



Welcome to the June 2021 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: substance over form in DoLS authorisations, complex questions of coercion in medical treatment, and the limits of fluctuating capacity in the context of sex;

(2) In the Property and Affairs Report: a brisk dismissal of an attempt to appeal a judgment of Senior Judge Hilder about charging by a deputy, and easy read guides to making LPAs;

(3) In the Practice and Procedure Report: an important rapid consultation on hearings and the judicial view of remote hearings;

(4) In the Wider Context Report: the CPR responds to vulnerability, strengthening the right to independent living, capacity in the rear view mirror and the ECHR and the CRPD at loggerheads;

(5) In the Scotland Report: the Mental Welfare Commission on hospital discharges, change at Scottish Government (but how much) and welfare guardianships and deprivation of liberty.

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. 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](#), and Neil a page [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

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Re JB: Supreme Court expedites hearing

The Supreme Court has expedited to 15 July the hearing of the Official Solicitor’s appeal against the decision of the Court of Appeal in *A Local Authority v JB* [2020] EWCA Civ 735. This will be the first time that the Supreme Court considers the vexed, and vexing question of capacity and sexual relations.

Capacity guide – relevant information

As discussed in Alex’s shedinar on [capacity fundamentals](#), one of the most common sources of unnecessary complexity in thinking about whether a person has capacity to make a decision is not being clear about what the

information is that is relevant to that decision – and what information is not relevant.

For some years, the [capacity guidance note](#) the 39 Essex Chambers Mental Capacity Report team produces has had an annex setting out the information that the courts have indicated is relevant (and irrelevant) for categories of decisions such as residence, care, contact, sexual relations and deprivation of liberty. We have now made it a standalone document, so it can be accessed directly. You can find it [here](#).

NB, the courts have [emphasised](#) that the guidelines that have been set down are the starting point for considering different types of decision, as the information must always be tailored to the actual decision in question, but

this will at least (1) both save you reinventing the wheel; and (2) if you start with the information as potentially relevant (or irrelevant) you will be doing so on the basis that you will be following a path adopted as appropriate by the courts.

The DHSC LPS factsheets

The DHSC published on 11 June six further factsheets about the LPS:

1. [Liberty Protection Safeguards: criteria for authorisation](#) (June 2021)

2. [Liberty Protection Safeguards: the appropriate person and Independent Mental Capacity Advocates](#) (June 2021)

3. [Liberty Protection Safeguards: the Approved Mental Capacity Professional Role](#) (June 2021)

4. [Liberty Protection Safeguards: Deprivation of liberty and authorisation of steps necessary for life-sustaining treatment or vital acts \(Section 4b\)](#) (June 2021)

5. [Liberty Protection Safeguards: authorisations, renewals and reviews](#) (June 2021)

6. [Liberty Protection Safeguards: the right to challenge an authorisation in court](#) (June 2021)

The other factsheets can be found [here](#). Alex's resources page gathering together materials and including video walkthroughs of the LPS and what can be done in pre-implementation is [here](#). Neil's LPSLaw website can be found [here](#).

Capacity, pregnancy, risk and the courts

A NHS Foundation Trust v An Expectant Mother [2021] EWCOP 33 (Holman J)

Best interests – birth arrangements

Summary

This case, which has attracted considerable discussion, concerned an expectant woman, aged 21 with what was described as severe agoraphobia. She had only left her house on a handful of occasions in the preceding four or five years, each time experiencing overwhelming sensations of anxiety, shortness of breath, dizziness and palpitations. She was pregnant and, in circumstances that are not set out in detail in what is a relatively short judgment, the medical teams responsible for her (it appears from the fact that there are two Trusts named in the title that one must have included a mental health team) considered that (1) the risks to her and her baby were sufficient if a home birth did not go to plan; and (2) she would not agree to leave her home to go to hospital in the event that a transfer was required. The Trusts therefore applied to court for endorsement of a plan which would see the mother transferred to hospital before she went into labour.

As to the timing of the application, Holman J referred himself to the decision of MacDonald J in *East Lancashire Hospitals NHS Trust v GH* [2021] EWCOP 18, which had been brought on an emergency basis whilst the woman (again, suffering from agoraphobia) was undergoing an obstructed labour, granted late at night, and where the woman had, in fact, given birth at home before the arrangements endorsed could be implemented. Holman J noted that:

15. It is, of course, possible to draw conflicting messages from that case and judgment. It could be said to illustrate that, even when doctors consider that there is an acute emergency, it may yet pass and the birth may take place at

home without (apparently) long-term damage. It could be said to illustrate the capacity in some situations for a hospital to obtain an urgent hearing and an order, even in the middle of the night, when an emergency has actually arisen. But the hearing will have taken time to set up, and itself lasted nearly two hours, far too long if there had been what Professor Walker described as "a blue light ambulance emergency".

16. Overall, the case illustrates, in my view, the need to anticipate problems of this kind and to face up to them as best one can in advance, even if that involves speculation and/or reliance upon statistics. In my view, therefore, it was entirely justifiable and appropriate that the hospital trusts in the present case have made the present application. Amongst other advantages, it has enabled a thorough and informed investigation to take place, as well as a fair and transparent hearing, lasting many hours, in which to test out the issues and the evidence, all of which is impossible in any kind of emergency out-of-hours situation. Further, the mother herself has been able to participate, and has participated, throughout the hearing, at a time when she is not in labour, pain or distress

As to the woman's capacity, the evidence before the court, including that of an independent expert psychiatrist, Dr Glover, was that the mother's agoraphobia was:

7. [...] so overwhelming that it exerts a significant effect on her ability to weigh matters in the balance if the activity in point entails her leaving her home. Further, in the opinion of Dr Glover, the mother has short-term memory

problems which limit her capacity to manage and process complex, multifaceted information.

8. For these reasons, Dr Glover and the consultant perinatal psychiatrist for the applicant trusts both agree, as do I, that the mother lacks capacity to make decisions about whether her baby should be born at home or in hospital. Put simply, she is so overwhelmed by her agoraphobia that she is unable to weigh and process relevant considerations and unable to make any sort of decision about it. I am, accordingly, quite satisfied - and the Official Solicitor on her behalf now agrees - that the mother lacks capacity to make decisions about the location of the delivery of her baby, and also lacks litigation capacity in relation to that issue, and I will so declare.

This therefore meant that Holman J was required to consider what was in the mother's best interests. He made clear (at paragraph 11) that he did not consider that the case was about the advantages or disadvantages of hospital birth or home birth, or vice-versa, upon which capacitous women may have different views and about which a capacitous expectant mother normally has autonomous and complete freedom of choice. However, he noted that the choice was normally made in the knowledge that if, during a home birth, a medical emergency arises which may imperil the wellbeing or even the life of the mother or the baby, the mother can be fairly rapidly transferred to a hospital if required. As he noted:

The nub of this case is the potential difficulty of transferring this particular mother to hospital if a medical emergency arose, but she was so

overcome by her agoraphobia that she would not go. That, of course, could potentially occur at any time of day or night, or during a weekend, when far fewer resources might be available than if the mother is taken to hospital, not in labour, in a planned way so as to give birth there.

The evidence before the court (limited somewhat by the fact that the mother had not attended hospital for scans, as a result of her agoraphobia) was that there were no specific indicators that the mother would not have an uneventful spontaneous labour and vaginal delivery. Holman J, however, identified that:

13. [...] although child birth is the most natural of human events, it is not risk free. There are statistics which indicate that, in about 45 per cent of cases in which a young, healthy, primigravida mother embarks on a home birth, she will be transferred to hospital before the birth occurs. Of that 45 per cent, about one quarter are for urgent medical emergencies. The remainder are for important but less urgent reasons, such as a failure to progress, pain relief, or repairing tears. On that basis, about 10 per cent of all such home births require an urgent transfer to hospital for serious medical emergencies, threatening the mother and/or the baby. Professor James Walker, the consultant obstetrician instructed as an expert witness by the Official Solicitor, considered that what he called "urgent blue light ambulance transfers" occur during about one to two per cent of home births.

14. There is an overall statistic that about one in 200 hospital births tragically result in a still-born or otherwise seriously

damaged baby. In cases which start as home births, that figure doubles to about one in 100. The difference between the two figures is largely, if not wholly, attributable to delays in effecting a transfer from the home to the hospital.

In the circumstances, and whilst "the medical witnesses do not in any way predict that there will be any emergency; [...] on the basis of those known statistics, they must, appropriately and responsibly, anticipate the possibility that there may be."

How, then, to respond to this risk? The doctors agreed, and, on the woman's behalf, the Official Solicitor agreed – an agreement endorsed by Holman J that it was: "preferable, and in the overall best interests of this particular mother and her baby, that she should give birth in hospital in a planned way around the [estimated due date], but before she goes into spontaneous labour" (paragraph 21). Having started with the medical position, Holman J also factored in the views of the woman, her partner, and her own mother:

- The woman, who participated by video, was clear that she would prefer to give birth at home, on the basis of her agoraphobia and fear of going out. Later in the judgment (at paragraph 30), he identified that there was a "known, if small, risk that, if a pre-planned birth cannot be achieved, some acute emergency may (I stress, may) arise in the home from which the mother cannot be rescued before some catastrophe occurs to either her or her baby. The risk may be low, but that which is at risk could not be potentially more grave. The mother is very, very clear that she does not want that to happen;"
- Her partner and her mother – whose

views fell to be considered by reference to s.4(7) MCA 2005, also were identified as preferring a hospital birth if it could be achieved.

It was also agreed that it would be in the best interests of the woman that sedation could be administered to her "so as to calm her and help her cope with the transfer." That could be administered orally or by intramuscular injection. Holman J noted that "[s]he does not like needles, but she accepts the need for injections and is not, as such, resistant to them. Indeed, moments before I commenced this judgment, she told me that the visiting midwife had just taken blood samples from her with no problem."

It is important to note that no one sought to persuade Holman J (and he did not find) that the mother lacked capacity to make the decision whether to give birth vaginally at the hospital (after being induced) or by Caesarean section:

23. [...] *The mother does have the capacity to make an informed choice between those methods, and unless there is a significant medical contraindication, the hospital will respect and be guided by her choice on the day. Similarly, if she elects a Caesarean section, she has the capacity to make an informed choice between a local or a general anaesthetic. Currently, she has clearly said that, if she is to have a Caesarean, she would prefer a general anaesthetic and to wake up when it is all over. But, of course, she has the right and capacity to change her mind about that until the last moment.*

The one area of disagreement between the representatives was as to the extent of additional force or restraint which could lawfully

be used on a pre-planned transfer and admission, if the woman was not actually in labour and no actual acute medical emergency has actually arisen. The Trusts sought provision for the use of (the minimum necessary) reasonable force. As Holman J noted, in an emergency, "[i] the Official Solicitor has, herself, agreed and accepted that force and restraint could, if it became necessary, be used. But she submits that, short of an actual current emergency, it is not justifiable or proportionate to use force or restraint for a pre-planned admission, however desirable such an admission might otherwise be" (paragraph 26).

The medical witnesses made clear that this was a finely-balanced decision:

28. [...] *Both psychiatrists have agreed that, if force is used, that may (this again is speculative) have a damaging psychological effect on this already agoraphobic person. It may entrench her agoraphobia. It may damage or impair her bonding with her baby. It may give her long-term flashbacks. It may compromise her attitude to future pregnancies, or her dealings with persons in authority. On behalf of the Official Solicitor, Ms Sophia Roper submits that these are known risks from the use of force or restraint which outweigh the more speculative and statistical risks, if the mother goes into labour at home but may then require an urgent transfer to hospital.*

Having outlined what the Trusts proposed, Holman J considered that this was:

30. [...] *an unattractive scenario and, on the face of it, if resorted to, a severe*

infringement of the mother's personal autonomy and liberty. But, on the other side of the balance here, there is the known, if small, risk that, if a pre-planned birth cannot be achieved, some acute emergency may (I stress, may) arise in the home from which the mother cannot be rescued before some catastrophe occurs to either her or her baby. The risk may be low, but that which is at risk could not be potentially more grave. The mother is very, very clear that she does not want that to happen.

31. Having very anxiously weighed and considered all the factors in this case, I am, on balance, satisfied, albeit in disagreement with the Official Solicitor, that it will be in the overall best interests of this mother if - if the necessity for it arises on the day - some trained and professional force and restraint are used to transport her to hospital, and I will so declare. The declaration will incorporate the final "care plan for delivery" of the baby, which has been amended by me and counsel during the course of the hearing. An official transcript will be made as soon as possible of this judgment, and an anonymised version of the care plan and the order will be annexed to it.

In a postscript, Holman J recorded that:

The judge was later informed that on 22 May 2021 the mother went into spontaneous labour at home. She contacted the hospital and travelled there with the support of her partner and mother and the community midwife. While still at home, she received 2mg of Lorazepam orally. Although initially resistant, she was guided by staff and her family into the ambulance and no

restraint was required or used. A few hours later she was safely delivered of a healthy baby boy with a good birth weight. She returned home with the baby within the next day or two.

Comment

This case has provoked strong reactions, which have been meticulously documented by the Open Justice Court of Protection project, which also commented critically on the fact that Holman J held the hearing in public, but did not permit members of the public to attend remotely. It should perhaps be noted that this is likely to be an issue which is going to be encountered more frequently as the courts potentially move back to a world where at least some hearings are held in physical court rooms where no-one attends remotely (there are, of course, a whole host of – sometimes finely balanced – issues about whether remote or in-person hearings are, substantively, better for the delivery of justice for the actual parties concerned). At that point, real questions are going to arise as whether remote access for members of the public – in effect broadcasting – is or should be required. These are definitely questions for another day, but they are going to be need to be answered in due course.

Turning to the **substance** of the decision, much of the focus of the discussion has been on (in essence) the excess risk aversion of the medical professionals involved, leading to a situation where, to pre-empt a small but very serious risk, entirely disproportionate steps were sought, agreed (in part) by the very person appointed to act as her representative, and endorsed by the court. Each of these criticisms raise entirely legitimate points (and Alex and Neil have co-

written a few years ago a [detailed article](#) examining the procedural justice problem caused by the role that the Official Solicitor is required to play).

However, each of the criticisms need to be placed in their context by reference to some points which may risk getting otherwise lost.

The first is to note that the woman's voice – ironically – seems at some points to have been lost in some of the debates. For ourselves, and having been hoping for the end of the story to come out, we would dearly love to be able to find out from her now about (1) why she contacted the hospital herself, as the postscript described her as having done; and (2) how she felt both about the process and the outcome, in circumstances where one construction of the evidence is (from a CRPD perspective) her overriding will was to be delivered of her baby safely, with all other considerations being secondary. We would not, though, purport to speak for her.

The second is that the vast majority of birth-planning decisions relating to those with mental health conditions ¹ are undertaken in collaboration with the woman, outside the court arena. That work almost invariably includes detailed and careful advance care planning (for a specific tool for use in the context of bipolar disorder, which can be adapted to address birth plans, see the [PACT](#) approach).

The third is that the woman's case may raise legitimate questions about the risk analysis undertaken by the two trusts involved in the context of their planning (involving, it would

appear from the judgment, not just doctors, but also the woman's community midwife and community psychiatric nurse). However, again, by way of context, it is important to recall that that approaches to risk on the behalf of medical professionals are dictated in part by anticipation of societal/regulatory responses in the event of a statistically low but substantively very high risk event coming to pass.

The fourth is that there will be some circumstances in which the interventions considered necessary to secure against the risks go beyond those which can be catered for under the provisions of ss.5-6 MCA 2005. At that point, it is clear that Trusts should consider approaching the court for endorsement of the plan: see, in this regard, the [Serious Medical Treatment Guidance](#) issued by Hayden J in January 2020. At one level, some of the criticisms of the judgment amount to a challenge to the idea that Trusts should approach the court for endorsement of the plan, and seek the endorsement of the court for a contingency plan. To the extent that they do, it seems that, with respect, those criticisms are misplaced, if the alternative is to leave things to unfold and then seek authority only if then required. That does not mean that, if the contingency plan is put before the court, it should not be rigorously stress-tested, but such stress-testing can in practice only take place if there is time to do so.

The fifth is that, if the Trust(s) do come to court, it is, in reality, impossible for a judge not to take into account the potential that they might endorse a plan which could lead to the death of a viable baby. Perhaps some of the discomfort

¹ Whatever the position might be about agoraphobia generally, it appears clear from the judgment that the

woman's agoraphobia was sufficiently serious that she was under the care of a mental health Trust.

expressed in relation to this case reflects the fact that Holman J was not allowed to hold that the foetus had its own independent legal rights. Had he been able to do so, he could have conducted an express balancing exercise of those rights against (if, in reality, they were against – we do not seek to give voice to the woman here) the rights of the woman. Because he could not then, in line with all other judges who have been in a similar position, he had to take them into account through an analysis of the mother's best interests which took into account her desire to be delivered safely of her baby. There are undoubtedly cases – although not necessarily this one – in which that analysis comes uncomfortably close to a misleading legal fiction.

Substance or form: when do repeated errors invalidate a DoLS authorisation?

Re YC [2021] EWCOP 34 (Senior Judge Hilder)

Article 5 ECHR – DoLS authorisations

Summary

What happens when the paperwork authorising a deprivation of liberty under the DoLS regime repeatedly refers to the wrong person? This question was posed before Senior Judge Hilder in the context of an appeal against the dismissal of a challenge to a DoLS authorisation purportedly granted by the City of Westminster in respect of a woman, YC. The 'Form 5' document, containing – in effect – the record of authorisation, referred to the wrong name 19 out of 25 times.

On the facts of the case, in circumstance where it was accepted on behalf of YC that the **underlying** assessments had been properly

conducted, Senior Judge Hilder (at paragraph 74) noted that:

The impression is [...] created that standardised phrases have been used in the administrative process of writing up a decision – which, I would suggest, is very poor practice – but overall, the frequency with which the same error appears points much more clearly to administrative, than substantive, inadequacy.

The wider headline points are that:

- (1) There is a material difference between the situation where assessments have been completed correctly but there are mistakes made in the form in which the authorisation is recorded, and where the 'outcome leads the process,' as in the Neary case (and also, although not brought to Senior Judge Hilder's attention, this disciplinary case before Social Work England where repeated plagiarism of forms by a BIA gave rise to a risk that individuals had been – substantively – unlawfully deprived of their liberty);
- (2) Errors of form do not *necessarily* invalidate the authorisation. Even in the serious domain of authorisations of deprivation of liberty, there is room for a degree of pragmatic realism, as is recognised in the ECHR decisions contrasting *ex facie* invalid orders and *prima facie* valid ones, and by the 'correcting' provisions of the Mental Health Act. As Senior Judge Hilder noted at paragraph 75: "[w]here there are standardised documents, and inevitable use of information technology (including the availability of 'cut and paste'), it would be disproportionate to conclude that every error

of form invalidates Form 5.”

(3) Senior Judge Hilder endorsed the following “workable and appropriate” procedure as good practice to improve the prospects of identifying and addressing errors promptly, if necessary by a completely new assessment process:

- a. *Firstly, the person granting the authorisation should carefully check that all details on Form 5 accurately reflect the other DOLS forms and relate to the particular P;*
- b. *The Form 5 should be checked for accuracy by another member of the DOLS authorisation team of the supervisory body;*
- c. *Form 5 should be provided to the RPR with a covering letter requesting that the RPR carefully checks that the forms, and all the information in them accurately relates to the relevant person;*
- d. *An express requirement for the RPR to confirm accuracy to the supervisory body would be disproportionate but the RPR could do so.*

Comment

In light of this decision, supervisory bodies will no doubt be checking (1) their administrative processes to seek to eliminate cut and paste disease; and (2) their communications with RPRs.

One important point to note is that Senior Judge Hilder was emphasising that the RPR has an important practical role in making sure that the

paperwork is, in fact, in order. However, she was **not** holding that this is required as a matter of law so that if the RPR misses something the authorisation itself becomes invalid. Of course, if it becomes clear that an RPR – especially a paid RPR – has simply put the authorisation in a drawer without noticing errors, especially glaring errors, that should be a red flag for whether the RPR is actually able to undertake their tasks under paragraph 140 of Schedule A1 DoLS of representing and supporting the person.

Deprivation of liberty: a spotlight on the (relatively) routine

AA v GA and An NHS Clinical Commissioning Group [2020] EWFC B67 (HHJ Pemberton)

Article 5 ECHR – DoLS authorisations

Summary

In this case, HHJ Pemberton considered a s.21A challenge to a standard authorisation of GA’s deprivation of liberty at ‘Placement A’. AA is GA’s mother, and GA’s care was provided by the CCG. GA was 22 years old, and had diagnoses of a severe learning disability, Autism Spectrum Disorder, ADHD, epilepsy and severe communication difficulties. The parties were in agreement that GA lacked capacity to make decisions as to her residence and care.

All parties appeared to be in agreement that it was in GA’s best interests to move from Placement A, and the decision before the court was whether it would be in her best interests:

1. To move to an alternative specialist residential placement, ‘Placement B’; or

2. To return to live with AA and GA's brother at the family home with no professional input from the CCG.

The standard authorisation was granted in January 2020 initially for a five-month period, but was extended by the court until the date of its judgment (approximately six months after the initial expiration date).

GA had lived in the family home with her mother and siblings until November 2019. The CCG had made an application in autumn 2019 to remove GA from the family home and accommodate her in a residential unit, arguing that *"significant concerns had arisen over the past 12 months that GA's needs were not being met in the family home. In addition, some child protection concerns in respect of the younger siblings had arisen which had caused children's services to become involved with the family and for the children to be recorded as being at risk of significant harm due to physical outbursts from GA including physical assaults towards staff, her mother and siblings (I accept that GA did not intend to hurt anyone)"* (paragraph 11). The CCG had provided carers in the home, but one agency withdrew in July 2019; GA also attended day services during the week. The court approved the application to move to Placement A in December 2019, and it was planned that *"a full functional, sensory and communication assessment was to be undertaken"* (paragraph 15) while GA was there. This application was supported by GA's litigation friend.

In February 2020, concerns were being raised that GA was being overmedicated at the placement; GA's family and IMCA were also raising other concerns about the placement.

The assessment completed in June 2021, *"and the recommendation of the multidisciplinary team was that GA should move to a small residential home for adults with similar needs or to a supported living placement with support from staff with expertise in working with adults with learning disabilities, autism and complex needs"* (paragraph 17). AA opposed this recommendation, and *"maintained that her daughter should return to the family home and put forward an alternative care plan for the family to care for GA with some domiciliary support"* (paragraph 18). However, *"[t]he CCG confirmed that it did not propose to commission any domiciliary care or support in the event that GA was cared for by her family as they did not consider that the entire package of care met her assessed needs"* (paragraph 19).

The court noted its position in considering these proceedings under s.21A Mental Capacity Act:

22. These are section 21A proceedings. The court's primary task is to determine whether or not GA meets the qualifying requirements in Schedule A1 to the Mental Capacity Act 2005: DP v London Borough of Hillingdon [2020] EWCOP 45. However, once an application is made pursuant to section 21A of the 2005 Act the court has broad powers to make declarations pursuant to section 15 as to whether P lacks capacity to make any decisions, and once such a declaration is made, the court has wide powers pursuant to sections 16 and 17 of the 2005 Act to make decisions on P's behalf concerning their personal welfare (CC v KK [2012] EWHC 2136 (COP); PH v A Local Authority [2011] EWHC (Fam)).

The court accepted *"that an indication of GA's wishes and feelings is that when GA is with her family, she has on occasions indicated wanting to*

leave the placement with them at the end of their visits. Her relationship with her family and the mutual love they have for each other is a significant factor which would support GA returning home" (paragraph 31). The court further accepted at paragraph 33 that "GA's family are able to provide her with love and commitment, with familiarity, with a cultural and religious lifestyle in accordance with her background. I have no doubt at all that if she were returned to the care of her mother with the support of MA and other family members that they would love her and care for her to the very best of their ability." However, the court found at paragraph 31 that "there is no objective evidence to support the family's submission that separation from her family has had a significantly detrimental impact on GA's emotional well-being."

The court accepted at paragraph 32 that GA's family had raised 'legitimate concerns' "in respect of some of the errors in the care provided to GA, the most serious being in respect of the Risperidone overdose and the failure to properly supervise GA and a male resident which resulted in an inappropriate encounter. I accept that such mistakes may happen in the proposed placement at Placement B." However, on balance, the court found that the evidence showed the family had struggled to meet GA's needs "on a 24-hour a day basis, seven days a week. It is apparent from the documents before me that they have struggled at times to fully meet GA's needs. The family's plan relies heavily on the availability of the Day Care Centre and weekend support which the CCG is not prepared to commission in the event that GA returned home. I note that whilst being cared for by her family, the family were provided with a considerable amount of additional support through the day care and domiciliary care services, which would no longer be available. Even with this level of

support concerns were increasing in respect of the family's ability to properly manage GA's needs and behaviour" (paragraph 34). The court did not consider that the family had addressed the concerns which had been raised regarding GA's care in the family home, and found at paragraph 36 there was "a clear discrepancy between the professional assessments in terms of GA's needs and how best to meet these, (examples being in respect of stimulation and engagement) and the family's understanding of those needs."

The judgment also included some of the evidence presented on the nature and intensity of GA's needs, both during the daytime and at night:

41. [...] GA requires a high level of support and supervision throughout the day to maintain her safety when engaging within day to day tasks. She has little danger awareness and within her current environment kitchen facilities are locked to ensure her safety. She will often throw items with little awareness of danger to self, others, or property. Throwing items does not appear to be in aggression but rather a play based, cause and effect seeking response for her. She requires support with her antiepileptic medication (potentially lifesaving) and with her complex sensory processing which in turn result in functional difficulties. She also needs support throughout the night to encourage a good sleep hygiene and monitor potential seizure activity. GA has Behavioural Dysphagia and this means that she is at risk of choking and aspiration by overfilling her mouth with food and drink, eating and drinking at a fast pace, vocalising with food and drink in her mouth and walking with food and drink in her mouth.

GA's MDT considered that GA's family would struggle to meet these needs, which

42. [...] would lead to an increase in the frequency and intensity of problem behaviours. This would in turn result in increased risks to both herself and to family members, particularly children. It is very likely that her medication would be increased if her environmental and relational needs were not met appropriately at the family home. A specialist home is able to provide a highly structured environment and teams of experienced staff who can provide the level of intensive interaction she requires whereas this would be exhausting and unattainable for a family unit.'

The court accepted at paragraph 43 *"that the level of care needed is such care that would only be available from a professional team (not an individual). As Dr B indicates, during her time at Placement A, GA's dosage of Risperidone has reduced significantly, with her behaviour managed through careful structure and planning rather than medication, and the plan is that this medication can be ceased entirely. In all probability, in order to manage GA's behaviour in the home, the family are likely to require Risperidone to be reintroduced or increased. This would not in my judgment be in GA's best interests."*

The court was satisfied that a move to Placement B was in GA's best interests, and any interference with her Article 8 rights was necessary and proportionate; plans were to be developed to *"enable[...] GA to maintain and enjoy a relationship with her family and the ability to celebrate important occasions"* (paragraph 46). The court did not adjourn the matter for consideration of trial at home or at Placement B,

but relisted the matter to review *"following a period of settling in for GA"* (paragraph 48).

Comment

The case presents a useful snapshot of the type of case often argued in the Court of Protection but relatively rarely reported: one in which the statutory bodies consider, in the absence of any allegations of abuse, neglect or bad faith, that a person's needs are beyond the ability of their family to meet. The judgment is also notable as a slight counterpoint to *DP v Hillingdon*: while all parties agreed that GA should not continue to live at Placement A (which, strictly, would have been the subject of the s.21A challenge), the court looked to *CC v KK* as authority that it had 'wide powers' to consider her broader welfare.

The case is also of note in relation to the CCG's position that it would provide no care for GA in the event that she were to live with her family. The judgment does not elaborate on this point fully, and it was noted that there had been some difficulty with the provision of care in the community, and at least one community care package had failed. Even in the absence of this important detail, we would observe two points in relation to this issue:

1. In our experience, the position that a person must choose between a residential placement or no package of community care is one regularly taken by health authorities providing care under NHS Continuing Healthcare, and very rarely taken by local authorities providing care under social care legislation; and
2. Generally, when explored vigorously with them, CCGs will not maintain the position that their Continuing Healthcare duties are

met by the mere offer of residential care if the Court of Protection indicates that it considers that the person's interests will be best served by living at their home or with family members, and typically will revise this position to make some offer of a community care package. The court cannot, however, **direct** the CCG to provide such a package, and the Supreme Court in *N v ACCG* made very clear that the Court of Protection should be careful before dedicating time to considering questions what might in the person's best interests in the abstract. The path for the parties – and the court – to tread can therefore be quite a narrow one.

Anorexia – why capacity matters

A Mental Trust v ER [2021] EWCOP 32 (Lieven J)

Best interests – medical treatment

Summary

In this case, Lieven J considered the capacity and best interests of ER, a 49-year-old woman with a diagnosis of anorexia.

ER's personal history with eating disorders had been a long and difficult one; the condition first emerged in her teenage years, and she had been treated in hospital from at least 2005. She had also had a very difficult personal life, and had served a custodial sentence for a number of years, during which time her anorexia worsened in severity.

From March 2012, ER had been repeatedly admitted to hospital as an informal patient, putting on some weight, and self-discharging quickly. The court noted at paragraph 6 that "[t]here is a pattern of her being unable to maintain

anything close to a healthy weight in the community."

By 2021, ER had also developed serious physical health conditions, including 'renal failure as well as osteoporosis, endocarditis and klebsiella' (paragraph 7). Her treating doctor estimated that as a result of her renal failure (for which she had no prospect of receiving a transplant) her life expectancy was limited. She remained severely underweight following her last hospital admission in 2019, with a weight of approximately 35-37 kg. She had also recently overdosed on prescription medication.

The Mental Health Trust and NHS Trust sought declarations that ER lacked capacity to conduct proceedings and to make decisions concerning her anorexia; however, they were in agreement that ER had capacity to make decisions regarding her physical health. The health bodies also sought declarations that "*ER should not be forced to accept treatment for her anorexia which she does not wish for, and that she should not be forced to go into a psychiatric hospital or a specialist eating disorder unit against her wishes*" (paragraph 10).

ER spoke with Lieven J directly, who found that ER was "*very articulate, clear in her views, and in my view, insightful as to her condition. I was concerned that given what I had heard directly, there was material that suggested that ER might well have capacity in respect of the two issues - litigation decisions and decisions regarding treatment for her anorexia*" (paragraph 11). As a result, the court heard oral evidence on ER's capacity in the relevant areas.

Capacity

The court readily accepted the conclusion of ER's treating clinician that she had capacity to make decisions in relation to her physical health conditions.

The issues in relation to her anorexia were more complex, and the court heard from both ER's treating psychiatrist (Dr P) and a psychiatrist offering a second opinion (Dr Cahill, who was also a specialist in eating disorders). ER's treating psychiatrist considered that

16...ER was unable to weigh up the information regarding the severity of her illness, and the impact it has had on her over the last years and in the immediate short term. She was also unable to understand the consequences of malnutrition and the risk that chronic low weight posed to her life. At that stage, Dr P considered that ER did have capacity to conduct proceedings.'

Dr Cahill's evidence noted that when he met with her, "she was depressed [...] she said she had had enough, and felt that dialysis and medical treatment seemed a waste of time. He also records that she said she was very lonely, and that she thought that being around other people might make her feel better about life and improve her mood" (paragraph 19). He considered that ER was unable to weigh up decisions about her anorexia, and particularly, her inpatient treatment. The court recorded relevant portions of his evidence at paragraph 20:

she is not aware of her own disability. There is ample evidence that she lacks the insight into the seriousness of her condition when, at desperately low levels of BMI around 10, believing that a BMI of around 12.8 is safe. It is concerning that when at an incredible low weight, there is

evidence of body image distortion, believing she is 'chunky.'

- While ER was able to understand and weigh up information regarding her renal disease, "there appears to be a lack of insight with regards to the physical health effects of poor nutrition and low weight. There is consistent evidence that [ER] believes she is eating enough to regain weight, despite evidence to the contrary."
- He noted that ER had never required nasogastric feeding or feeding under restraint – her inpatient treatment had functioned by helping her to be "in a much better place psychologically...we are not considering a 'traumatic' admission as such. If anything, [ER] is being looked after, with a reduction in isolation and loneliness."
- He considered that "at the heart of the condition is a fear of weight gain, a drive for thinness, and a body image distortion. [ER] is likely to be fearful of this, whether she perceives this as relinquishing of control, a threat to her safety, security, and identity, or simply that she cannot tolerate the inevitable weight gain." ER stated that she did not "find the eating disorder units helpful, but gave reasons around it feeling military, regimented, controlled, and that the other patients were immature. Yet, through all the admissions, [ER] managed to restore weight, and was discharged at a more stable physical position than at admission. Although she talked about being watched in the bathroom as 'disgusting' which I do acknowledge, there was no evidence from [ER] that the admissions have been traumatic for her. She even recognised herself that she regained weight and came out

'stronger.' Therefore, it is very likely that her anorexic cognitions are driving her decisions regarding admission, and therefore, due to this impairment of the mind, in my opinion she struggles to weigh up the information."

The court also noted at paragraph 21 Dr Cahill's finding that ER *"has no desire to die and does wish to take steps to avoid that,"* which appeared to be in opposition to her rejection of treatment for her anorexia.

The court also considered the evidence of ER's solicitor, Ms Turner, who was very experienced in the field and considered that ER lacked litigation capacity. ER set out her own views:

22. [...] she does not like eating disorder units and sets out, in my view, perfectly rational reasons for this. In particular, that she is much older than other patients and finds their behaviours unhelpful for her condition. She also finds the approach of being encouraged to eat large meals very unhelpful to her.

ER expressed that she would like more support in the community, and felt that more support would be useful to her. She said she was interested in moving a residential placement or supported living, and that she felt lonely living on her own with visiting carers. She was clear she would not wish to be treated as a psychiatric inpatient, but did not want to die, and did want medical help.

The court noted the history of cases considering anorexia in the Court of Protection. Lieven J wrote that she considered the determination of capacity 'difficult' and even though there was consensus on ER's best interests, the issue of whether she had capacity was not academic and

should not be 'fudged' with a view to the collateral impacts on ER:

31. [...] It is also right to acknowledge that it might strongly be in ER's interests to be thought not to have capacity as it allows the Court of Protection to have continued oversight of the case, which itself can provide more focus on the services that she needs. However, capacity and autonomy are such important principles, that lack of capacity cannot be assumed for the sake of expediency.

The court considered that ER was not a 'normal' anorexic patient. *"Her renal failure is terminal, and she has a limited life expectancy, so the decisions she makes about not wanting an inpatient admission have to be seen in that context. Treatment would not prolong her life, therefore the views she expressed seemed potentially rational"* (paragraph 32).

The court reluctantly accepted the evidence of the psychiatrists that ER lacked *"capacity to make decisions about her anorexia treatment and, it follows, litigation capacity"* (paragraph 33). Lieven J noted the views of Dr P, and observed that she would be *"very slow to depart from the view of a treating consultant psychiatrist, absent any concerns about the closeness of the relationship, which I do not have here"* (paragraph 33). The court was further fortified by the analysis of Dr Cahill, a clinician with *"long and considerable experience of treating patients with anorexia nervosa and I wholly accept that is experience I do not have."* The court accepted *"that there is evidence of unrealistic thinking, especially around her weight levels"* and *"that there is evidence that ER does not act rationally in respect of some of the decisions she makes around her eating problems"* (paragraph 33).

Best interests

In considering best interests, Dr P gave evidence that a best interests meeting had been convened, and it was agreed by all in attendance *“that another inpatient admission against ER’s wishes would not be in her best interests, given ER’s strong opposition, and the fact that it is unlikely to have any impact on her renal position (so her physical condition is unlikely to improve significantly), but that it may impact on her mental condition significantly”* (paragraph 17). The court agreed with the conclusion

34... [...] that it is not in ER’s best interests for her to be forced to accept treatment for her anorexia which she does not wish to accept. In particular, she should not be forced to go into any inpatient hospital and treated against her wishes. In my view, it is plain that this is in her best interests given her renal failure and extreme dislike of eating disorder units and psychiatric hospitals. I also note that this conclusion accords with ER’s wishes and feelings.

The court did emphasise that *“it is in ER’s best interests to be given more support in the community’ and ‘the evidence is fairly clear that if she could be moved to a supported living placement where she can have dialysis and more support and company, this could much improve her mood and potentially improve her physical health over the next few months”* (paragraph 36). The court listed the matter for a review hearing and joined the local authority and CCG with directions to produce evidence on what support ER could be provided in the community, and consideration of a move to supported living.

Comment

The case is a useful reminder of that the obligation of the court to formally consider capacity and best interests are not vitiated because the outcome would appear to be the same whether the person were found to have capacity or not – here, ER would have chosen to forgo further treatment for anorexia, and her clinicians felt that she should not be obliged to accept it against her wishes. ER’s capacity in this case was complicated by her serious physical health condition: a decision to forgo anorexia treatment during what appeared to be the last month or year of her life and which she found very unwelcome was one which to outward appearances to would also seem easier to understand. However, the court carefully considered both whether she had capacity, and where her best interest lay, coming up with a slightly different take to what had been proposed: namely, that further information was required of the local authority and CCG to ensure she was being offered support on terms she was willing to accept.

Anorexia – the Court of Protection and the MHA

A Midlands NHS Trust v RD & Ors [2021] EWCOP 35 (Moor J)

Best interests – medical treatment

Summary

RD concerned a 37-year-old woman suffering from an extremely serious and debilitating condition, anorexia nervosa, since the age of 13. The NHS Trust sought declarations that:

1. *RD* lacked capacity to make decisions about her nutritional intake and about her care and treatment in general; and,

2. it was in RD's best interests to receive the care in her care plan, specifically that it was lawful not to take any steps towards forcing nutrition against her wishes, notwithstanding that, by so doing, it might in the short-term prevent her death.

RD had first been first admitted to an inpatient unit in 2000. Thereafter, there had been 14 admissions, approximately four of which were pursuant to the Mental Health Act 1983 on a compulsory basis. On most occasions, RD gained some weight but it was virtually all lost immediately following discharge. In 2019, there was a further significant deterioration in her physical health with possible vomiting (whether voluntary or involuntary).

During her admission in early 2020, the Trust commissioned a report from Dr Matthew Cahill, a consultant psychiatrist. He agreed with the Trust that RD was suffering from a severe and enduring anorexia nervosa; her prognosis was very poor and her recovery was very unlikely. He recommended two further interventions: (1) discharge on a Community Treatment Order ("CTO") with four visits per day and (2) admission at a specialist rehabilitation unit. The second proved impossible because she did not meet the requirements of the unit – her BMI was too low; she did not demonstrate a willingness to engage and make changes; and she was not physically stable.

The CTO was put in place; but unfortunately, RD had to be readmitted to hospital in July 2020 and she was put on a NG tube. There was some physical restraint, but sedation and extended restraint were rejected due to the risks to her. There was no significant improvement in her BMI; and she was therefore discharged home.

The application to court was then made.

It was agreed that she lacked capacity – she understands that, if she does not eat or drink her juices, it will not be good for her but she does not understand that it will lead to her death and that she needs to comply with the treatment.

The clinical evidence was that all viable inpatient treatment options had been exhausted. Any further detention under the MHA 1983 was likely to have a detrimental effect on her wellbeing and make the situation worse. The risk of force-feeding under sedation or physical restraint far outweighed any likely benefit. There was a risk of choking on her own vomit or aspiration pneumonia. It would also cause extreme distress and psychological trauma and, in consequence, also significant physical harm as there was a risk of bone fracture and bruising. The treatment was causing more harm than good. Dr Cahill agreed and considered that the treatment options were increasingly unethical and disproportionate if administered coercively. He considered that the case was 9 out of 10 on the seriousness scale.

RD agreed with the NHS Trust that, if she refuses treatment, it should not be forced on her, despite the possible grave consequences. She was clear that she wanted to live but that she did not want NG feeding and she did not want to go back into hospital under compulsion. She wanted to be at home.

Moor J observed that RD's life is undoubtedly a life worth living, but that the problem was she had been overwhelmed by her anorexia nervosa. He considered that the cycle of compulsory admissions had been distressing to her and that they had achieved very little. He accepted that

everything should be done in the community to convince RD to take, voluntarily, the nutrition, treatments and drinks she needs. He decided to remove the threat of compulsion or compulsory admission from RD; and that he would remove the requirement to have NG feeds, unless she wished to have them. He urged RD to comply with the doctor's recommendations, but authorised and made the declarations sought.

Comment

The hope of all before the court was that RD would follow the doctor's recommendations, but Moor J feared that if she did not, then she was likely to deteriorate quickly and would need palliative care.

The case also raised two important procedural points. The first in respect of the interaction between the MCA 2005 and the MHA 1983 in cases such as this; and the second was whether the hearing should be heard in private.

The declarations were sought pursuant to both the MCA 2005 and the inherent jurisdiction of the High Court. Moor J cited Mostyn J in *Nottinghamshire Healthcare NHS Trust v RC* [2014] EWCOP 1317 in respect of the need for an application to court where a decision is taken not to impose treatment pursuant to s.63, where Mostyn J had held that:

In my judgment where the approved clinician makes a decision not to impose treatment under section 63, and where the consequences of that decision may prove to be life-threatening, then the NHS trust in question would be well advised, as it has here, to apply to the High Court for declaratory relief. The hearing will necessarily involve a 'full merits review' of the initial decision. It would be truly

bizarre if such a full merits review were held where a positive decision was made under section 63, but not where there was a negative one, especially where one considers that the negative decision may have far more momentous consequences (i.e. death) than the positive one.

Moor J accepted that he should determine the application under both the MCA 2005 and the inherent jurisdiction notwithstanding the fact that he was undertaking a full merits review pursuant to the MCA 2005. That was because he considered that a full merits review under the MHA 1983 engaged public law matters, in particular, the safety of the public (although it is fair to note that it is not obvious that the safety of the public was central to the issues in RD's case).

Alongside Moor J's main judgment, there was also a short decision [\[2021\] EWCOP 36](#) in respect of the case being heard in private. He determined that in light of the parties' representations, particularly the express wishes of RD that the intensely personal matters should not take place in public, it was appropriate for the case to be heard in private.

Dialysis – how far is coercion justified?

University Hospital Birmingham NHS Foundation Trust v AI & K [\[2021\] EWCOP 37](#) (Hayden J)

Best interests – medical treatment

Summary

In this case, the Trust sought a declaration from Hayden J that it was lawful and in AI's best interests to discontinue any further attempts to provide dialysis.

AI had a history of schizophrenia and was diagnosed on 30 September 2019 with end stage kidney disease. He had required long term haemodialysis to remain well but had only intermittently accepted treatment. He had a fixed delusional belief, as a consequence of his schizophrenia, that there was nothing wrong with his kidneys and he did not need dialysis. He also considered that the hospital was stealing his blood and he was accruing a large bill that he was unable to pay. This was causing him significant agitation.

It was not in dispute that AI lacked capacity to decide whether or not to have dialysis.

In July 2020, AI had required hospital admission, which included spending some time on ICU before being transferred to the Renal ward at Queen Elizabeth Hospital. He received haemodialysis twice a week, verbally refusing each time but when the nurse arrived at his bedside, he would passively let them connect him to the machine using his dialysis line. No sedation or restraint was required.

The stage was reached that AI was physically well enough to be discharged but continued to state that he would not attend his outpatient dialysis appointments. The clinical view was that it was in his best interests to be discharged back to his care home and should not be compelled to attend and receive dialysis. Instead, the Trust would act "reactively", which meant that a vehicle would be sent to AI's home on the day that dialysis was required and it was left to him as to whether he would comply or not. His family took the view that AI should be compelled to attend and receive dialysis. Hayden J agreed with the clinicians that chemical and/or physical restraint was not in AI's welfare interests.

An application was made to the Court of Protection. Theis J made the first order sought on 23 November 2020, including that AI lacked capacity to make decisions about his treatment in relation to dialysis for End Stage Kidney Disease. She declared that it was lawful and in AI's best interests to be discharged from Queen Elizabeth Hospital, to receive reactive treatment for dialysis for End Stage Kidney Disease, and not to be compelled to receive dialysis by any form of restraint.

After his discharge on 11 December 2020, he voluntarily attended a number of sessions of dialysis, but then he did not attend again from 12 January 2021. His health seriously deteriorated and he required further hospital admission. He cooperated with dialysis in hospital but was again then discharged. This pattern continued. His non-compliance led to fluid volume overload, which resulted in severe breathlessness. His physical deterioration had also significantly worsened.

AI was admitted to Accident and Emergency on 18 May 2021 with breathlessness. He accepted oxygen. He initially declined dialysis, following which he agreed to it for a short period of time before pulling his tunneled line out. Eventually, he was persuaded to accept the insertion of another temporary line.

Dr Hewins, the consultant neurologist, was extremely concerned by his presentation. There was prolonged bleeding from the groin where the dialysis was inserted. He was at risk of heart failure and significant risk of death over the next 24-48 hours. Even if his blood pressure were to stabilise, the clinicians could attempt to insert another tunnel but the likelihood of being able to achieve that was significantly uncertain. It would

be a potentially painful and distressing procedure. Dr Hewins' opinion was that the clinicians were in danger of pursuing inappropriate offers to re-establish dialysis without any realistic likelihood of durable benefit when the focus should be on palliative care.

Hayden J observed that AI had been consistently resistant to cooperating with dialysis. He had only passively cooperated when he was physically weak and struggling to breathe. He then disengaged when he felt better. He noted that AI's superficial cooperation with dialysis had gradually reduced and that on his most recent admission, he had withdrawn the tunnel line, which would have been painful. Hayden J drew the inference that AI has become tired by the effort of dialysis. He had also become neglectful and disinterested in his appearance, which was contrary to his personality.

The neurologists considered that if AI was administered further dialysis he would last for a maximum of 2 to 3 weeks; and that the process of dialysis might precipitate collapse and death.

Hayden J also heard evidence from AI's family to ensure that the court was considering his welfare in the widest sense. They described his upbringing in Pakistan and that he was sociable, as well as his enjoyment of spiritual Pakistani song and food. He had recently become a grandfather and was delighted by that. He also attended all family events.

As to prognosis, Hayden accepted that AI was at the end of life; and therefore, the question was determining how, over what period and in what circumstances, he died. He endorsed the palliative care plan because he considered that it conveyed dignity on AI at the end of life and

granted the declarations sought.

Comment

This case has interesting resonances with that of *RD* also covered in this issue. In both, it would be possible to construct coherent legal arguments that coercion **could** occur, but the real issue was whether it **should**.

It is worth remembering, in the context of the best interest assessment, that section 4(6) MCA 2005 requires the decision-maker to consider the person's past wishes and feelings "*so far as is reasonably ascertainable*". In this case, that exercise involved Hayden J forensically analysing AI's behaviours in response to this dialysis in order to understand his wishes and feelings. Hayden J observed that "*behaviour, when assessed carefully, may sometimes communicate feelings more effectively and accurately than words.*" Ultimately, as Hayden J acknowledged, the court is charged with the protection of AI's autonomy, and his wishes and feelings are integral to that. He cited in this regard his own judgment in *SS v London Borough of Richmond Upon Thames & Anor* [2021] EWCOP 31, covered further also in this issue.

Securing autonomy – Article 8 ECHR in the balance

A Local Authority v TA & Ors [2021] EWCOP 22 (Cohen J)

Mental capacity – best interests – contact – residence

Summary

The contours of this difficult case were sketched out economically in the opening paragraphs of the judgment:

1. This case concerns the health, welfare, and care of GA, an 87-year-old lady. She is a widow with six surviving children - three girls and three boys - and there are 10 grandchildren, by two of the girls. Since 2004, she has lived at an address in a city in West Yorkshire. She is the tenant of that property which is a housing association property. Of her six children, at all material times, two of the boys, TA and HA, have lived with her.

2. HA has some form of mental disability and is in receipt of a care package, the details of which are not known to me or, I think, to the social workers dealing with GA, but I have no reason to think that either (a) he presents any risk to GA or (b) he is able in any way to assist GA in her care.

3. TA is plainly an intelligent man and he presents himself as his mother's sole carer and the proprietor and manager of a care home - an inappropriate description of his mother's home but one which he says should entitle him to £1 million a week by way of salary, for the care that he says that he provides to GA and HA.

4. It is the case of the local authority that TA exercises abusive and controlling behaviour towards his mother and so dominates her life that she (i) is unable to enjoy personal dignity; (ii) has lost contact with her community and with her family, apart from HA and TA, and to some extent XA [one of GA's daughters]; and (iii) is denied access to important healthcare and treatment.

The local authority sought to remove TA from GA's home and bar him from returning so that a local authority care package could be put in to

look after her.

TA had previously been the property and affairs attorney for his mother, but had been removed in 2018, having been convicted in February 2016 of five counts of fraud and abuse of position. Those five counts related to money that he had misappropriated, that money being due to or for the benefit of his mother, and she was the subject of three of the five counts. TA had been sentenced to a term of 45 months' imprisonment. TA asserted that his conviction was wrong and that he should never have been charged but had not appealed, and blamed the local authority for wrongful prosecution of him.

There was an extensive procedural backstory to TA's non-attendance before the court, notwithstanding the fact that he had been ordered to attend. The backstory included publication of meetings involving professionals on YouTube and this [judgment](#) from Cobb J addressing TA's wish to record proceedings (and also his conduct towards court staff).

There being no doubt as to GA's lack of capacity to make the material decisions, Cohen J was squarely confronted with determining what was in her best interests. Despite his non-attendance, TA's case was squarely before the court, and the most economical way in which to outline how Cohen J reached his decision is to set out how he responded to that case:

71. I agree with the local authority that what is being sought is draconian and I have considered it very carefully. I should return to the concerns of the local authority and the Official Solicitor. I deal with them under these headings. First, they say that GA is at risk of immediate harm. TA goes out, as he agrees, leaving

GA, and it is presumed HA, shut in the house. This happens most days for about an hour and they are there on their own. If there was a fire in the house, or GA suffered a stroke, the result could be fatal. TA says that he can tell what is going on in the home by looking at his mobile phone and by picking up the remote surveillance but that, of course, is no substitute for presence and is inherently dangerous.

72. Secondly, the local authority argue that GA is deprived of many of her basic rights by TA. She is isolated; she does not go out; and she remains in her own room. Neighbours report to the local authority that they have not seen GA since 2019 and that previously, she was a sociable woman. It is not known whether she is, in fact, able to go out and enjoy being outside and seeing other people. That simply does not happen and cannot be investigated at the present time.

73. Thirdly, she is deprived of medical attention. As I have already mentioned, there have been occasions when nursing teams have been prevented from entering the house and there is no record of any GP attendance either at the home or at a surgery, so far as the local authority has been able to find, since 2019. At aged 87 and having had a heart attack and been the subject of a whole series of heart medications, it is plain that she should be receiving medical attention.

74. Fourthly, there is no evidence that GA is receiving any form of medication. TA refused to provide any information. I do not know why. Maybe he feels information is power. However, the result is that, so far as the local authority and the court are concerned, there is no

evidence that GA is receiving statins, blood thinners, and her heart medication and there is no evidence that there have been any of the necessary tests undertaken to ascertain if the medication previously prescribed is still appropriate.

75. Fifthly, she is cut off from at least three of her children and all of her grandchildren. Whatever TA may say about their failings, RA, MA, and DA all feel prevented from seeing their mother. MA and DA are the only ones with children. So GA does not see her grandchildren at all. GA wants to see them but they will not come and see her with TA running her home.

76. Sixthly, all her intimate care is carried out by TA, when she would much prefer a female to do that. It can only be degrading for her to be washed, bathed and have her pads changed and cleaned after using the toilet by her adult son. For a woman of her faith [i.e. Muslim], it must be particularly humiliating.

77. Seventhly, she is under video surveillance 24-hours a day. I accept, of course, that in some medical settings that happens, but it is degrading to anyone's sense of privacy and cannot be justified for a lady who seems to spend nearly all of her hours in bed.

78. Finally, she is deprived of any form of professional assistance. Those who offer essential services simply will not go into the property because of TA's dominating and controlling presence and his insistence on filming what goes on.

In the circumstances, Cohen J identified that in making the best interests decision on behalf of GA, it was common ground that:

80. [...] above all GA would want to stay in the home in which she has lived for some time. I am sure she would want to receive appropriate medical treatment and medication. She would want to be able to see her doctor. She would want, for example, to receive treatment for the pain she demonstrated she was suffering on 26 and 27 January. She would want to see her children, all of them, and her grandchildren. That is what she said. She would want to be cared for by women. She would want care and stimulation. All these are very much in her interests. I am sure also that she would want to be cared for by those who know her and from whom she is used to receiving care.

Cohen J had to consider TA's rights: TA lived in the property and no other home of which he was aware. Cohen J did not know where he would live if required to live – although observed that it was TA's fault that he was without that information. He also observed that to deprive him of the company of his mother was a significant interference in his family life. In the circumstances, and had there been any way of enabling care to be shared to make good the deficits of the care GA was receiving from TA, Cohen J made clear (at paragraph 82) that he would have grasped it. The problem that he was satisfied that:

82. [...] the history, from the evidence, and from the argument, that that is simply not possible. The video clips make it very clear why it is not possible. There is no suggestion from TA, even in the video clip that he sent today, that anything will change. He does not see a single deficit in the care that he provides and I come to the clear view that a different regime must be put into place in GA's best interests.

Cohen J expressed the hope that, as time could go on, TA could be brought back into the fold and able to see his mother and spend time for her, as he was sure that would be to their mutual benefit, but:

83. [...] a continuation of the current situation, where his mother is locked away by him from the world and the rest of her family without others being able to reach her, except occasionally with the most stringent court orders, is not a situation that is in her best interests. I accept that this is a draconian order. It should have been capable of being avoided but it is TA, and TA alone, who has brought this about. I therefore accept the local authority plan must be one that would be implemented.

Cohen J found that the interference with TA's rights were necessary and proportionate because there was no other way of promoting his mother's rights and interests (paragraph 85). He also accepted that the provisions within the care plan amounted to a (justified) deprivation of GA's liberty.

The order sought by the local authority – and endorsed by Cohen J – provided for the immediate vacation of TA from the home (the tenancy being in his mother's name, and TA being only a licensee there, Cohen J did not have to grapple with the complexities which would have arisen if he had his own rights in the property). The local authority had undertaken to provide TA with fully funded accommodation in a bed and breakfast for 14 days. As Cohen J had not heard from TA at all as to what his proposals might be and whether or not he can go and stay with other members of the family, he considered he could not do anything other than endorse the

proposal for 14 days. The order also sought the removal of XA from GA's home; Cohen J considered that XA would no doubt return to home in Greater Manchester.

The order also contained a cordon put around the property of about 100 yards by reference to six named streets in which TA was forbidden from entering. The local authority did not want him watching the house or monitoring who goes in and out. He was barred from removing the Motability car from the property which is there for his mother's benefit. There was a further prohibition about him putting articles or other information in the public arena, including on a social platform, and Cohen J considered that was plainly needed in light of the history of the case. Cohen J also made an order limiting TA's ability to correspond with the local authority and with the Official Solicitor.

Cohen J made a civil restraint order against TA for a period of two years, noting that: "there have been four occasions before this hearing began when applications have been dismissed as totally without merit, all of them within the last year. In addition, I have dismissed three applications as being totally without merit in the course of this hearing. There are another four recent occasions when applications have been dismissed as showing no reasonable grounds or no good reason. The threshold for the making of a civil restraint order is plainly crossed. I therefore will make a civil restraint order as the only way to restrict the level of applications. The local authority no longer pursues an extended civil restraint order and there will be a civil restraint order for a period of two years" (paragraph 91). Cohen J made provisions for a further hearing further to consider questions

relating to deprivation of liberty, contact, and also committal proceedings which were on foot in relation to TA.

Comment

Whilst not establishing any new propositions of legal principle, the case serves as a reminder of the stark issues that arise when the Court of Protection is grappling with what (in effect) are adult care cases. As noted above, it made Cohen J's life considerably easier that he did not have to consider how to navigate a position where TA had his own rights in the property, a feature of many such cases. Given the history of the case, it is overwhelmingly likely that Cohen J would have found some way in which to remove TA, but it would have made his (necessary) balancing of XA and TA's rights even more challenging.

COVID-19 vaccination – best interests is not code for mandatory vaccination (and a reminder you can't fail a capacity assessment)

SS v LB Richmond on Thames and SWL CCG [2021] EWCOP 31 (Hayden J)

Best interests – medical treatment

Summary

This vaccination decision is different to others that have been reported to date (such as *E (Vaccine)* [2020] EWCOP 14, because it was clear that the objection to the vaccine came from the person themselves, not from family members. SS, the person in question, was 86, and had a diagnosis of dementia. Proceedings had been brought on her behalf under s.21A challenging her placement in a care home. During the

course of those proceedings, it became clear that SS was increasingly resistant to medical interventions of any kind, although, as Hayden J noted, it was not clear whether this was due to her advancing dementia or was a longer-term feature of her personality and general approach to life is unclear.

The care home in which SS lived was a large one, 28% of whom (27 residents) had died during the first lockdown. Since January 2021, a GP, Dr N, had been visiting on a regular basis to administer initial and follow-up vaccinations to residents and staff. She had regularly spoken with SS to try to encourage her to have her vaccination. This has been reinforced by the care staff. Dr N conducted a capacity assessment with SS on 23rd March 2021, she noted:

"patient appears confused and unable to fully understand. Initially agrees to have vaccination and reports will go down the road to her usual doctor and get it. Subsequently refuses the vaccination. Carer.. re explained what I had relayed to the patient and the patient has difficulty understanding the reason for the call and the vaccinations. Doesn't appear to understand what Coronavirus is despite being explained to twice. Unable to retain any information given. Patient then declines to continue with the consultation. Patient failed capacity assessment as unable to fully understand the information given nor retain the information [SS] doesn't have capacity to consent for Covid-19 vaccination.

In the event of a best interest meeting, I would support vaccination and it would not be necessary to review the patient's capacity at the time of administration of

vaccine given that her dementia is a progressive condition since at least 2019 when it was last formally assessed."

At paragraph 13, Hayden J observed that *The ambit of this assessment strikes me as entirely consistent with that contemplated in: SD v Royal Borough of Kensington And Chelsea [2021] EWCOP 14; E (Vaccine) [2021] EWCOP 7. I hope Dr N will not think me too pedantic if I make the observation that "patient failed capacity assessment" strikes me as awkwardly expressed. It is not a test that an individual passes or fails, it is an evaluation of whether the presumption of capacity has been rebutted and if so, for what reason.*

An application was made to court following discussions between SS's Accredited Legal Representative and the local authority, and Dr N provided a more detailed assessment, in which she noted that the:

administration would be challenging with this patient. Any physical restraint would need to be necessary and proportionate with the minimum amount of force for the shortest period of time. I believe restrictive physical intervention will be required in this case to protect the patient and staff from coming to harm. Clinical holding by several staff members should be sufficient for administration in this case. However, this would be a decision taken jointly with the vaccine administrator and care home staff."

Under the sub-heading 'belief structure,' Hayden J set out his understanding of the picture of SS's beliefs about medical treatment:

18. SS is recorded as having been compliant with her medical regime when she first arrived at the care home. However, as has become clear from several sources, there came a point when she discovered a newspaper article which she read as arguing that medicine "did more harm than good". Quite when she first came by this article is unclear. In any event she had not been at the care home for very long before she started to brandish it, with characteristic forcefulness, at anybody who sought to afford her medical care of any kind. The consequence has been that SS has been almost entirely non-compliant with any attempted intervention. Ms Kelly Fisher [team leader at the care home] told me that some attempt had been made to administer covert medication to keep SS's blood pressure more stable. However, she said SS was "like a blood hound" who could tell something was amiss and this plan was abandoned. I hasten to add that she made this remark in an affectionate way. Indeed, I was struck by the extent to which all Ms Fisher's remarks about SS were both kind and respectful.

19. In June 2020 SS developed a rash on her legs. Even though this only required the application of cream SS resisted steadfastly. Staff and medical professions made great effort with her to encourage her to receive the treatment, but the outcome can only best be described as having "limited success".

20. In her report, (see para 13 above) Dr N reviewed the medical records and noted that there is no record of SS receiving any vaccination of any kind at all. The records go back to 1997. Even more strikingly there is an unambiguous note that SS declined both seasonal influenza and

pneumococcal vaccines when offered them by the surgery. The first of these refusals is recorded in 2002 with entries identified in 2010, 2012 and 2014. Thus, there is a clear and consistent pattern of behaviour which predates SS's diagnosis of dementia by a significant period.

21. As Ms Hancock, counsel for SS, points out, whilst the above behaviour gives a strong indication of what SS's capacious wishes and feelings might be on the question of the Covid-19 vaccination, that must still be placed in the context of medical records which signal a history of co-operation and engagement with medical professionals. The notes prior to 2015 reveal SS to be a woman who is responsible and proactive in her treatment. Thus, there is a pattern of routine blood tests every few years; vital signs checked and monitored annually by the GP surgery; she has attended walk-in clinics, out-patients hospital clinics (on six occasions, with various complaints, between 2002 and 2010). It is also notable that she underwent a series of sometimes intrusive investigations between 2004 and 2009 e.g. endoscopy, x-rays and ultrasounds. As the dementia took hold, SS was noted to have presented to her pharmacist seeking to collect her prescribed medications before finishing the previous prescription. It seems likely that this behaviour reflected her deteriorating short-term memory. Reinforcing this is a changing pattern, after 2015, when SS misses appointments, fails to pick up prescriptions etc.

Hayden J then set out in some detail the analysis of the risk faced by SS, which merits reproduction in full as largely representative of

the risk faced by many residents in care homes as at April-May 2021:

22. Apart from her cousin, TB, who has, in the past, visited approximately 3 or 4 times per year and during the period of social restriction spoken to her occasionally by telephone, SS receives no visitors at all. She is reserved and private in her approach to life and temperamentally inclined to keep her distance from others. She is at very low risk of infection from the other residents, all but one of whom has been vaccinated.

23. As care homes finally open up to more visits from family and friends, an identifiable risk is presented which has to be negotiated. This large care home makes provision for compulsory lateral flow test to visitors, many of whom will themselves be fully vaccinated. There is a further risk presented by staff members. The team leader in the care home has told me that 77 of the 100 members of staff have been vaccinated. Of the 23 who have not been, a few have declined for recognised medical reasons. The remaining individuals resist the vaccine in principle, some believe that it is, as yet, insufficiently tried and tested. By this, as I understand it, they are contemplating some unidentified adverse reactions which have yet to be exhibited.

24. Certainly, nobody could sensibly doubt the efficacy of the vaccination programme. The National Health England statistics, almost daily updated in the public domain, tell their own explicit success story. A few weeks ago, Covid-19 was reclassified as 'endemic' in the UK i.e. no longer 'pandemic'. The forthcoming months generate cause for optimism but

without any guarantees. The need for booster vaccinations and/or vaccinations modified to combat Covid variants remains a likelihood. **Thus, the greatest risk, statistically, to SS comes from unvaccinated members of staff circulating in the community away from the care home.** Properly recognising this risk Ms Christine Fisher [the care home manager] tells me that all staff members are required to have two lateral flow tests per week and one Polymerase Chain Reaction (PCR) test. The extent of the weekly testing reflects the calculation of risk. Having manifestly given the matter very deep consideration, Ms Fisher told me that ultimately, though she would wish all staff to be vaccinated, she considered the decision to have the vaccination to be an exercise of personal choice. (emphasis added)

A further indication of risk was provided by Dr Prabhakaran, a psychiatrist instructed to give expert evidence as to SS's capacity. He summarised the position as follows:

8. General infection risk in care homes in England has reduced considerably due to various factors, as below.

- Covid infection rates are currently very low in England.
- There has been a high level of vaccination uptake amongst care home residents and health and care staff. Vaccines have been effective with studies demonstrating that healthcare staff are 86% less likely to develop infection after two doses of vaccine.
- Sero-positivity rate in age group 70-84 is high at 98.4 in weeks 12-

15 2021(April data – see attachment)

- Effective use of PPE. And other infection prevention and control measures.
- Effective test and trace including use of rapid lateral flow testing visitors to care homes.

9. However, SS would be considered 'clinically vulnerable' based on Public Health England criteria primarily due to age, presence of advanced dementia and other medical conditions such as hypertension and high cholesterol. Although current infection levels remain low, residing in a care home environment confers a higher risk of being infected with coronavirus compared to being in a private residence. There are concerns of a third wave of Covid 19, which would place SS at higher risk.

In the circumstances, it was clear, Hayden J found that SS lacked capacity to decide as to vaccination, such that:

25. [...]The issue for the court therefore is one of determining what is in SS's best interests. Having regard to the available evidence I consider that there is substantial material from which to conclude that SS if capacitous would most likely have declined the vaccination. Though she attended quite fastidiously to her general medical welfare, she plainly resisted vaccinations. The evaluation of what SS would have wanted is in this case, inevitably imperfect. Capacitous individuals facing a frightening pandemic might very well take a different view of a vaccination which restores them to their liberty than, for example, a decision not to take a flu vaccine. Ultimately, the forensic tapestry can only be woven from the

available thread. However, it must be borne in mind that even though a capacity to weigh and balance the decision in focus has long disappeared, SS has nonetheless consistently and volubly opposed the vaccination. SS's reality is undoubtedly delusional, but that does not stop it being her reality. This has to be both recognised and respected.

Hayden J considered, and rejected, a suggestion by SS's cousin that she be told that her father, who was long dead, but who everyone understood to be very much alive in her mind, had requested that she take the vaccination. At paragraph 32, Hayden J identified that:

32. [...] This involves feeding into a delusional belief system. Whilst that may occasionally have been necessary in negotiating routine day to day challenges, it risks, in this context, compromising all involved. It requires there to be a collusion to trick SS into complying with a vaccination which, on balance, it seems unlikely she would have wanted whilst capacitous and certainly does not want at this point. It is an artifice of a different magnitude and complexion to those earlier more mundane negotiations. It becomes disrespectful to her, not merely as the woman she once was but to the one she is now. Though undoubtedly a well-intentioned suggestion, it risks compromising her dignity and suborning her autonomy. It cannot, in my judgement, be in her best interests. I entirely understand TB's instinctive view that such means might justify the end, given the protection that the vaccine would afford SS. I hope he does not read my reasoning above as, in any way, intended to be a criticism of him. It most certainly is not.

In the face of a submission by the CCG that it was in SS's best interests to have the vaccination, Hayden J noted that he would have no doubt that this would be correct:

36. [...] *were I to confine the issue solely to the health-related states, events and data he identifies. A determination of "best interests" in this context however is, for all the reasons discussed above, not to be confined to the epidemiological; it requires evaluating welfare in the broader sense. As Baroness Hale said [in Aintree], it requires us to put ourselves in the place of the individual concerned.*

In SS's case, it was clear that there:

37. [...] *was no question of SS being supine or passive if she recognised that the vaccination was being given against her will. One of the carers noted that those involved in attempting any "gentle restraint" had better be "kung fu experts", as she put it. The plan which involves both sedation and restraint contemplated the carers' involvement. Ms Fisher did not think that was appropriate. She told me that she thought that SS would look to her carers for help. They would not be able to intervene; that would be distressing for both parties. Moreover, in Ms Fisher's analysis it would most likely dismantle the tentative trust that had been established over the months and in consequence of sensitive and determined professional effort. I find this reasoning to be measured and persuasive. The Local Authority and the Accredited Legal Representative on SS's behalf both submitted that when evaluating welfare in the broader sense, it could not be said to be in SS's best interests. I agree.*

On a procedural note, Hayden J noted that cases relating to COVID-19 vaccination are now usually heard by Tier 1 or Tier 2 J judges (for an example of the latter, see Re CR), but that this had been allocated to a Tier 3 judge because it presented "for the first time, an opportunity to evaluate strongly and consistently expressed views by P relating to vaccination and the weight they should be given, in the broader landscape of the insidious risk arising from the Covid-19 public health crisis" (paragraph 35).

Comment

This decision serves as a strong reminder that decision-making in relation to COVID-19 vaccination must be undertaken on an individual basis where the person lacks capacity, and that the answer is not always that it is in their best interests. It also serves, more generally, as a summary both of the (devastating) ravages of the pandemic in care homes, of the risk matrix as at spring 2021, and also a reminder of where risks are most likely to come from in the case of those in care homes who do not have visitors.

More broadly still, Hayden J's observations about best interests decision-making in relation to a person with beliefs that can properly be described as delusional are important – that a person may be living in a reality entirely different to that experienced by anyone else does not mean that is not their reality, around which the decision has to be constructed. They chime also with the earlier observations of Peter Jackson J in the Wye Valley case that it was "no more meaningful to think of Mr B without his illnesses and idiosyncratic beliefs than it is to speak of an unmusical Mozart." And Hayden J's observations about the dangers – for all – of embarking upon a path of deception are powerful (even if there

may be cases where such could be justified: see, for example, *Re AB* [2016] EWCOP 66); for more on the importance of truth-telling in relation to dementia, see the important 2016 Mental Health Foundation report: [What is truth? An inquiry about truth and lying in dementia care | Mental Health Foundation](#).

Lastly, Hayden J's observation about the (familiar) use of the phrase that SS "failed her capacity assessment" is an important reminder that there's no such thing as failing an assessment. An assessment is the process of thinking, with an open mind, about the person's decision-making capacity (and providing them with all practicable support along the way); that assessment continues for so long as is required, and including gathering such external evidence as necessary - e.g. observation of the person in action - until it is possible to reach a conclusion as to whether or not the person has capacity to make the decision in question.

Sex and the limits of fluctuating capacity

Re DY [2021] EWCOP 28 (Knowles J)

Mental capacity – sexual relations

Summary

When and how does the concept of fluctuating capacity apply in the context of sexual relations? This was the question confronting Knowles J in this case. DY had just turned 18; she had been diagnosed with two chromosomal duplicities: fetal alcohol spectrum disorder, and a moderate learning disability. She had also been diagnosed with developmental trauma disorder or complex post-traumatic stress disorder. The applicant local authority had had responsibility for her as a looked after child since 2012 and had ongoing

responsibility for her adult care services. The local authority initially sought authority to deprive DY of her liberty under the inherent jurisdiction of the High Court (DY at that point still being under 18). The case ultimately came before Knowles J, at which point it was common ground that DY **lacked** the capacity to conduct the proceedings and to make decisions about care, contact, social media use and her finances. However it was accepted that she **had** capacity to decide between the two residence options which were capable of meeting her assessed needs. DY was, at the time of the hearing in a "boyfriend/girlfriend" relationship with a man, AB (who did not have learning difficulties).

The issue in dispute was DY's capacity to decide to engage in sexual relations (Knowles J noting that the Court of Appeal had 're-cast' the test in *JB*). The positions adopted were:

- On behalf of the local authority, DY was able to make a capacitous decision when settled or in a familiar situation or surroundings, but might be unable to do so when unsettled or distressed;
- On behalf of DY by her litigation friend, the Official Solicitor, that she had capacity, and that the independent expert, Dr Claudia Camden Smith, might have set the bar too high in her analysis of DY's understanding of the distinction between consenting to sexual relations within and outside a relationship.

Knowles J summarised Dr Camden Smith's final position (after giving oral evidence) thus at paragraph 20:

In her oral evidence, Dr Camden Smith conceded that she may have set the bar

too high in terms of her analysis of DY's understanding of the distinction between consenting to sexual relations within and outside a relationship. Whilst she accepted that DY had capacity to consent to sex, her concern was how DY would make that decision outside of a relationship. It was difficult to say what her capacity would be if her relationship with her present boyfriend were to end. When unsettled, DY may be unable to make a clear and rational decision. DY did not think the sex act was very special and had a pragmatic unemotional view of sex that could be something quite transactional rather than something particularly intimate because of her experiences growing up. Dr Camden Smith accepted that her view that DY thought sex was not special had not been specifically explored with DY but was based upon DY's presentation. She confirmed that DY understood the mechanics of the sexual act, the risk of pregnancy, and the risk of a sexually transmitted disease. DY had told her that she had said no to sex within the context of her relationship with her boyfriend and that she had had penetrative vaginal intercourse with her boyfriend. The main confusion arose because DY could not conceive of not being in a relationship with her present boyfriend and the nature of DY's cognitive deficit meant that it was much harder for her to analyse things in abstract terms. It would be possible to support her if she expressed a wish in future to have a relationship with someone else. There were times when, unsupported, DY would lose capacity but if she were provided with support then her capacity would not fluctuate.

At paragraph 22, Knowles J acknowledged the "real tension" between:

a desire to protect DY and a decision to permit her freedom to engage in sexual relationships which might place her at some risk. Whilst the MCA 2005 and the case law warns me against losing sight of the fundamental principle that the obligation to protect the incapacitous must be tempered by respect for the autonomy of those with mental disabilities/disorders, my personal experience of meeting DY served to highlight her vulnerability. She was eager to please and found it hard to identify any risks she might face either generally or in relation to the issue of consent to sexual relations. When coupled with an awareness of her difficult personal history, I found myself concerned about her vulnerability in general and acutely conscious of how easy it would be to exploit and harm her. My experience of DY is, I believe, shared by those who have daily contact with her and those who are responsible for her care. Their anxieties about DY shaped the local authority's position in these proceedings and, whilst it was unfortunate that this was not initially as clearly articulated as it might have been, I do not criticise the local authority for taking the stance it did.

The parties were agreed that DY had capacity to engage in sexual relations when she was not upset or distressed, the issue in fact being the narrow – but important – one of whether she had that capacity when she was unsettled or distressed. The local authority – having been required by Knowles J to specify exactly what they sought – sought a prospective declaration to that effect or, alternatively, a declaration in identical or similar terms pursuant to the inherent jurisdiction. The Official Solicitor submitted that the local authority's approach was wrong in principle and wrong on the facts

because (a) the court was required to assess capacity on a general and non-specific basis; (b) the evidence before the court could not rebut the statutory assumption that DY had capacity on that basis; and (c) any concerns about her vulnerability or ability to assess risk could and should be addressed through provision of support and best interest decisions on care and contact.

Rejecting the approach urged upon by the local authority, Knowles J identified that:

25. The law requires that capacity to decide to engage in sexual relations should be assessed on a general non-specific basis. The local authority asserted that its formulation did not fall foul of that requirement because it related to "circumstances as opposed to a particular person". I note however that the requirement to assess capacity on a general basis and the policy underpinning it applies to the timing and circumstances of the decision and not just to the identity of the sexual partner. The passage in IM v LM quoted above [16] makes plain that assessment of capacity to consent to sexual relations can only be on a general basis rather than tied to the specific prospect of a sexual relationship with a particular individual in specific circumstances. Likewise, Hedley J in A Local Authority v H [2012] EWHC 49 (COP) held that capacity had to be decided in isolation from any specific circumstances of sexual activity.

26. Absent from the local authority's written submissions were any standards by which DY's level of distress or unsettledness should be judged to determine whether or not she had capacity to engage in sexual relations.

Though Mr Foster suggested in his oral submissions that plain words such as "upset", "unsettled" and "distressed" would be sufficiently descriptive and that it might be open to the court to provide greater specificity in that regard, I found myself unpersuaded by that submission. Whilst all those particular words might describe DY's mood at any given time, they did not adequately describe the point at which she might cease to have capacity to engage in sexual relations. As I understand the local authority's case, that would seem to be a matter of degree. The difficulty with Mr Foster's submission was that, on each occasion that DY appeared to be unsettled or distressed and was proposing or had the potential to engage in sexual relations, the prospective declaration sought would require an assessment of whether DY was sufficiently distressed or unsettled so as to have lost capacity to engage in sexual relations. That would give wide discretion to individual professionals without any check to ensure that DY's autonomy was respected, and that decisions were not being driven by the desire to protect her.

27. Whilst I acknowledge that prospective declarations of incapacity are permissible pursuant to s 15 MCA 2005, these are exceptions to the general approach. They may be appropriate in cases where there is clear evidence of the circumstances in which a person would or may lack capacity in the future and where there were practical reasons why a declaration or declarations should be made in advance. Neither of those conditions applied in this case. Here, the distress and unsettledness were not well defined and, even if DY did experience such emotions, it could not be assumed

that this would impair her decision-making ability without an analysis of the particular facts pertaining at the time.

Knowles J was clear that she had heard no evidence that would justify an order in the terms sought:

28. Dr Camden Smith's written report did not assert that DY's capacity fluctuated. Although she conceded that, if DY's relationship with AB ended, it might be difficult to say what her capacity was in those circumstances and that, when unsettled, DY may be unable to make a clear and rational decision, Dr Camden Smith did not say that DY would lack capacity applying the relevant statutory criteria. Even if DY's capacity were to fluctuate as was suggested by Mr Foster in questioning, Dr Camden Smith was clear that, if DY were provided with support, she did not think her capacity on this issue would fluctuate. DY's social worker agreed with me that it was very difficult to tease apart how DY might respond to someone other than AB and conceded that she was speculating about what might happen in other situations. At its highest, the local authority's concern that DY may lack capacity to make decisions about engaging in sexual relations when distressed or unsettled was based on speculation as to how DY would respond in circumstances which may not even arise if care and contact were appropriately managed.

The local authority identified a wide range of generic factors about DY's presentation and vulnerabilities. Many of them related to DY's difficulties in assessing the risk that may be posed by others and her awareness of her own

particular vulnerabilities. However, Knowles J considered that they were in fact more directed to an assessment of DY's capacity to make decisions about those with whom she had contact. *"None of them supported a conclusion that DY lacked capacity to make decisions about engaging in sexual relations generally or when she was distressed or unsettled"* (paragraph 29).

Knowles J noted that, although the Court of Appeal had used the word "may" in relation to the information required by its reformulated test in *JB*, following submissions from the parties, she had "tempered her enthusiasm" to add to the list of relevant information. On this basis, and:

33. Standing back and considering the issue in the round, I am satisfied that, at the time she was assessed, DY understood and was able to weigh all relevant information and had the capacity to decide to engage in sexual relations on a general non-specific basis. There was no dispute that she had the capacity to make decisions about sexual relations with her boyfriend, the only person with whom there was any current prospect of having sexual relations. The evidence of both Dr Camden Smith and YZ, DY's social worker, as to how she might respond in other circumstances was uncertain and speculative. She should not be assessed as lacking capacity unless all practicable steps have been taken to support her to make the decision without success, that included putting in place a package of support to limit and/or mitigate the effect of any periods of distress or unsettledness. The local authority's concerns about the risk of abuse and exploitation could be addressed through an appropriate package of care and contact arrangements, decided in DY's best

interests. The prospective declaration proposed by the local authority was unworkable and imprecise.

The local authority had submitted that it would be “unconscionable if the court, recognising [DY’s] vulnerability, held itself unable to protect her due to her situation not fitting within the framework of the MCA 2005.” Whilst Knowles J understood the instincts prompting that submission, she noted that: “DY’s care would be supported within the framework of the MCA 2005 as it is agreed by the parties, and I accept, that DY lacks capacity to make decisions about her care and contact with others. In those circumstances, the MCA 2005 provides an appropriate legal framework for a care package which protects DY from abuse and exploitation. I see no justification for invoking the inherent jurisdiction since it affords no greater scope for making a declaration of incapacity on grounds of a disturbance of the functioning of the mind than exists under the MCA 2005” (paragraph 34).

Knowles J therefore made a final declaration that DY **had** capacity to decide to engage in sexual relations, and directed the local authority “to prepare a care plan that will facilitate this in a way that reduces risk and supports DY to make informed decisions.”

Comment

Starting at the end, it was on one view not open to Knowles J to direct the local authority to prepare a care plan to facilitate DY’s ability to engage in sexual relations, not least in light of her finding that DY had capacity to make that decision. It is, however, entirely understandable why she sought to do so, not least to guide a local authority who were – again for understandable reasons – concerned as to

navigate the line between protection and empowerment.

It might be thought on one view that DY’s case could have been resolved much more simply on the basis of a person-specific test: i.e. by simply being allowed to ask whether DY had capacity to decide to engage in sexual relations with her boyfriend – to which the answer would clearly be yes (whether, in respect of any particular act between them, the act was consensual on both of their parts would be a different issue, falling to be considered, if at all, through the prism of the criminal law as would be the case with anyone). The question of whether DY had capacity to decide to engage in sexual relations would simply not fall to be considered by the court as it was not a live issue, and the court could properly decline to determine it (see, by analogy, *Re SB* [2020] EWCOP 43).

The case also clearly indicates the limits to the courts’ increasing willingness to grapple with the concept of fluctuating capacity, as with (in a different context) the case of *CDM*, DY’s situation could not sensibly be considered through this prism, and Knowles J was plainly correct to conclude that she had to determine either that DY had the capacity to make the material decision or she did not.

This case illustrates in clear terms the difficulties facing statutory bodies – local authorities and CCGs most obviously – tasked with safeguarding vulnerable individuals in the context of sexual relationships.

The jurisdiction of the Court of Protection is, as Knowles J’s judgment reflects, a limited one; the inherent jurisdiction of the High Court, as the judgment also reflects, cannot fill the many gaps

in protection the Court of Protection leaves unguarded. How to protect those who, like DY, fall into those gaps, is still unclear.

There is, in reality, some intellectual incoherence in the determination both that DY *has* capacity to make decisions on sex and the order that the local authority should make care plans to facilitate her sex life in a safe manner. Any lay person reading such a direction would rightly query: how can it be right that DY is assessed to be able to have sex but at the same time to require others to facilitate it? At the coal face of delivery, such orders can lead local authorities open to criticism for facilitating or encouraging sexual activity for vulnerable people in its care – see *Manchester City Council v LC* [2018] EWCOP 30; alternatively, they can face criticism for failing to protect the rights of those who wish to enjoy a sex life and have capacity to do so.

Analysis of the case law – compare the facilitative approach in *TZ* with the protective impulse in *Manchester v LC*; likewise *JB* in contrast to *A Local Authority v B* [2019] EWCA Civ 913 – does, arguably, reflect something of divergence of approach with regard to male and female service users. Perhaps this reflects the continued divergence of views with regard to male and female sexuality that society maintains. How this works in practice remains complex and difficult to advise upon – and may inevitably require a more and more tailored approach to individual capacity assessments as espoused by the Vice President in *Tower Hamlets v NB* and, in turn, more work for those tasked with caring for the vulnerable. How any of this works in the context of the s.27(1)(b) MCA 2005 exclusion of decisions regarding consent to sexual relations remains an open question.

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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](#).

**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](#).

**Rachel Sullivan: rachel.sullivan@39essex.com**

Rachel has a broad public law and Court of Protection practice, with a particular interest in the fields of health and human rights law. She appears regularly in the Court of Protection and is instructed by the Official Solicitor, NHS bodies, local authorities and families. To view full CV click [here](#).



Stephanie David: stephanie.david@39essex.com

Steph regularly appears in the Court of Protection in health and welfare matters. She has acted for individual family members, the Official Solicitor, Clinical Commissioning Groups and local authorities. She has a broad practice in public and private law, with a particular interest in health and human rights issues. She appeared in the Supreme Court in *PJ v Welsh Ministers* [2019] 2 WLR 82 as to whether the power to impose conditions on a CTO can include a deprivation of liberty. To view full CV click [here](#).

**Arianna Kelly: arianna.kelly@39essex.com**

Arianna has a specialist practice in mental capacity, community care, mental health law and inquests. Arianna acts in a range Court of Protection matters including welfare, property and affairs, serious medical treatment and in matters relating to the inherent jurisdiction of the High Court. Arianna works extensively in the field of community care. To view a 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](#).



Scotland editors

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

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](#).

Neil is doing a DoLS refresher (by Zoom) on 29 June 2021. For details and to book, see [here](#).

Neil and Alex are doing a joint DoLS masterclass for mental health assessors (by Zoom) on 12 July 2021. For details, and to book, see [here](#).

Advertising conferences and training events

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

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

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