that they cannot process) then they will not lack capacity to make decisions about their residence and care arrangements. This is the case even where P is unrealistic about their ability to limit or moderate their substance abuse, so long as that lack of realism does not

equate to inability to process the risks of that abuse. While the latter may be illustrative of unwise decision-making, it does not lead to the conclusion that P actually lacks the ability to make the relevant decision.

### Capacity conundrums

In two decisions of interest, not least because in both the person was found to have capacity to decide to use the internet and social media, the Court of Protection has continued to use the tailor-made guidance/list of relevant information approach endorsed by the Court of Appeal in *Re B*. Both cases illustrate the fine line between a capacitous unwise decision and a lack of capacity.

In *A Local Authority v AB and SB* [2020] EWCOP 32, a 30-year-old woman with moderate intellectual disability spent most of the week living with her mother, AB, and the weekends with her partner. A number of expert reports were prepared, focusing on SB's decisional capacity regarding many matters. It was not in dispute that she had capacity in relation to sex and the withholding of information and lacked capacity to conduct the proceedings. But in relation to residence, care, internet/social media, contraception and financial affairs, her mother – described as clearly a concerned and committed parent – contended that her daughter lacked capacity whilst the local authority and Official Solicitor agreed with the expert evidence that she had capacity.

Her mother recalled her daughter's vulnerability, including the 3-4 times SB left with known offenders and became pregnant by them on 7 occasions, the times she went missing and had to be tracked down by her mother. And how SB

was largely funding her partner's flat whilst he uses his money to gamble and buy illicit substances, with limited understanding of money. However, the court agreed with the expert evidence, observing "*An evaluation of capacity does not and must not require or allow the court or others to substitute its own values and priorities with those that belong to a patient*" (para 37). This emphasises that where someone is able to understand, retain, use and weigh relevant information, the amount of weight or importance to attach to salient details is a matter for them, not others. As the judge noted, "*The weight to attach to that information is a matter for SB. The consequences that have in the past arisen as a result of the weight that she has attached to this information are in my view a quintessential example of an unwise decision*" (paragraph 57).

The other case of *A Local Authority v RS* [2020] EWCOP 29 concerned a man in his mid-20s with autism and mild learning disability. As a child he was exposed to domestic and alcohol abuse, bereavement, and inappropriate sexual activity and now lived in a supported placement. His fetish was paraphilic infantilism, or ABDL (adult baby / diaper lover), involving adults role-playing a regression to an infant-like state, including the wearing of nappies. The concern was that pursuing this interest in the exploration of his sexuality led him to engage in risky behaviour, including meeting males found on the internet. The judge was asked to determine RS's ability to decide on residence, care, contact, and internet/social media use. MacDonald J concluded that RS had capacity for all four matters.

The judgment navigates the tightrope between unwise decisions and incapacitated views:

*42. ... As I have noted, risky behaviour is not inevitably evidence of a failure to understand the risk being taken or evidence of an inability to weigh that risk when deciding whether to act despite it. The repetition of risky behaviour can also indicate that a person has understood the risk, weighed it and decided to take it anyway notwithstanding the dangers.*

The social work evidence of past occasions of objectively risky or unwise decisions failed to address *why* they demonstrated incapacity as distinct from other possible reasons for unwise/risky behaviour. Moreover, *"The fact that a decision to make contact with a man to satisfy fetish urge may be considered risky is not of itself evidence of a lack of capacity to take that decision"* (paragraph 49). There were also issues as to the causative nexus, particularly whether RS's decision-making were influenced by a mental impairment *"as opposed to from his psychological makeup, his sexual proclivities and desire and the fact he is a young man with a level of impulsivity commonly seen at his age, which factors cause him to make unwise but capacitous decisions"*. The expert evidence developed under cross-examination:

*52. Dr Lawson clearly articulated in cross examination the factors that led him to this revised conclusion. First, that it is important not to use, as the local authority had sought to use, repetitive risky behaviour to justify an assessment of lack of capacity. If RS's risky behaviour stemmed from his learning disability and autism it would be seen in all areas but it is not. Second, further consideration had to be given to the significant issues of*

*RS's maturity and his actual age and he gave these more weight in coming to a balanced view as to why he makes unwise decisions. Third, and within this context, caution was required against making the mistake of attributing RS's impulsive decision making to his learning disability and autism where elements of RS's history and development may explain that conduct, which falls within the ordinary recklessness demonstrated by young people. Fourth, the sexual element is a powerful drive and RS's mild learning disability and autism are not the driving force behind his fetish and ABDL behaviour. Fifth, on the totality of the evidence Dr Lawson could not consider RS to have an abnormal level of impulsivity. Sixth, whilst the possibility cannot be excluded that RS's impulsive and reckless decision making is linked to his learning disability and autism, his decision making could also represent a normal level of impulsivity and recklessness for a young person of his age.*

With regard to the use of the internet and social media in particular, the judge noted that *"the behaviour of RS in meeting up with strangers after only limited contact with them online, which the local authority seeks to characterise as so fundamentally irrational that it must demonstrate that RS lacks capacity, is now also the basis of some widely used social media applications"* (paragraph 54). In conclusion, therefore, it was declared that RS had capacity to decide the four matters and no changes to his support were anticipated. Nor was he deprived of his liberty, so no authorisation was required.

## **Stem cell donation, altruism and the Court of Protection**

*A NHS Foundation Trust v MC* [2020] EWCOP 33 (Cohen J)

*Best interests – medical treatment*

Cohen J has confirmed that it can be in the best interests of a person to donate stem cells, applying the test set down in s.4 MCA 2005. The case concerned a young woman, MC, who had turned 18, and the potential donee was her mother, who had chronic leukaemia. The precise basis upon which it was said that MC lacked capacity to consent to the harvesting and use of the stem cells does not appear from the judgment, the focus being upon whether it was in her best interests to do so.

The decision does not, perhaps, come as a surprise given that it had been understood long before the MCA was enacted that altruistic donation could be in the (common law) best interests of an individual: see *Re Y (Mental Patient: bone marrow donation)* [1997] Fam 110. It is, however, helpful to have the confirmation of the position by reference to the MCA itself. It is also of no little interest that Cohen J was careful to identify the risks to the woman, MC, as well as the benefits to her, which he identified as follows:

*15. Without the transplant MC's mother's prospects are poor and deteriorating. Whilst there is no certainty of the outcome of the procedure it elevates a poor chance of survival to a 43-45% survival rate at 5 years, and that is obviously a potentially highly significant benefit. MC lives at home with a loving*

*family and there are clear benefits, emotional, social and psychological, to MC of her mother's life being extended.*

*16. Next I must give weight to the fact that although MC has not understood the details, she understands that her mother is not well and that she may have ability to extend her mother's life and perhaps enable her to recover. MC wants to do that – it has been her repeated wish expressed to the doctors and to the Official Solicitor that she wants to give what help she can.*

*17. I also give some weight, although lesser weight, to the fact that MC may be seen by others positively by acting altruistically.*

*18. I agree with both Counsel that it is overwhelmingly in MC's best interest to participate in the proposed programme and donate her stem cells for the benefit of her mother. It is in MC's best interests as much her mother's.*

Cohen J identified that (perhaps surprisingly) this was the first time that an application for the extraction of bone marrow or stem cell donation by someone lacking capacity had come before the Court of Protection and the first time the Human Tissue Authority ('HTA') had been involved in a case of this nature.<sup>1</sup> The HTA has a statutory responsibility to assess all donations of bone marrow or peripheral blood stem cells from adults who lack capacity to consent and children who lack competence to consent.<sup>2</sup>

<sup>1</sup> The exact nature of its involvement is not clear, because they were not a party and it does not appear that it made any submissions to the court.

<sup>2</sup> By virtue of the Human Tissue Act 2004 and the Human Tissue Act 2004 (Persons who Lack Capacity

to Consent and Transplants) Regulations 2006 ('the Regulations'). The restrictions on and requirements for living organ donation and transplantation are set out in sections 33 and 34 of the Human Tissue Act and sections 9-14 of the Regulations. They require that

Potential donors that lack capacity or competence must be referred to an Accredited Assessor (AA), who submits a report to the HTA following interviews with the donor, the person/s acting on the donor's behalf and the recipient. Cohen J expressed some views about the process undertaken by the HTA, noting at paragraph 22 that *"there should be a considered risk and benefit analysis by the accredited assessor. [...] However, it could only be beneficial if a considered deliberation of the factors set out within s.4 of the Mental Capacity Act 2005 was performed in each case where the HTA is faced with an issue of capacity of the donee."*

One other point of interest is that Cohen J appeared to take it as self-evident that the decision to consent had to be taken by the court as there was neither an LPA nor a deputy who had the power to consent on MC's behalf (see paragraph 19). This appears to have been reflecting the approach taken by the HTA itself, on the basis that the Human Tissue Act makes no provision for appropriate consent for the removal of material from a living adult who lacks capacity to consent for himself or herself, such that, where there is no ADRT refusing consent or LPA or deputy to consent, the HTA considers that Court of Protection must make the decision on behalf of the person.<sup>3</sup> Interestingly, however, the HTA's approach is founded upon the statement in the Code of Practice to the MCA that, where an adult lacks the capacity to consent to the removal of bone marrow, the case

must be referred to a court for a declaration that the removal would be lawful. The HTA "believes that the same approach should be adopted for donation of PBSCs. Donation may then only proceed if court approval has been obtained and, following court approval, the case is referred to, and approved by, an HTA panel." However, as the Supreme Court identified in *NHS Trust v Y* [2018] UKSC 46 (in the context of life-sustaining treatment), the Code of Practice cannot, itself, establish a legal obligation to bring a case to court – it would, perhaps, be helpful in the next case which comes before the Court of Protection in this area for the court to spell out precisely why there is such an obligation in this context.

### Medical treatment cases – when to come to court

In two recent medical treatment cases, Hayden J has taken the opportunity to reinforce the message about when applications should be brought.

The case of *Hull University Teaching Hospitals NHS Trust v KD* [2020] EWCOP 35 concerned a 57-year-old woman with paranoid schizophrenia who smoked around 60 cigarettes a day and whose collapsed right lung required 15-20 minutes of keyhole surgery to which she objected but without which she would die. Because of active persecutory delusions and anxiety, Hayden J determined that KD lacked capacity to decide whether to have the proposed treatment and that the procedure and aftercare

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donations of bone marrow and peripheral blood stem cells from children (anyone under the age of 18) who are not competent to give consent, or from adults lacking capacity, must be approved by the HTA. The Regulations include the requirement that the HTA is satisfied that consent for removal of the material has

been given, or the removal is otherwise lawful (for example sanctioned by the Court).

<sup>3</sup> See paragraph 36 of the HTA's Code of Practice G: [Donation of allogeneic bone marrow and peripheral blood stem cells for transplantation](#).

was in her best interests. Moreover, his Lordship agreed with the Trust's decision that the case required an application to be brought to court, consistent with the Serious Medical Treatment Guidance [2020] EWCOP 2: it is not quite clear whether this was solely because the treatment would be against KD's wishes, or whether it was because the steps taken to enable surgery and recovery would go beyond restraint to a deprivation of liberty requiring judicial authorisation.

In *University Hospital Coventry and Warwickshire NHS Trust v K and Mrs W* [2020] EWCOP 31, a woman in her mid-30s had recently been diagnosed with cancer. Without radiotherapy and chemotherapy, she would likely die a painful death within a year. The treatment offered a 30-40% prospect of survival for more than 5 years, after which she would have a normal life expectancy. However, the treatment would render her infertile as it would expedite the menopause. K had been enthusiastically cooperative with treatment so far, but there was much worse treatment to come.

The reasons behind the application were threefold:

1. It was highly intrusive treatment over a considerable period of time;
2. It would cause infertility;
3. There was a distinct possibility K might withdraw her cooperation when the treatment became more distressing.

The pre-emptive, rather than reactive, nature of the application was commended by the court.

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<sup>4</sup> Note, Katie having been involved in this case, she has not contributed to this note.

On the evidence, Hayden J concluded that K lacked capacity to consent to treatment because she was unable to retain the relevant words and concepts to evaluate them so as to be able to use or weigh them. In terms of best interests, 10 radiotherapy sessions and 2 sessions of chemotherapy were proposed, during which it may be necessary to address her anxiety with sedative medication. If she were to refuse to attend hospital for treatment, he agreed that it would not be in her best interests to compel her to travel there. Indeed, he agreed with the clinicians that to restrain would be more likely to exacerbate her withdrawal than encourage her cooperation.

### Short note: incapacity and the limits of persuasion<sup>4</sup>

In *Avon and Wiltshire Mental Health Partnership v WA & Anor* [2020] EWCOP 37, Hayden J had to consider the capacity of a young Palestinian man to make decisions about his nutrition and hydration and, if he lacked capacity, what would be in his best interests. The factual matrix of the case is exceptionally complex, sensitive, and tragic which we do not set out here. The decision as to his capacity was, as was clear both from the evidence and the judgment, as borderline as it is possible to get. Ultimately, however, Hayden J concluded that the young man, WA, lacked capacity to make decisions about his nutrition and hydration, but that it was not in his best interests for forced naso-gastric feeding to be carried out without his agreement. It was, he considered:

*102. [...] fraught with unmanageable and significant risk. Ultimately, it cannot be reconciled, in my judgement, with the protection of WA's autonomy. I consider that every effort should be made, with the parents at the centre of the process, to persuade, cajole and encourage WA to accept nutrition and hydration. Attempts to deploy these techniques should be permitted with far greater persistence than would be considered appropriate in the case of a capacitous adult. I have no doubt that the attempts of persuasion will be delivered in the kindly and sensitive way that is most likely to persuade WA. I make no apologies for repeating that I consider WA has a great deal to offer the world as well as much to receive from it. No effort should be spared in encouraging him to choose life. This said, I have come to the clear view that when WA says no to CANH his refusal should be respected.*

On the face of it, it might be thought difficult to square this conclusion with the prior conclusion that WA lacked capacity to make decisions as to his nutrition and hydration. Put another way, why should his refusal be respected if it is incapacitous? The answer can perhaps best be understood by locating it in the specific context within which the treating team found themselves in which, as Hayden J indicated, the consequence of the judgment was two-fold:

1. The team were to be 'armed' with the confidence to seek to persuade WA in a way that they would feel uncomfortable doing with a person whose decision-making was unimpaired;
2. The treating team could, at the same time, be confident that if, despite this persuasion, WA did not actively assent ('consent' here

would appear to be a slightly difficult word to use) to receiving nutrition and hydration, they would be acting lawfully if they did not then seek to impose such treatment against his will.

The judgment also contains the following points of wider importance.

WA who, unusually, but not uniquely, was found to have litigation capacity even though his subject matter capacity was in doubt, took part in the proceedings remotely. Hayden J observed that:

*60. It is an interesting feature of remote hearings that they have served, in a number of cases, actively to promote the participation of P in the court process. I have visited WA (remotely) in his hospital bed, with his parents in attendance, on two occasions. Firstly, at the directions hearing and again when he gave his evidence. It was possible to set up an arrangement where I could see him but the Advocates and everybody else present in the court could only hear him. He has listened to every word of evidence with keen attention and self-evidently been able to provide full instructions to his legal team, in whom he plainly and rightly has great confidence. There are wider lessons to be learnt from this for the future.*

Hayden J was astute to identify that, in the particular circumstances of WA's case, "passive submission" had clearly to be distinguished from consent:

*95. In some circumstances a plan predicated on compliance without actual agreement may be entirely legitimate. I think, for example, of transfusion cases*

where Jehovah's witnesses will often indicate that they will submit to an order of the Court in the face of their religious beliefs. Ms Sutton has collated the various phrases that have been used to try to capture the essence of the Treatment Plan which is intended to communicate with clarity what is expected of those charged with providing treatment. She identifies: "gentle persuasion"; "tacitly compliant"; "passive acceptance"; "tacit cooperation" and "acquiescence". Set out in this way they illustrate the complexity of the challenge to the treating clinicians and nurses, particularly to having regard to WA's background. Moreover, looked at collectively, the phrases reveal themselves to be that which they are i.e. euphemisms for force feeding. A plan which stated specifically that WA will be force fed unless he actively resists would, I suspect, cause most people to recoil from it. It does not become any less disagreeable when dressed in softer language.

Conversely, Hayden J identified that there might be circumstances in which non-verbal consent could be manifested:

97. I have observed before, most notably in *M v N* (by her litigation friend, the OS), *Bury Clinical Commissioning Group* [2015] EWCOP 9 that feelings and even strong feelings can often be expressed non-verbally. In fact, I noted in that judgment that feelings can sometimes be communicated, in contra distinction to what is actually said. DT told me in her evidence that there can be times when she considers that WA demonstrates to her both that he understands a proposed treatment and that he does not actively resist it. I took this to mean that this was

absent expressed agreement. The reassuring and kindly presence and encouragement of his parents, particularly DT has, I am sure, resulted in WA receiving treatment in which there has been real and nonverbally expressed consent. It is this that the plan has tried to capture.

Finally, and in terms of the presumption of capacity, Hayden J observed that:

Ms Scott, [on behalf of WA] submitted that in circumstances where the evidence was so finely balanced as to be on a "knife edge", it could not easily be said properly to have rebutted the presumption of capacity enshrined within the framework of the MCA. Though that submission is superficially attractive, Ms Scott agreed, in the course of exchanges, that it did not absolve the court from its duty rigorously to analyse the evidence. The presumption of capacity serves to place the burden of proving incapacity squarely on the shoulders of the applicants. The burden of proof remains the balance of probabilities, nothing more nothing less (see *Re: B* [2008] UKHL 35). In some cases, the evidence will tip the balance significantly in one direction. In other cases, such as this, the balance will be more delicately poised, though still identifiably weighted to one side.

### DoLS under COVID-19

In the CQC's 3rd "Covid Insight" published on 15 July 2020, it notes that, since the start of lockdown, it has seen notifications from adult social care services drop by almost a third (31%), and in hospitals by almost two-thirds (65%).

The decrease has varied across the regions. In adult social care, London saw the largest

percentage change with a 37% drop, followed by a 35% reduction in the East of England. For hospitals, the South East saw the largest percentage reduction of 82%, followed by 71% in London.

We will wait with some considerable interest, and no little anxiety, to see whether this trend is reversed as the impact of lockdown lessens.

### Deprivation of liberty and 16/17 year olds – practice guidance

[Research in Practice](#) has made freely available practice guidance written by Alex and Camilla Parker to help professionals identify when a deprivation of liberty may be occurring in the context of a 16 or 17-year-old, in particular in light of the Supreme Court decision in *Re D* in 2019, and to provide key pointers as to what should happen at that stage. The guidance can be found [here](#).

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## Conferences

Members of the Court of Protection team are regularly presenting at webinars arranged both by Chambers and by others.

Alex is also doing a regular series of 'shedinars,' including capacity fundamentals and 'in conversation with' those who can bring light to bear upon capacity in practice. They can be found on his [website](#).

### **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.

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We are taking a break over August, and hope that at least some of you are able to do so too. Our next edition will be out in September. Please email us with any judgments or other news items which you think should be included. If you do not wish to receive this Report in the future please contact: [marketing@39essex.com](mailto:marketing@39essex.com).

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