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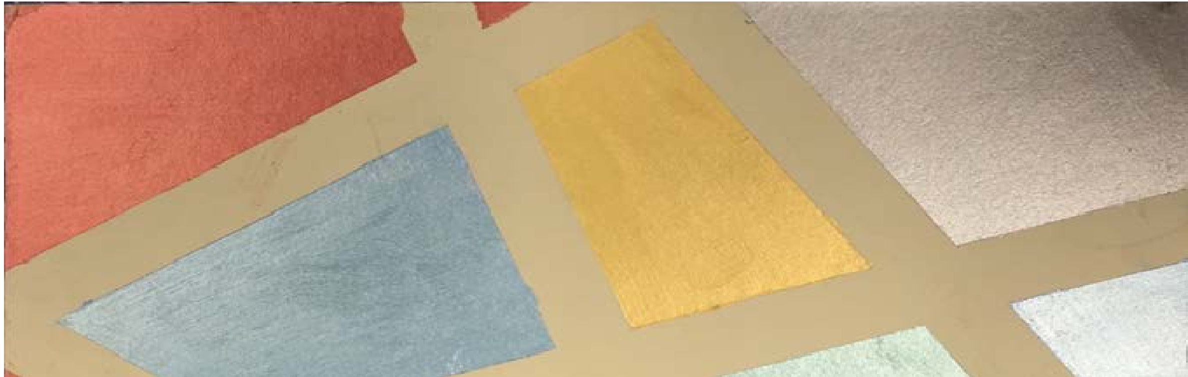

Welcome to the November 2023 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: reasonably adjusting to disability in the context of dialysis and identifying will and preferences across a spectrum of difficult medical cases;

(2) In the Property and Affairs Report: the Law Commission's further consultation on wills;

(3) In the Practice and Procedure Report: two sets of 'Ps' and the costs of welfare appeals;

(4) In the Wider Context Report: the CQC's State of Care report, deprivation of liberty and those under 18, litigation capacity and access to court, and the inherent jurisdiction in Ireland;

(5) In the Scotland Report: bureaucracy vs justice and a tribute to Adrian upon his retirement from one of his posts.

You can find our past issues, our case summaries, and more on our dedicated sub-site here, where you can also sign up to the Mental Capacity Report.

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

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The Court of Protection and reasonably adjusting to disability in the context of dialysis

Norfolk and Norwich University Hospitals NHS Foundation Trust & Ors v Tooke & Ors [2023] EWCOP 45 (Hayden J)

Best interests – medical treatment

Summary

As explored in this paper and this "in conversation with," the potential for discrimination in the treatment of conditions requiring dialysis and/or organ donation is large where the person has impaired decision-making capacity. This case shows the steps which are required to ensure that such discrimination does not take place, in the case of a young autistic man with severe learning disabilities and William's syndrome, suffering from end-stage renal failure.

We know the name of the young man at the heart of the case – Jordan Tooke – as Hayden J expressly permitted its publication at the behest of his parents, not least in hopes that it might lead to the identification of a suitable kidney donor, and, more immediately, specialist clothing for him which might help in the dialysis process.

As Hayden J identified at paragraph 3 of his judgment, Jordan had a long-standing phobia of hospitals in general and needles in particular, such that, when the case was last before him in April 2023, "i*t was thought by all concerned, not least Jordan's parents, that he would not be able to tolerate the considerable restrictions and privations involved in haemodialysis treatment.*" At that stage, the question was whether it might be possible for him to receive a kidney transplant, with a consultant nephrologist identifying that "[t]*he capacity to participate, co-operatively, in haemodialysis was a prerequisite of eligibility to be placed on the transplant list.*" He was placed on the transplant list but despite his achievements on the desensitisation programme, a conclusion was reached that he would not be able to undertake haemodialysis without sedation.

This meant that, before Hayden J in October 2023:

> *16. […] as Mr Patel KC, on behalf of Jordan, through the Official Solicitor, rightly says, "stripped to its basics this case is truly about life-sustaining treatment" i.e., whether it would be lawful, right and in Jordan's best interests to receive haemodialysis even where that can only be achieved by the unusual measure of intravenous*

> *sedation throughout the process. I agree with that characterisation, it follows that we are really considering matters of life and death.*

As Hayden J identified (at paragraph 31) in relation to the plan for the actions required to ensure that Jordan could receive haemodialysis in that fashion:

> *There is no doubt that the proposals contemplated by the plan are beyond what has previously been undertaken with other patients. The plans may properly be characterised as pioneering. At every dialysis session, there would need to be an anaesthetist, an operating department practitioner, and airway equipment, including anaesthetic machine/ventilator. This would require haemodialysis to be on the main site and, inevitably, involve allocating important resources which are much in demand.*

As identified by the consultant anaesthetist, Dr M, the plan carried "*significant and troubling risks. Some of those risks involve potentially very serious consequences*" (paragraph 33), but, as Hayden J identified "*the calibration of risk really requires confrontation with the alternatives. Jordan's parents have been both intellectually and emotionally rigorous in the way that they have addressed this issue. They have identified Jordan's quality of life, as I have set out. They have reflected on Jordan's temperament and personality and concluded that he would choose to live. I agree with that conclusion*," such that:

> *35. In many cases where the Courts are asked to consider issues of this magnitude, the contemplated treatment, usually advanced by the family, is often burdensome but ultimately futile. Here, though dialysis is undoubtedly burdensome, it is certainly not futile. On the contrary, it holds out the possibility, by transplantation, of a restoration to health. The real issue is whether the process of dialysis with all its attendant risks is so contrary to Jordan's best interests that it should not be pursued. Having regard to Dr M's clear view that Jordan's sedation can be managed, I have come to the view that the opportunity of dialysis ought to be afforded to Jordan and that such opportunity can properly be said to be in his best interests.*

Comment

In Equality Act terms, this case shows what it means to make reasonable adjustments in order to respond to the needs of a person with both cognitive and physical impairments. The question of resources, hinted at paragraph 31, may well feature in a future case, and we do not envy the judge who has to grapple with the dilemma that will arise at that point.

In MCA terms, the case shows the proper location of decision-making capacity (i.e. relevant only insofar as it was going to make compliance with the requirements of haemodialysis more difficult), and analysis of best interests (i.e. probing the availability of relevant options, and proceeding carefully in light of those options to respect the person's known will and preferences).

In human terms, the case shows the difference that having an advocate makes – in Jordan's case, he had his parents, but what about all of those cases where there is no such advocate?

Termination, will and preferences – another difficult dilemma for the Court of Protection

Re H (An Adult; Termination) [2023] EWCOP

183[1] (John McKendrick KC (sitting as a Tier 3 Judge))

Best interests – medical treatment

Summary[2]

This very difficult case stands out for the careful attempt by the judge – John McKendrick KC (sitting as a Tier 3 judge) – to comply with (in CRPD language) the will and preferences of a woman with a mental disorder undergoing a profound crisis. The questions he had to answer were whether the woman, H, had capacity to make the decision to consent to terminate her pregnancy,[3] and, if she lacked that capacity, whether a termination was in her best interests; and, if a termination were to be in her best interests, whether this should be carried out by a medical procedure (i.e. the administration of drugs) or a surgical procedure.

Ms H was detained under the Mental Health Act 1983 and, with one exception, had been consistent in her wish to terminate her pregnancy, and the judgment contains numerous very graphic descriptions of how she was expressing her wishes. After some judicial probing to obtain clarification, it was common ground that the test under s.1(a) of the Abortion Act 196 had been met in that two registered medical practitioners had in good faith formed the opinion that the termination was less than 24 weeks, and that continuing the pregnancy involved greater risk to her mental health than if the pregnancy were terminated.

No one before the court contended that Ms H had capacity to make the decision whether to terminate her pregnancy, and, endorsing and applying the approach set down by HHJ Hilder in *S v Birmingham Women's and Children's NHS Trust And Another* [2022] EWCOP 10[4] to the relevant information, John McKendrick KC agreed that H lacked the material decision-making capacity.

No one before the court contended that a termination was anything other than in H's best interests. In circumstances where there was in the view of the court, a "*sustained negative view of her pregnancy and a sustained wish for a termination*" (paragraph 116), John McKendrick KC identified that:

> *124. Considering the terms of section 4 2005 Act and the case law above* [including the 'usual suspects' such as *Aintree*]*, in the context of this personal and profound decision for Ms H, I attach significant weight to her wishes and feelings. The fact that her wishes and feelings are supported by the two applicants, their professional witnesses and the Official Solicitor on her behalf, adds significant weight within my assessment of the section 4 2005 Act factors.*
>
> […]

[1] Note, this case citation is clearly wrong, because the Court of Protection has decided very many more than 183 cases in 2023, only 46 have so far been placed in the public domain with neutral citations. For people who want to understand more about why so many cases are not reported, section 2.4 of this article may be useful.

[2] Katie was involved in this case, but has not contributed to the summary or comment.

[3] Parenthetically, and whilst this was the way it was framed before the court, it might in this case be thought that it was not so much a question of consent to a termination, but rather to seeking a termination, in the same way that in JB's case, it was not a question of consenting to sexual relations, but seeking to engage in sexual relations. Indeed, later in the judgment, the judge talks in terms of "capacity to decide whether to terminate her pregnancy" (see, for instance, paragraph 106 ff).

[4] And gently but firmly distinguishing the somewhat problematic decision of Holman J in *Re SB (A Patient: Capacity to Consent to Termination)* [2013] EWHC 1471 (COP).

> *126. Applying significant weight to Ms H's wishes and feelings and the clear medical evidence which points to the significant harm to her mental health, and in the context of manageable risks to her physical health of what is often a routine medical procedure, I am satisfied that a termination represents the correct balancing of the section 4 2005 Act factors and make an order to that effect.*

The much more difficult matter, however, was what form the termination should take – medical or surgical. Ultimately, and agreeing with the approach set out by the Official Solicitor, John McKendrick KC found that:

> *137.* […] *Ms H's very strong wish for a termination and her stronger wish not to have a surgical termination have a powerful role in the section 4 2005 Act best interests analysis. Whilst I have found her to lack capacity to make this decision and I have found her to have false and delusional beliefs, the termination of her pregnancy remains a profoundly personal one for her. It may not matter very much to her whether the foetus is alive or dead, whether it is one foetus or twins or whether the conception was a result of rape. She has a visceral desire to be free from her pregnancy and she has elaborated consistently and clearly her firm desire for a medical termination and opposition to a surgical termination. This perspective is not one the court is unable to give effect to. On the contrary, it is supported by two NHS Trusts. It is also, on balance, supported by the Official Solicitor. Notwithstanding my concerns in respect of Ms H's non-compliance with a medical termination and the risks of her being deeply anguished during the 24-48 hour period, I consider this less psychologically harmful to her than being conveyed and possibly restrained en route to Newcastle* [where a surgical termination could take place], *where she would then be faced with being in hospital against her will for around 24 hours and would quite likely require chemical or physical restraint, given her opposition to a surgical termination.*
>
> […]
>
> *139. Sadly, there is no good option for Ms H. Both procedures are fraught with risk to her mental health and lesser risks to her physical health. Having heard all the evidence and met with Ms H, when she clearly told me she wants a medical termination, respect for her autonomy and dignity in matters of her reproductive health, lead me, by applying section 4 of the 2005 Act, to authorise a medical termination in her best interests. I will make that order accordingly pursuant to section 16 of the 2005 Act.*

Whilst he was content to the authorise covert medication as potentially having a "powerful role" in comforting Ms H (paragraph 140), John McKendrick KC was much more uncomfortable with the proposal to authorise restraint:

> *141.* […] *This arises primarily because the case articulated by the Trusts is that such a procedure is consistent with Ms H's wishes. I also consider that the state must pause very carefully before authorising the restraint of a vulnerable young woman as she undertakes an intimate procedure in respect of her reproductive health. However, I am persuaded to authorise restraint only in circumstances where the medical termination has begun, Ms H has been administered the medication described above, but after the passage of time, either the foetus or placenta or both have not been discharged and the clinicians require, to protect Ms H's*

> *safety, to carry out a vaginal examination.*

However, he was not prepared to make further orders or declarations beyond those identified above:

> *142. […] If there is a medical emergency then clinicians must be guided by what is necessary to safeguard Ms H's life. Those clinicians, in the moment, are likely to have better information than the court has, considering hypotheticals now.*

Having focused on Ms H's immediate needs, John McKendrick KC concluded with a marker that:

> *144. […] I have not had time to consider whether this application has been delayed and whether it should have been brought earlier. If an application is made for further relief, I shall consider that matter. I note Mrs MH's anguish that it has taken until now for a decision to be made on behalf of her daughter.*

Comment

Unlike the only other reported case where the question of whether a termination is in the best interests of the woman lacking the material decision-making capacity – *AB* – this case was, on one view, 'easier,' because of the very clearly expressed, if incapacitous, wishes and feelings of Ms H. However, following through on her will, and her preference not to have a surgical termination, placed the court in a very difficult situation. And, as with his judgment in *Barnet Enfield And Haringey Mental Health NHS Trust & Anor v Mr K & Ors* [2023] EWCOP 35, John McKendrick's judgment here is conspicuous in the way in which he sought to work methodically (even under very considerable time pressure) through that dilemma.

Procedurally, John McKendrick's observations in relation to his judicial visit are also of wider relevance:

> *12. At the outset of the hearing on 16 October 2023 I was informed by Mr Hallin that Ms H wished to meet with the judge who was making the decision. I consulted the Practice Note on Judicial Visits found at [2022] EWCOP 5, dated 10 February 2022. I endeavoured to follow this guidance. I consulted with the parties regarding the purpose of the meeting and the practicalities. I agreed to meet with Ms H by way of Microsoft Teams with her solicitor, Ms O'Connell, present. Ms O'Connell took a note of our meeting which I approved the following day which was then circulated to all parties. When I met with Ms H she was in a room at the hospital where she is detained. She was initially present with her two support workers and Ms G (the family liaison officer). As she is a witness, I asked Ms G to leave, which she agreed to. I spoke with Ms H for around ten minutes in the presence of her two support workers. She was agitated. She told me she was wanted a termination and when I asked her whether she would want a medical or surgical termination she clearly chose a medical termination.*
>
> *13. The purpose of my visit was largely to comply with Ms H's wish to meet with the judge. Given the terms of section 4 (4) of the 2005 Act, there is a duty on the court "so far as reasonably practicable, [to] permit and encourage [Ms H] to participate, or to improve her ability to participate, as fully as possible in any act done for her and any decision affecting her." I did not require to see Ms H to ascertain her wishes and feelings. These had been comprehensively set out in a most helpful attendance note exhibited to a witness statement (see below).*

> *14. A decision to terminate a pregnancy is a profoundly personal one. It would have been inconsistent with the duty on the court to both promote Ms H's autonomy, and to respect her dignity, for the judge not to have met with her, at her request. It was a privilege to meet with Ms H.*

Short note: is the will to live determinative?

Northern Care Alliance NHS Foundation Trust v KT & Ors [2023] EWCOP 46 concerned a 53 year old man with end-stage kidney failure who had sustained brain damage during treatment and was now in a prolonged disorder of consciousness. The treating Trust sought a determination that continued dialysis was not in KT's best interests given the risks of treatment, his limited life expectancy, his lack of awareness and the risk of an unplanned and unpleasant death. The application was opposed by members of KT's family, all of whom were Pentecostal Christians who believed in the power of prayer and the potential for miracles. KT himself was a pastor, and his family argued that in light of his firmly held religious beliefs, he would want treatment to continue. They also considered that KT retained some minimal awareness.

Despite neither the Trust nor the Official Solicitor accepting the family's evidence., the court unhesitatingly found that KT would not have wanted treatment to be withdrawn notwithstanding the medical evidence. '*He would rather suffer and hold out for the will of God'*.

Nevertheless, Hayden J found that continued treatment was not in KT's best interests. His likely wishes were not determinative, and, the court found, he would not have wanted to cause distress to medical professionals and carers by requiring them to continue to provide futile and burdensome treatment to him.

Previous cases have held that where a person's wishes as to the continuation of life sustaining treatment prior to losing capacity should be followed, where they can be ascertained with sufficient certainty. This case suggests that the same approach will not necessarily be applied when those wishes are for the continuation of treatment rather than its withdrawal, though no explanation of the difference in approach is given.

Short note: anorexia and the impossibility of the Official Solicitor's role

Gloucestershire Health & Care NHS Foundation Trust v FD & Ors [2023] EHWC 2634 (Fam) concerned the capacity and best interests of a 17 year old woman who first developed anorexia around the age of 4 or 5, and who had been in one medical institution or another since 2007. She described her situation as 'torture.' The treating Trust responsible for her care sought declarations that she did not have capacity to conduct the proceedings, or to make decisions regarding her nutrition and hydration, and that it was not in her best interests to for active treatment to be provided in the face of her wishes. The Trust also sought declaratory relief as regards their obligations under the Mental Health Act 1983.

Francis J's judgment is careful and comprehensive, but it is not necessary for present purposes to set out the details of FD's life and challenges, underpinning his decision to grant the declarations sought. Of wider relevance are the observations about the role of the Official Solicitor in circumstances where FD assert she had capacity to make decisions about nutrition and hydration. Francis J set out a note on the role of the litigation friend prepared on behalf of the Official Solicitor, to explain to FD the "*apparent dichotomy between FD's wishes and what been advocated to me by the Official Solicitor*

on her behalf" (paragraph 41). The note concluded that:

> *Hence, in acting as litigation friend, the Official Solicitor must act in P's best interests. In so doing, the Official Solicitor will have careful regard to P's wishes and feelings, but ultimately she [the Official Solicitor] must act for P's benefit and in P's interests. She must consider and assess legal advice that she receives. In fulfilling her role she may sometimes have to take a position that is contrary to the wishes and feelings of P.*

In acceding to the Trust's application in relation to the MHA 1983, Francis J accepted the Trust's' submission that declaratory relief not to impose such treatment was likely *"to be extremely helpful to FD in understanding that compulsory treatment has, on the basis of current evidence, been taken off the table*" (paragraph 57). Francis J did not order, because he could not, that FD be discharged from detention under the MHA 1983, but accepted that what he had decided in relation to treatment would have that effect – if that turned out to be different, he wished to be kept informed so that consideration could be given to what should be done.

As with the case of *A Mental Health Trust v BG* [2022] EWCOP 26, this case is fact-specific, and not a general judicial statement about how to address cases of severe and enduring anorexia in teenagers. It is also extremely important to remember that the cases which reach the Court of Protection in this field are, by definition, the most difficult, and there are very many where it is possible to provide appropriate care and treatment so as to enable the person not only to survive but to go on to thrive.

The note read into the record about the role of the Official Solicitor for FD's benefit is to not surprising, reflecting as it does long-standing case-law. It is, however, a standing problem for the representation of P – in this case, as in very many others, the Official Solicitor is having to do the dual role of being the advocate for P, and assisting the court with what might be best for P. Many, including Alex, have long thought that this is – properly analysed – to give rise to a fundamentally impossible position, no matter how diligently and conscientiously the current incumbent of the post, her office holders, or the lawyers she instructs are. In the instant case, I note, had FD's case been determined before the Family Division, it is quite possible that she would have had her own lawyer arguing the case on her behalf, and CAFCASS assisting the court to tease out what, ultimately, the right course of action to take would be. It might be thought that the time has come to rethink whether or not there should be a similar split in the Court of Protection.

Sexual capacity and sexual risk

Re PN (Capacity: Sexual Relations and Disclosure) [2023] EWCOP 44 (Poole J)

Mental capacity – sexual relations

Summary[5]

This matter related to PN, a 34-year-old man who had diagnoses of a mild learning disability and autistic spectrum disorder. There was no dispute as to PN's diagnoses or his lack of capacity to conduct proceedings, or to make decisions as to his residence, care, contact with others and use of the internet and social media. The issue before the court was whether PN had capacity in relation to three issues:

[5] Tor having been involved in the case, she has not contributed to this note.

(1) to make decisions about engaging in sexual relations;

(2) disclosing information about the risk of sexual harm he posed to others; and

(3) about allowing the Local Authority to disclose information about the risk of sexual harm he posed to others.

The local authority heard evidence from forensic psychiatrist Dr Chris Ince, and PN's social worker, Mr Curran (who gave evidence only in relation to the second and third domain). By the conclusion of the hearing, all three parties in the matter agreed that PN had capacity to take decisions in the three domains above for himself.

PN had a history of sexual offending, and the judgment states that it had been given "*a very long list of incidents of concern stretching back to 2001 which includes multiple examples of sexual assault by unconsented-to touching, typically of women's breasts or legs*" (paragraph 5). The judgment states that most of these acts were opportunistic, and there was no evidence that PN had ever committed rape or had sexual intercourse with consent. He had one police warning but no convictions. PN's sexual interests related to adult women, not children. PN had a full-scale IQ of 69 and Dr Ince felt that where PN had been offered a range of interventions over a matter of years, he would not likely to "make substantive gains in terms of the internalisation of risk management and self-awareness of risk" (paragraph 4).

PN's ability to make decisions regarding sex appears to have been considered over a period of years, by many professionals. The evidence appeared to be consistent that PN did understand what sexual assault and consent were, and what conduct was illegal. The primary issue was that PN continued to behave impulsively when he was in proximity to women. PN did accept that he had touched women without their consent in sexual manner, but appeared to minimise his conduct by saying that the incidents were not "serious" (paragraph 6(v)). In discussions with his social worker, PN stated that others might want to know about his history for their own protection.

Poole J summarised the evidence at paragraph 6(vii)-(x):

> *vii) In his oral evidence, Dr Ince was asked to analyse why, if as he confirmed, PN can understand, retain, and weigh the relevant information in relation to the decision to engage in sexual relations, including the relevant information in relation to consent, he nevertheless sexually assaults women. Dr Ince's view was that PN was able to use the relevant information but that he chose to touch women even though he knew they had not consented to him doing so. His impulse to touch women in this way was not rooted in his ASD. He was not generally impulsive – there is no evidence that he acts on impulse in other fields of activity. Dr Ince does not accept that PN is overwhelmed by impulse due to his impairments.*
>
> *viii) Reports are that when PN is with his brother or with a member of staff whom he respects, he does not engage in sexual offending. This suggests that he is capable of suppressing his sexual impulses.*
>
> *ix) After the most recent sexual assault, on 24 August 2023, PN admitted what he had done and told staff afterwards that he felt bad about his actions. This shows awareness both of the consequences of his actions and that he ought not to act as he did on that occasion.*
>
> *x) Dr Ince's opinion is that even if the view were taken that PN is unable to use the relevant information about consent*

> *at a moment when he has an impulse to touch a woman sexually, that inability is not caused by his ASD and/or learning disability. His impulsive actions are not a manifestation of his impairments but are behaviours that stem from PN's character and outlook.*

Poole J applied the test for capacity as set out by the Supreme Court in *A Local Authority v JB* [2021] UKSC 52, [2022] 3 All ER 697, and considered other cases (in particular the judgment in *Hull City Council v KF* [2022] EWCOP 33, in which he previously adopted a person-specific approach) where the court had applied a test for sexual capacity which was tailored to the individual circumstances of the person. Poole J considered that in *JB*:

> *10.* [...] *Lord Stephens judgment appears to me to recognise that the relevant information may differ from case to case. He expressly held that in certain cases the approach should be person-specific and that the "reasonably foreseeable consequences of deciding one way or another may be different" [72]. He gave the example that the risk of a sexually transmitted infection may not be part of the relevant information that has to be understood, retained, weighed or used if the circumstances of the case render that irrelevant. Hence, Lord Stephens' judgment establishes that there is no requirement that all of Baker LJ's relevant information must apply in every case. The relevant information will depend on P's circumstances, their sexual orientation, sexual practices and preferences, whether there is an identifiable person or persons with whom they are likely to have sexual relations, and what the characteristics are of that person or those persons.*

Poole J also considered the 'protection imperative' post-*JB*, finding that:

> *11.* [...] *there may be a natural desire to protect those with whom P might want to have sexual relations, in particular in cases where P has a history of sexual offending. Lord Stephens repeatedly refers to the MCA 2005 protecting not just P, but others – at [92], [106], and [107]. However, it seems to me, although the issue of the consent of others to sexual relations has entered the list of relevant information, the Court of Protection must not allow the desire to protect others unduly to influence a clear-eyed assessment of P's capacity. The unpalatable truth is that some capacitous individuals commit sexual assault, even rape, but also have consensual sexual relations. An individual with learning disability, ASD, or other impairment, may act in the same way, but it is only if they lack capacity to make decisions about engaging in sexual relations that the Court of Protection may interfere. If P would otherwise have capacity, then the court should not allow its understandable desire to protect others to drive it to a finding that P lacks capacity, thereby depriving P of the right they would otherwise have to a sexual life. The Court of Protection should not assume the role or responsibilities of the criminal justice system. One of the core principles of the MCA 2005 is that "a person is not to be treated as unable to make a decision merely because he makes an unwise decision" – s1(4). Deciding to act in a way that might be a criminal offence would be an "unwise" decision. Such decisions might contribute to a determination of a lack of capacity, but P is not to be treated as unable to make a decision merely because they may make a decision to act in a way that might amount to a criminal offence.*

In applying this framework to PN, Poole J considered that "[d]*ue to his living arrangements, character, and impairments he is not, has never*

been, and is very unlikely to be involved in a relationship or even in an encounter where there is a prospect of the other person becoming pregnant or where there is a chance of either contracting a sexually transmitted infection. The decisions he will be making in the future are in relation to touching others. I cannot completely exclude the possibility that PN might find himself having to decide about engaging in sexual intercourse but in reality, paragraphs (1), (4) and (5) of Baker LJ's formulation of the relevant information are not likely to be relevant to PN's decision-making about sexual relations. Nevertheless, as it happens, the evidence is very clear that he has an understanding of and is able to retain, and weigh or use the relevant information within those paragraphs of Baker LJ's formulation" (paragraph 12).

Poole J similarly considered that there was no history of PN being propositioned to engage in sexual activity, and PN did not fixate on any particular person. The evidence was that PN did understand, retain and was able to use and weigh the bilateral nature of consent, and was able to do so even when he felt the impulse to touch a woman without her consent:

> *16.* [...] *He chooses to surrender to the impulse but that does not mean that his ability to use the information is lost. To borrow a phrase used by Dr Ince during his oral evidence, PN knows that he should not touch, but thinks "Hang it! It is what I want to do." In any event, accepting as I do the expert opinion evidence of Dr Ince on this matter, I find that PN surrenders to his impulse because of his character and outlook not because of his impairments. His impairments do not cause him to lose his control in other fields of activity, or his sexual control in other settings. His sexual impulsivity is not a manifestation of his ASD and/or learning disability. There is no pattern of impulsivity due to his impairments of which his sexual offending is a part. When with his brother or others whose disapprobation he might want to avoid, he controls any impulses to sexually touch women. He disregards the need for consent but he remains able to use the information he retains, namely that the consent of the other person is necessary.*

Poole J was mindful that PN might ultimately end up committing criminal offences, but emphasised that the court must make the decisions currently before it on the basis of the MCA. Poole J considered whether to have capacity, it was necessary for PN to understand, retain and use and weigh information about the likely repercussions for him of sexually assaulting people. Poole J noted that as a matter of fact, PN had had very few such repercussions, and he had "*managed to avoid sexually assaulting others in circumstances where they or another person with them might react violently towards PN. I am quite satisfied, on the evidence provided to me, that PN understands and retains the information that there are liable to be such repercussions from his decisions*" (paragraph 18).

Poole J considered the extent to which "*the potentially harmful consequences to the other person of sexual assault or even rape should be part of the relevant information P must be able to understand, retain, and weigh or use in order to have capacity to make a decision to engage in sexual relations*" (paragraph 19). Looking to *JB*, Poole J considered that "[t]*he Supreme Court has determined that understanding of the necessity of consent is sufficient. If P is able to understand, retain, and weigh or use information that it is necessary for others to be able to consent, and to consent in fact to sexual relations with him, then the court need not enquire into whether P has the ability to understand or envisage the ramifications of initiating or continuing sexual relations without consent*" (paragraph 19).

Poole J concluded that PN had the requisite capacity both to give consent to sexual relations and to initiate sexual activity.

In relation PN's capacity to make decisions relating to disclosure of information, Poole J noted that PN would at times deny his history. However, the view of his social worker, who knew him well, was that PN was motivated by embarrassment and fear of getting into trouble. At more candid times, Poole J found that "*PN does understand that he has a history of sexual offending which others might wish to know in order to protect themselves*" (paragraph 22). Poole J queried the practicality of how disclosures of his offending history would be made – and identified that people with capacity might also struggle to decide when to share information about a history of offending. Poole J also noted that decisions about sharing information would need to be taken in the best interests of PN, rather than the best interests of those who might be protected from him. Poole J was also unclear the extent to which decisions about disclosures would be required.

> *24. […] …He has never been in a relationship, he has not, it appears, had intercourse, and he has not ever been accused trying to rape anyone or to persist with an assault after his initial sexual contact has been repelled. Decisions about disclosure of information about past behaviour to others are very complex. Many capacitous individuals would struggle with them. It is important not to allow consideration of capacity to make a complex decision on disclosure to deprive PN of autonomy in relation to his decisions to engage in sexual relations for which he does have capacity.*

Poole J was keen to establish that his findings should not be taken as 'guidance for future decision-makers,' but set out that "*for present purposes I assume that the relevant information will include the risks to others that arise from the previous offending, how the disclosure of information might be given so as to allow others to avoid or mitigate such risks and prevent P from committing offences which could have adverse consequences, and the reasonably foreseeable consequences of sharing or not sharing the information*" (paragraph 25).

Poole J found that PN had the requisite capacity "*to make decisions about sharing information about his offending history with others*" (paragraph 26). PN had been clear about his opposition to the local authority's sharing information on his offending history with others, even though he recognised that it would do so to keep himself and others safe.

Poole J finally considered whether the totality of the findings on capacity were consistent (in particular the finding that PN lacked capacity to make decisions about contact with others). He concluded that these findings were consistent, as while

> *28. […] PN understands sexual boundaries but he does not understand social boundaries. He sometimes stares at other people and he stares at women's breasts. He knows, as I have found, that he ought not to touch them without their consent. He retains that understanding, and can weigh or use the information even when the urge takes him to touch the other person. However, he does not have the same understanding in relation to staring at or speaking to others. He does not understand the foreseeable consequences of speaking offensively to others, but he does understand the foreseeable consequences of touching them without consent. His lack of understanding in relation to non-sexual contact with others is because of his impairments. That was the conclusion*

> *of Dr Ince. Mr Curran's evidence is consistent with that conclusion. Sexual boundaries are perhaps clearer and so more easily understood by PN even with his impairments, whereas social boundaries are less clear to him and are not understood by him because of his impairments.*

Poole J noted that while there were "*no particular issues about PN's past decisions about whether to spend time with specific people, such as his brother, but there is a concern that he might wish to have in person contact with someone he has "met" online. With PN, his inability to understand social boundaries because of his impairments, means that he cannot understand and weigh or use information about the positive or negative aspects of interacting with members of the public, or other people with whom he does not have a relationship. He cannot foresee the reasonable consequences of interacting with others with whom he has contact when he says offensive things to them or acts in an intimidatory manner*" (paragraph 28). Poole J thus made a refinement to its previous contact capacity declaration, amending it to a finding that he lacks capacity "*in relation to non-sexual contact with others*" (paragraph 28).

Poole J concluded by noting the need for the court to make clear and coherent decisions for those caring for PN, while acknowledging that "[t]*he more refined the decision-making under consideration, the more difficult it can be to delineate the boundaries between different kinds of decision-making and to implement practical care and support. Rather than seeking to identify yet more specific kinds of decision-making, it might be simpler and of more practical use to focus on the core decision-making areas, such as residence, care, contact, marriage, sexual relations, property and affairs, use of social media and the internet, and conduct of litigation, but to be astute to apply the principles involved in assessing capacity to the particular individual characteristics and circumstances of P*" (paragraph 29).

Comment

The case is an interesting and careful consideration of sexual capacity post-*JB*. It appears that in making a finding that PN had capacity, the court and parties both put weight on PN's ability to control his impulses in certain circumstances, and his ability to use and weigh up information about the consequences of offending behaviour. Poole J also repeatedly cautioned against setting the bar for capacity too high, and against succumbing to the 'protection imperative.' The judgment is one which recognises that inherent in autonomy is that people will sometimes use that freedom make bad decisions, or even decisions that harm others, and the Court of Protection must be cautious not to equate poor decisions with an inability to make those decisions.

Separately, it was also helpful that Poole J reiterated the need to approach questions of sexual capacity when they were before the Court of Protection by reference to the MCA 2005, and not by reference to the criminal law. In this regard, some may find useful this webinar on *When P is an Offender*, together with this article: *What place has 'capacity' in the criminal law relating to sex post JB?*

The MHA / MCA interface on discharge

ML v Priory Healthcare Ltd & SSJ [2023] UKUT 237 (AAC) (Upper Tribunal (AAC) (UTJ Jacobs))

Mental Health Act 1983 – interface with the MCA 2005

The interface between the MHA 1983 and the MCA 2005 has recently been considered at the point of entry. In *ML v Priory Healthcare Ltd & SSJ* [2023] UKUT 237 (AAC), UTJ Church considered

the question from the point of view of exit from detention under the MHA 1983.

The appeal concerned a 63 year old man, ML, who was a restricted patient detained under ss.47/49 MHA 1983. He had been detained for over 35 years, the last 15 years of which had been spent in secure psychiatric hospitals. His tariff (i.e. the criminal aspect of his detention) expired more than 30 years ago. In practical terms, ML wanted to secure a conditional discharge by the Secretary of State. The first step towards this was to seek a notification from the First-tier Tribunal under s.74(1)(a) MHA 1983.

The First-tier Tribunal heard evidence that ML lacked capacity to make decisions in relation to various matters, including whether he should take prescribed psychotropic medication. While the ML's responsible clinician and all but one of the other witnesses for the detaining authority supported ML's continued detention in hospital, expert evidence from an independent forensic consultant psychiatrist instructed by ML and an independent social worker and approved mental health professional instructed by ML, as well as the evidence of ML's primary nurse at the hospital, indicated that he could be managed effectively in the community with 24 hour support in the context of a conditional discharge, with any necessary deprivation of liberty being authorised under MCA 2005, in accordance with the principles set down in *MC v Cygnet Behavioural Health Ltd and Secretary of State for Justice (Mental Health)* [2020] UKUT 230 (AAC).

It was argued before the First-tier Tribunal that, in light of this evidence: (a) continued detention in hospital was not necessary; (b) s.72(1)(b)(ii) MHA 1983 was not satisfied; and (c) s.73 MHA 1983 required that ML be discharged from detention.

The First-Tier Tribunal decided, however, that (a) each of the statutory criteria for detention were satisfied; and (b) had ML been subject to a restriction order under s.41 MHA 1983, he would not have been entitled to be discharged from liability to be detained in hospital for medical treatment. UTJ Church noted that:

> *25. While the First-tier Tribunal acknowledged Mr Pezzani's submission, it did not say what it made of it: "Mr Pezzani also contends that the Patient lacks capacity to make decisions about many of his post discharge needs and that a DoLs care plan would be available" (see para. 16 of the FtT Decision at p. 258 of the appeal bundle).*
>
> *26. It appears from this short acknowledgement, and its "noting" in para. 21 that "the only environment where his medication regime can be enforced is in hospital" that, rather than rejecting Mr Pezzani's argument, the First-tier Tribunal simply ignored it.*

On appeal, UTJ Church endorsed the approach taken by UTJ Jacobs in the *Cygnet* case. He had:

> *38.* […] *considerable sympathy for the First-tier Tribunal having to grapple with what was a very complex matrix of considerations, but Mr Pezzani had made a clear case, supported by evidence, that conditional discharge with a full care package to 24-hour staffed specialist accommodation represented an alternative means of containing the risks that a failure by the Appellant to comply with his prescribed medication might eventuate. It was incumbent on the First-tier Tribunal to address that case and to explain how it came to conclude that the section 72(1)(b) criteria were nonetheless satisfied, and that continued detention represented the least restrictive option for the management of the concerns arising from the Appellant's mental disorder.*

> *39. It appears that the First-tier Tribunal was under the misapprehension that there was no way for it to co-ordinate the 1983 Act proceedings with a 2005 Act authorisation, and it made its decision on the section 72(1)(b) criteria without reference to the possibility that an alternative framework for managing the Appellant was available. That amounted to a material error of law.*

If, contrary to UTJ Church's understanding of the position, the First-tier Tribunal considered the possibility but dismissed it, he found that the Tribunal's failure to deal with it expressly rendered the reasons inadequate which, itself, amounted to a material error of law.

The decision therefore fell to be remitted to the First-Tier Tribunal to be reconsidered on the correct legal basis.

Comment

The decision provides a helpful reiteration of the need for coordination between those concerned with the MHA 1983 and those concerned with the MCA 2005 on exit from detention under the MHA 1983. It might be thought that the presence of alternative frameworks in the community to manage the concerns arising from mental disorder should be considered equally relevant to the question of whether a person should be detained under the MHA 1983 in the first place.

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Conferences

Members of the Court of Protection team regularly present at seminars and 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.

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

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