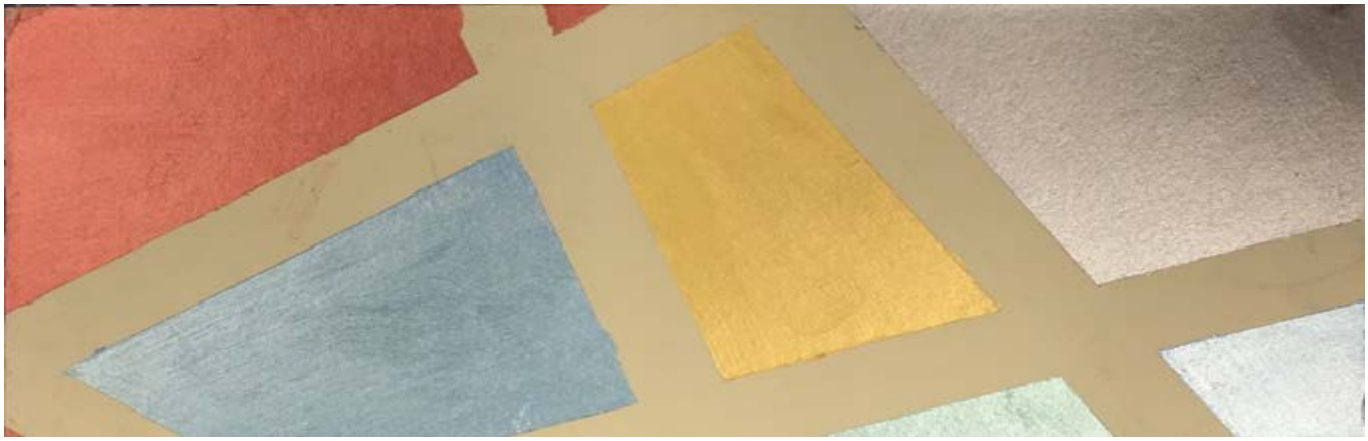
MENTAL CAPACITY REPORT: HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

February 2017 | Issue 73



Welcome to the February 2017 Mental Capacity Report. You will note a new look, and also a new title, which reflects the fact that over the years we have evolved to carry material that goes considerably wider and deeper than in a conventional Newsletter. We have also retitled the individual sections of the Report (which you can continue to get in compendium and screen-friendly forms).

Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: positive obligations under Article 5, deprivation of liberty in the intensive care setting, and best interests in the context of childbirth and anorexia;

(2) In the Property and Affairs Report: common mistakes in making LPAs;

(3) In the Practice and Procedure Report: costs in medical treatment; an important case on time-limits in HRA cases, frustrating the Court of Protection and the end of era marked for the Court of Protection Practice;

(4) In the Wider Context Report: a new MCA/DOLS resource, capacity and the MHT, restraint in the mental health setting, mental health patients in general hospitals and truth and lying in dementia;

(5) In the Scotland Report: solicitors claiming an interest and the *nobile officium* comes to the rescue.

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You can find all our past issues, our case summaries, and much more on our dedicated sub-site here. 'One-pagers' of cases of most relevance to social work professionals will also appear on the SCIE website.

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

Contents

Briggs update

By way of update to our report upon the decision of Charles J in *Briggs v Briggs (2)* [2016] EWCOP 53, the Official Solicitor ultimately decided not to appeal. Mr Briggs died in a hospice on 22 January.

Positively Article 5

Secretary of State for Justice v Staffordshire CC & Ors [2016] EWCA Civ 1317 (Court of Appeal) (Sir Terence Etherton MR, Elias and Beatson LJJ)

Article 5 – Deprivation of Liberty

Summary

The Court of Appeal has dismissed the Secretary of State's appeal against the decision of Charles J in *Re SRK* [2016] EWCOP 27. By way of refresher, Charles J found in that case that the state was indirectly responsible for "private" deprivations of liberty arising out of arrangements made by deputies administering personal injury payments. The Secretary of State for Justice ('SSJ') appealed the decision on two grounds.

1. The combination of the existing civil and criminal law and the obligations of public bodies to safeguard vulnerable individuals were sufficient to satisfy the positive obligation of the State under Article 5 where the day to day care of a person, who was objectively deprived of liberty but lacked capacity for the purposes of the MCA to consent to that loss of liberty, was being provided entirely privately rather than by the State. In particular, the SSJ contended that Charles J was wrong to conclude that, in such a situation, the State's positive obligation under Article 5(1) ECHR can only be discharged if a welfare order is made by the CoP under s.16 MCA authorising the deprivation of liberty pursuant to s.4A(3) MCA;

2. Responsibility for a "private" deprivation of liberty could not be attributed to the State where, as in SRK's case, there was no reason for the local authority or any other public

> body to have any suspicions about abuse, that there was some deficiency in the care provided to the person, that something has been done that was not in their best interests or that the deprivation of their liberty was greater than it could and should have been.

Sir Terence Etherton MR, giving the sole reasoned judgment, had little hesitation in dismissing both of these grounds of appeal.

State's Article 5 obligations

The only live question on the appeal was whether SRK's deprivation of liberty was imputable to the state under the third limb identified in *Storck*: i.e. by way of its failure to discharge its positive obligation to protect him from deprivation of liberty contrary to Article 5(1).

The Master of Rolls held that the SSJ had been correct to identify that the State's positive obligation under Article 5(1) is to take reasonable steps to prevent arbitrary deprivation of liberty, and that Charles J had adequately expressed that test in his own language. As Charles J had noted in his judgment, *Storck* does not help on whether, in any particular case, the proper or the defective performance of a regime that has been put in place pursuant to the positive requirement of Article 5(1) would amount to a violation of that positive obligation. In other words, the Master of the Rolls held (at para 63) "*Storck* does not identify what has to be in place to meet the minimum requirement of Article 5(1)."

The Master of the Rolls accepted that the ECrtHR in *Storck* left open the possibility that a regime short of the requirement of a Court order and court supervision might be adequate for the State to meet its positive obligations under Article 5(1). It was the SSJ's case, he noted, that "notwithstanding the absence of a requirement for a welfare order from the CoP, the United Kingdom's existing domestic regime of law, supervision and regulation in respect of incapacitated persons who are being treated and supported entirely in private accommodation by private providers is sufficient compliance with the State's positive obligation under Article 5(1), at least where the public authorities have no reason to believe that there has been any abuse or mistreatment" (para 65). The SSJ relied particularly on the functions of the Care Quality Commission, the functions of the Public Guardian, the professional responsibilities of doctors and other health professionals, the safeguarding obligations of local authorities, and (in the words of the SSJ's skeleton argument) "the general framework of the criminal justice system and civil law."

However, Sir Terence Etherton MR held, Charles J had been both entitled, and right, to dismiss that argument:

> *74. The critical point, as Ms Nageena Khalique QC, for the Council, emphasised, is that, although local authorities and the CQC have responsibilities for the quality of care and the protection of persons in SRK's position, they will only act if someone has drawn the matter to their attention and there is nothing to trigger a periodic assessment. The same is true of doctors and other health professionals. Save where there are already proceedings in the CoP (when the functions of the Public Guardian will be engaged), the current domestic regime depends on people reporting something is wrong, and even then it will only be a notification of grounds for concern at*

that specific moment in time. That may be particularly problematic in cases where no parents or other family members are involved in the care and treatment. It does not meet the obligation of the State under Article 5(1) to take reasonable steps to prevent arbitrary deprivation of liberty.

75. For the same reasons, as was stated by the ECrtHR in Storck*, criminal and civil law sanctions which operate retrospectively after arbitrary deprivation of liberty has occurred, are insufficient to discharge the State's positive obligation under Article 5(1).*

Sir Terence Etherton MR therefore held that:

78. The Judge was fully entitled, and right, to conclude in the circumstances in paragraphs [143] and [146] that, absent the making of a welfare order by the CoP, there are insufficient procedural safeguards against arbitrary detention in a purely private care regime.

79. The fact that, as the Judge acknowledged in paragraph [147], in the present and in many other such cases, a further independent check by the CoP will add nothing, other than unnecessary expense and diversion of resources, does not detract from the legitimacy of his conclusion since, as he observed in paragraph [148], there are other cases where the person lacking capacity will not have supporting family members or friends, and deputies and local authorities may not act to the highest requisite standards. No doubt, as the Judge observed in paragraph [148(v)], the practical burden of such applications would be reduced, in a case such that of SRK, by a streamlined paper application for the making of the initial welfare order and paper reviews.

The relevance of abuse

Sir Terence Etherton MR was equally dismissive of the second ground of appeal:

83. Turning to the second substantive part of Ms Kamm's submissions, I do not accept the SoS's argument that, since each case of an alleged breach of Article 5(1) is fact dependant, there was no breach by the State of its positive obligation under Article 5(1) in the present case because SRK's care regime was in his best interests and was the least restrictive available option, and there was nothing to suggest the contrary to the Council or that there was any abuse. That is an argument that, even where there is objective and subjective deprivation of liberty of an individual, of which the State is aware, there can be no breach of Article 5(1) if the individual is being cared for, supported and treated entirely privately and happens to be receiving a proper standard of care in accordance with the requirements of the MCA at the particular time the State becomes aware of the deprivation of liberty. There is nothing in the jurisprudence to support such an argument. It runs counter to the interpretation and application of the spirit of Article 5(1) in, for example, HL and Cheshire West, in which the focus was entirely on the State's duty to prevent arbitrary deprivation of liberty and not on the quality of care and treatment actually being provided or, indeed, on whether the best and least restrictive treatment would not have involved deprivation of liberty of the individuals in those cases.

By way of concluding observation (without express reference to the Law Commission's work, but surely with this in mind), the Master of the Rolls noted:

> *83. Finally, it is important to note that, while an application to the CoP is necessary in the present state of law and practice for the State to discharge its positive obligation under Article 5(1), such a step might not be essential if a different legislative and practical regime were to provide for proactive investigation by a suitable independent body and periodic reviews. It would, as Ms Kamm said, be for the Government to fill the gap as it had done in the case of the Bournewood gap.*

Comment

It is difficult to see how the Court of Appeal could have reached any other conclusion than that reached by Sir Terence Etherton MR, although it is notable that he did not seem to have reached it with the same degree of reluctance as did Charles J.

The ratio of the decision of the Court of Appeal would appear to apply to "private" arrangements made by any court appointed deputy (whether or not they are administering a personal injury payout). Trickier is the question of whether or not they apply to "private" arrangements made by an attorney as an attorney, unlike a deputy, is not appointed by the state. However, Charles J had at first instance referred to the potential for an attorney paid personal injury damages as one of those who should be required to know that the regime of care and treatment creates a deprivation of liberty within Article 5(1), and Sir Terence Etherton MR made no comment upon this (see para 60).

More broadly, in the circumstances, it seems that there is now really very little distinction between "public" and "private" deprivations of liberty: wherever the state is or, ought, to be aware of a person being confined under arrangements to which they cannot consent, then they will need to take steps to ensure that confinement is authorised. Absent legislative change to enable administrative procedures to be used, it will be necessary to obtain authority from the Court of Protection under the *Re X* procedure.

It is in this regard unfortunate that the Court of Appeal did not take the opportunity to confirm whether it is, in fact, the responsibility of the deputy (or – by analogy – attorney) to seek such an order in such cases. What, of course, is particularly problematic with any approach which requires steps to be taken on behalf of the person concerned is that they will inevitably cost money, money which (in most cases) will have to come from their estate. In cases such as SRK's, it is possible to factor this into any personal injury award, but in other cases it does come dangerously close to suggesting that people should pay for the privilege of having their detention authorised to comply with the State's obligations.

The Secretary of State for Justice is not seeking to appeal this decision. Until and unless the Supreme Court or Strasbourg determines that "deprivation of liberty" has a narrower meaning than that given at present (as to which, see the discussion of the *Ferreira* case below), it remains the case, therefore, that the tentacles of the state

will – inevitably – have to extend ever further into private settings in the name of protecting Article 5 rights. Alex, at least, has his own thoughts as to how we might find a principled way to define deprivation of liberty in a way which returns to its core meaning of coercion, but those are for another day.

Deprivation of liberty in ICU

R (Ferreira) v HM Senior Coroner for Inner South London and others [2017] EWCA Civ 31 (Court of Appeal (Arden and McFarlane LJJ, Cranston J))

Article 5 – deprivation of liberty

Summary[1]

Maria Ferreira died in an intensive care unit after she dislodged a tube with her mittened hand. An inquest was to be held but whether a jury was required depended upon whether she died in "state detention" under ss 7 and 48 of the Coroners and Justice Act 2009. A key issue, therefore, was whether "state detention" equated to "deprivation of liberty" under Article 5(1) ECHR and the relevance of the Supreme Court's decision in *Cheshire West*.

The Court of Appeal concluded Ms Ferreira was not in state detention for three alternative reasons: (1) *Cheshire West* did not apply; (2) if it did apply, she was free to leave; and (3) unlike MCA s 64(5), the CJA 2009 does not expressly require consideration of Article 5 and ICU is not state detention.

(1) Cheshire West distinguished

Arden LJ (giving the sole reasoned judgment of the court) accepted that there was a substantial overlap between "state detention" and "deprivation of liberty", although it need not bear the exact same meaning. The primary answer to the issue was to be found in Article 5 (para 78) and, accordingly, she was:

> *10… not deprived of her liberty at the date of her death because she was being treated for a physical illness and her treatment was that which it appeared to all intents would have been administered to a person who did not have her mental impairment. She was physically restricted in her movements by her physical infirmities and by the treatment she received (which for example included sedation) but the root cause of any loss of liberty was her physical condition, not any restrictions imposed by the hospital."* (emphasis added)

It seems that, where a person's deprivation of liberty could not be justified under the exceptions in Article 5, regard could be had to the purpose of the liberty interference (para 81). Moreover, relying upon *Nielsen v Denmark* (involving a 12 year old in a psychiatric hospital) and *HM v Switzerland* (elderly person in residential care):

> *85… This case shows, where the detention was not capable of coming within any of the exceptions to Article 5(1), justification is not treated separately from the question whether the person is*

[1] Note, both Tor and Alex being involved in this case and permission being sought by the Appellant to appeal to the Supreme Court, this note has been prepared by Neil Allen.

> *deprived of her liberty. Moreover, the reason for his detention was relevant, and thus the fact that a person is deprived of his liberty in his own interests may prevent the deprivation of liberty from being a relevant deprivation of liberty for the purposes of Article 5.*

The court went on to hold that there is in general no deprivation of liberty where the person is receiving life-saving medical treatment:

> *88… The Strasbourg Court in Austin has specifically excepted from Article 5(1) the category of interference described as "commonly occurring restrictions on movement". In my judgment, any deprivation of liberty resulting from the administration of life-saving treatment to a person falls within this category. It is as I see it "commonly occurring" because it is a well-known consequence of a person's condition, when such treatment is required, that decisions may have to be made which interfere with or even remove the liberty she would have been able to exercise for herself before the condition emerged. Plainly the "commonly occurring restrictions on movement", which include ordinary experiences such as "travel by public transport or on the motorway, or attendance at a football match", can apply to a person of unsound mind as well as to a person of sound mind.*
>
> *89. On this basis, any deprivation of liberty resulting from the administration of life-saving treatment to a person falls outside Article 5(1) (as it was said in Austin) "so long as [it is] rendered unavoidable as a result of circumstances beyond the control of the authorities and is necessary to avert a real risk of serious injury or damage, and [is] kept to the minimum required for that purpose". In my judgment, what these qualifications mean is in essence that the acute condition of the patient must not have been the result of action which the state wrongly chose to inflict on him and that the administration of the treatment cannot in general include treatment that could not properly be given to a person of sound mind in her condition according to the medical evidence.*

An example of physical treatment falling the other side of the line and amounting to a deprivation of liberty requiring authorisation was *NHS Trust I v G* [2015] 1 WLR 1984. Here, a woman of unsound mind was to be prevented from leaving the delivery suite and might be compelled to submit to invasive treatment (a Caesarean section). This treatment would be materially different from that given to someone of sound mind: "*By contrast, I do not consider that authorisation would be required because some immaterial difference in treatment is necessitated by the fact that the patient is of unsound mind or because the patient has some physical abnormality*" (para 90).

The Supreme Court's decision in *Cheshire West* was distinguished "*since it is directed to a different situation, namely that of living arrangements for persons of unsound mind*" (para 91). And policy did not require the acid test to apply to urgent medical care:

> *93… There is in general no need in the case of physical illness for a person of unsound mind to have the benefit of safeguards against the deprivation of liberty where the treatment is given in good faith and is materially the same treatment as would be given to a person*

> *of sound mind with the same physical illness. The treatment is neither arbitrary nor the consequence of her impairment…*
>
> *95. In addition, in my judgment, Article 5(1)(e) is directed to the treatment of persons of unsound mind because of their mental impairment. The purpose of Article 5(1)(e) is to protect persons of unsound mind. This does not apply where a person of unsound mind is receiving materially the same medical treatment as a person of sound mind. Article 5(1)(e) is thus not concerned with the treatment of the physical illness of a person of unsound mind. That is a matter for Article 8. Where life-saving treatment is given to a person of sound mind, the correct analysis in my judgment is that the person must have given consent or the treating doctors must be able to show that their actions were justified by necessity or under section 5 of the MCA. If this cannot be shown, then there has to be some method of substituted decision-making, such as obtaining an order from the Court of Protection." (emphasis added)*

(2) If acid test was applicable, Ms Ferreira was free to leave

If distinguishing *Cheshire West* turned out to be wrong, the court held that Ms Ferreira was under continuous supervision and control but was not deprived because she was free to leave. Contrary to the Law Society guidance, the court held that the focus is on the patient's wish to leave, not that of her relatives to remove her (para 96). The issue was unlikely to arise in practice where a patient with an acute condition was in ICU. If it did, clinicians would likely try to persuade the patient from leaving, but not prevent it. The evidence suggested that clinicians would go so far as to seek urgent advice from the legal team. The court goes on to say:

> *98. Moreover, as I read it, the two-part acid test formulated by Lady Hale in Cheshire West in my judgment was designed to apply only where the second element – lack of freedom to leave – was the consequence of state action, particularly state action consisting of the continuous supervision and control constituting the first element of the test.*
>
> *99. In the case of a patient in intensive care, the true cause of their not being free to leave is their underlying illness, which was the reason why they were taken into intensive care. The person may have been rendered unresponsive by reason of treatment they have received, such as sedation, but, while that treatment is an immediate cause, it is not the real cause. The real cause is their illness, a matter for which (in the absent of special circumstances) the state is not responsible. It is quite different in the case of living arrangements for a person of unsound mind. If she is prevented from leaving her placement it is because of steps taken to prevent her because of her mental disorder. Cheshire West is a long way from this case on its facts and that, in my judgment, indicates that it is distinguishable from the situation of a patient in intensive care.*
>
> …
>
> *105… there was no evidence to suggest that the hospital would have refused a proper request to remove Maria or that Maria would have asked to leave…. her inability to leave was the consequence of her very serious physical condition.*

(3) Not "state detention" under CJA 2009

The final, alternative, basis for dismissing the appeal was that the jurisprudence of the European Court of Human Rights did not apply when interpreting the words "state detention" in the JCA 2009:

> *108… section 48(2) of the CJA 2009, properly construed, does not include ICU treatment as "state detention" because there is no clear and constant jurisprudence of the Strasbourg Court that such treatment involves a violation of Article 5.*

Un/authorised detention

Paragraph 66 of the Chief Coroner's Guidance No 16, *Deprivation of Life Safeguards,* revised 14 January 2016, stated that "*The person is not 'in state detention' for these purposes until the DoL is authorised*." In other words, the death need not be reported to the coroner unless an authorisation was in place. However, the Court of Appeal held that this was wrong:

> *104… It would be highly anomalous if, in order for there to be "state detention", there had to be authorisation for removing a person's liberty. Parliament cannot have intended such an absurd result.*

Comment

Whilst many may agree with the conclusion that a person in intensive care should not generally be described as being in State detention, the court's reasoning to that conclusion is likely to prove controversial, and permission to appeal is being sought. It is a shame that the court declined to consider the submission that Article 5 is about coercion (para 71). For interpreting a deprivation of liberty as coerced, or compulsory, confinement may ultimately provide a more principled answer to the restriction-v-deprivation dilemma. After all, according to *Winterwerp,* whether the unsoundness of mind justifies "compulsory confinement" is what Article 5(1)(e) is about.

The fact that the court found the primary answer in Article 5 means that it is likely to have significant consequences, not least of course in ICUs to which, in 2014/15, there were 163,000 admissions in England and Wales. What we seem to be witnessing is "deprivation of liberty" being interpreted differently in different contexts, with policy considerations very clearly in play. In *Cheshire West*, the policy was to ensure extremely vulnerable people had independent periodic checks on their best interests. In intensive care, this court was content to rely more upon the good faith of the clinicians. Without expressly referring to it, the approach of the court appears to reflect the type 1 / type 2 distinction which Lady Hale found "helpful" in *Cheshire West* (paras 43-44). Type 1 being situations that could be justified under Article 5(1) and type 2 being those that cannot.

The judgment is likely to be applied in other analogous care settings, such as palliative care, and disorders of consciousness because, typically, the person is receiving the same physical treatment as that given to a person of "sound mind". For example, it may well be difficult now to contend that *Paul Briggs* was deprived of his liberty. Distinguishing physical from psychiatric treatment is not straightforward. And trying to draw these fine distinctions when determining the scope of

Article 5 will be challenging. Indeed, much of the judgment refers to "unsound mind" or "mental impairment". But it is not clear what that means in this context. Does it mean "mental disorder" or "mental incapacity"?

That para 66 of the Chief Coroner's Guidance was held to be wrong is not a surprise but does have significant ramifications. It means that it does not matter whether the deprivation of liberty is authorised or not, a death therein will need to be reported to the coroner. Of course those caring at end of life, and best interests assessors, may use this judgment to contend that the person is not deprived of liberty. But, that apart, this ruling is likely to lead to an ever-growing demand on coroners to consider typically naturally deaths. In that regard, the amendment to the Coroners and Justice Act 2009 contained in the Policing and Crime Act 2017 (to which Royal Assent was given on 31 January) may only provide limited assistance. That amendment provides that "*a person is not in state detention at any time when he or she is deprived of liberty under section 4A(3) or (5) or 4B of the Mental Capacity Act 2005.*" This means that natural deaths occurring where a person is deprived under DoLS, Court of Protection authorisations, or whilst applications to the court are being made will not need to be reported. But non-authorised deprivations of liberty will still have to be.

Ultimately, perhaps the court's conclusion is best explained by the underlying policy concerns:

> *111 … to require authorisation of the deprivation of liberty in what would be a normal ICU case would involve a significant dilution and distraction of clinical resource, time and attention. That must inevitably risk jeopardising the outcome for all ICU patients, for no apparent policy reason.*
>
> *112… the fact that the conclusion which I have reached will avoid substantial expenditure of human and financial resources, for which no semblance of a policy reason has been given to us, in my judgment is also supportive of the conclusion that I have reached.*

Public protection and s.21A (again)

N v A Local Authority [2016] EWCOP 47 (Peter Jackson J)

Article 5 ECHR – DOLS authorisations – best interests – contact

Summary

This was a second s.21A challenge, the first being reported as *Y County Council v ZZ* [2012] EWCOP B34, where Moor J upheld the supervision arrangements. It concerned a man in his 40s with mild learning disability and 'paedophilic disorder'. He had a history of fire-setting and self-harm and a tendency to try to make contact with children for sexual gratification. However, he had not engaged in any obviously risky behaviour for the past six years. Deprived of liberty in a locked residential placement for those with challenging behaviour, he was escorted at all times outside and closely monitored inside. Since 2016 he had been offered daily shadowed leave in the community.

The s.21A challenge was issued in April 2014, soon before the standard authorisation was to expire. Since then his detention had been authorised by interim court orders. During the

length of these proceedings, he had separately unsuccessfully challenged his guardianship order in the tribunal. The issues before the court were (1) whether N had capacity to decide on his care arrangements, and specifically to decide whether or not he should be accompanied in the community, and (2) if he did not, whether the deprivation of his liberty was necessary and proportionate and in his best interests.

On the first issue, Peter Jackson J found that:

> *11. N himself does not consider that he poses a risk to himself or others, and points to the fact that he has been largely compliant for the past six years. I note, however, that when speaking to MM he described his feelings for children as natural, saying that everyone has them to some extent. Also, for some years, he has expressed a wish to adopt a child, despite being repeatedly counselled that this is unrealistic. These are to my mind clear examples of his inability to understand the issues that have to be considered when making decisions about his care arrangements. I note Dr Noon's view that they might also be an example of minimization, but he too considered that N's paedophilic disorder probably also affects his capacity, though the fundamental difficulty springs from his learning disability…*
>
> *13. Having considered all the evidence, I accept the professional conclusion and, like Moor J, find that N lacks the capacity decide on his care arrangements. His learning disability deprives him of insight into the persistence of his paedophilic disorder. For him to go into the community alone would not be merely an unwise decision, but an action taken without any real understanding or balancing of the risks he poses and the risks he faces.* (emphasis added)

In relation to the second issue, Peter Jackson J held:

> *15 … The boundaries that are being set allow N to develop in a way that he is not able to achieve for himself. The level of risk if he was unsupervised is real and the nature of the risk is serious. It could lead to N being returned to a prison or hospital environment indefinitely, quite apart from the risk of a violent response from others.*
>
> *16. Mr O'Brien argues that the professional position has been over-influenced by an understandable concern to protect others, as opposed to giving benefit to N. I found no sign of this in the witnesses' evidence.* (emphasis added)

His Lordship found that the lack of risky behaviour over the past six years showed the success, rather than lack of necessity, of the supervision arrangements. They were necessary, proportionate and in his best interests. However, the efforts to relax supervision were to continue. After all, "*The granting of a deprivation of liberty authorisation permits controls but does not compel them*" (para 18). Accordingly, it was authorised for a further 12 weeks to allow the local authority to arrange a standard authorisation. Any further s.21A challenge was to be referred to his Lordship for directions or summary disposal.

The court was critical of the length of proceedings. The first case, before Moor J, had lasted for two years and ended in 2012. These proceedings lasted for 2½ years but should have been concluded within around six months. His

Lordship contrasted this with the guardianship appeal where "*the tribunal system was able to resolve the objectively more serious issue of guardianship in a matter of seven or eight months, appeal included*".

Comment

The first thing to note about this judgment is the interesting reference to N's "paedophilic disorder", for the psychiatric labelling of paedophilic thoughts is a controversial issue, albeit envisaged by the Mental Health Act 1983. Secondly, this case illustrates the interaction between harm to self and harm to others in the context of best interests, necessity and proportionality. There is clearly pressure in similar cases to liberally interpret "harm to P" by including the consequences to P if P's risk to others materialises.

Secondly, Peter Jackson J noted that Counsel for N "*rightly queried whether the Court of Protection should use its powers to extend a deprivation of liberty for longer than the statutory scheme allows. The short answer is that the question of an extension for longer than 12 months should not have arisen at all because the proceeding should have been concluded within, say, six months*." Whilst he did not expressly hold that the Court of Protection could not so use its powers, we suggest that the Court of Protection cannot lawfully extend authorisations beyond 12 months (see also in this regard the observations of Charles J in *Re UF*). It is important also to recall in this regard, as Charles J has recently reminded us in *Briggs v Briggs (1)*, the importance of ensuring that authorisations remain in place during the life of any CoP proceedings so as to ensure that there are no doubts as to the availability of non-means-tested legal aid.

Finally, it is worth emphasising that there was no criticism in principle to a second s.21A challenge being brought in this case, although there was significant delay, and the court envisaged further such challenges. The Court of Protection has yet to rule on the issue of the frequency by which P or their RPR are able to exercise their rights under Article 5/MCA s.21A.

Best interests and childbirth

Re CA (Natural Delivery or Caesarean Section) [2016] EWCOP 51 (Baker J)

Best interests – medical treatment

Summary

This case concerned a 24 year old woman, CA, with a diagnosis of autism and a mild learning disability who, it was thought, had undergone some form of female genital mutilation as a child. CA was very reluctant to allow herself to be examined and had only agreed to limited examination of the foetus during her pregnancy. She did not want to go to hospital, saying it was associated with too many bad memories of her childhood and her life. She wanted to give birth at home on her own. She appeared to have little or no understanding of what giving birth would be like, and the expert evidence was that her failure to take relevant information into account was the direct consequence of her autism.

Baker J concluded that CA lacked capacity to make decisions about the method of delivery, and a detailed balance sheet was drawn up comparing the options of a planned caesarean

section and vaginal delivery. The treating doctors considered that 'taking into account her history of non-compliance and lack of capacity to consent to surgical intervention, an elective Caesarean section would be the safest, least traumatic and most appropriate mode of delivery.' A consultant psychiatrist expressed the view that the 'option of a vaginal delivery was unrealistic due to CA's refusal to allow the midwife to carry out repeated vaginal examinations to monitor the progress of her labour; her refusal to talk through various options for pain relief; her refusal to allow administration of any necessary injectable medication if required; her anticipation that the baby would just "pop out"; her lack of realisation that the experience of first delivery may be long and often painful; her reluctance to comply with instructions and the consequent risk of lack of cooperation, for example when instructed to push, leading to an uncoordinated or chaotic labour process.' Dr I also expressed the view, which the court accepted, that 'an emergency Caesarean section would cause the greatest degree of psychological damage to CA, and that a planned Caesarean section is likely to lead to the least psychological damage of the options in this case.'

Baker J authorised a plan for a caesarean section to include sedation and physical restraint if necessary.

Comment

As is common in these cases, the application was brought very late – less than two weeks before the due date. Baker J was very critical of the Trust's failure to follow the clear guidance previously given by the court about the need for prompt applications, and it is likely that in future cases, applications at short notice are likely to result in serious criticism and/or costs consequences for Trusts.

It is unsurprising given the unanimous medical evidence that the Trust's proposals were endorsed by the court, despite going against CA's clearly expressed wishes. A postscript to the judgment notes that CA's baby was born with minimal restraint to hold her hand to administer intravenous sedation, and that her baby was in the breech position.

This case and others will be discussed in the forthcoming seminar on Childbirth and the Court of Protection at 39 Essex Chambers on 8 March – please see the 'seminars' section of the newsletter for further details.

Anorexia – handing back control?

Cheshire & Wirral Partnership NHS Foundation Trust v Z [2016] EWCOP 56 (Hayden J)

Best interests – medical treatment

Summary

In *Re Z*, Hayden J had to contemplate three options on behalf of a woman, Z, detained under the Mental Health Act 1983, with very severe anorexia who had, in the 31 years since being diagnosed at age 15, had never engaged in any meaningful way with treatment, and who had, in consequence, both an extremely low BMI, severe osteoporosis and a low white blood cell count, and who was held not to have capacity to make decisions as to whether to undergo treatment for her anorexia.

The first possibility was to continue treatment under s.3 Mental Health Act 1983 which would involve detention in hospital and naso-gastric feeding under physical restraint until Z's weight and physical health improved to the point where it would be possible to discharge her. This possibility was agreed both by her treating doctor and the independent expert, Dr Glover (who has appeared in almost all reported cases involving anorexia under the MCA) to be highly unattractive, with a "*real risk that feeding under restraint here would be dangerous, to the extent that death might be caused iatrogenicaly i.e. the treatment risks killing the patient. The obvious psychological distress to Z and, if I may say so, to her parents and to the medical staff is difficult to justify. In addition, Z's osteoporosis is so severe that the medical consensus is that physical restraint faced with the resistance that is likely would probably result in significant musculoskeletal injury*" (paragraph 7).

The second possibility also involved continuation of feeding, again under s.3 Mental Health Act 1983, involving detention in hospital, but with the feeding to take place under chemical sedation. However, given her parlous state of health, the medical consensus was that sedation would involve a very significant risk, most particularly of respiratory or cardiac arrest. Hayden J held that anaesthesia would plainly be inappropriate even for insertion of the naso-gastric tube, and that even with the sedation, the risk that Z may try to remove the tube, whilst diminished, is not extinguished. Her treating clinician considered that there was a "*very high risk" of respiratory or cardiac arrest as well as the risk that the sedation option could lead to some other iatrogenic cause of death, which, as I referred to in relation to option 1, would be very traumatic for Z and all concerned*."

Both of these options had profound disadvantages considered in isolation, and it was also clear that the severity and duration of Z's anorexia itself indicated a resistance to treatment; it was therefore reasonable to predict, Hayden J held, that that she would use her very best efforts to resist them. The third option, by contrast, was very much less draconian, namely that she should be discharged from the framework of the Mental Health Act 1983 and treated, if she is prepared to engage at all, only on a voluntary basis. This was subject to a structured plan which had at its heart the objective of providing support and encouragement to comply with a feeding programme and general therapeutic assistance.

Hayden J noted that:

> *11. Reflecting his detailed knowledge of his patient, who has now been in his care since February 2011, Dr Cahill noted that Z at least fares better emotionally when she is not subjected to an enforced medical regime. Thus, it is hoped, and, in my judgement, it can be no more than that, that an indication to her that the hospital, the Trust and the doctors will withdraw from her life, to respect her wishes and her autonomy, may lead to a sense of emotional wellbeing which may at least enable her to cooperate and in some way, perhaps, to prolong life. It is only when this option is contrasted against the previous two that it has any real credibility. It is almost certainly a pious hope that Z will, if left broadly to her own devices, manage effectively to confront this terrible illness, which has darkened her life since she was 15. I am*

aware that her parents express a belief that she can manage this and I have no difficulty in understanding why they might cling to that hope. I however must be more objective in my analysis and reasoning. Although it will be a terribly painful for Z and her parents to hear it expressed in these terms, I have come to the clear conclusion that I am choosing between 3 palliative care options.

12. Of course the further and obvious benefit of this third option is that it allows Z to take responsibility for herself, in so far as her illness permits her to do so. Through Dr Cahill and Mr. Patel, the Trust have been at pains to emphasise, and it is important that I repeat it, that the hospital doors are always open to Z and that she is encouraged by them to engage to whatever extent she can.

In analysing where Z's best interests lay, Hayden J held that:

13. […] the Court, through the offices of the Official Solicitor, will look not only at what the doctors and nurses say but will also look at the broader canvas of her life, family and her interactions with the wider world; see: Re S (Adult Patient: Sterilisation) [2001] (Fam) 15; County Durham & Darlington NHS Foundation Trust v SS [2016] EWHC 535 (Fam). Sadly, in this case that has proved to be a very short exercise. Z's world, since she was 15 years of age, has been entirely circumscribed by her eating disorder. It has been described as 'her profession'. I have been told her anorexia is how 'she identifies her place in the world'. It has disabled her from making any significant interpersonal relationships or developing any kind of interests or hobbies beyond watching television programmes with her parents, who live only a few doors away.

14. All this of course does not augur positively for the future. Z's own wishes (and feelings), communicated through the Official Solicitor on her behalf, are that she would wish to stay at home with her parents where she believes she is likely to survive. Despite a lifetime of evidence to the contrary she asserts, without rationalisation, that she will "do much better at home." As I have said Z is supported in that perception by her parents.

Hayden J considered the case-law in this area, thus:

18. I am aware that the Courts have had to confront a number of particularly challenging cases involving patients with chronic anorexia nervosa. In A Local Authority v E [2012] EWHC Peter Jackson J considered that treating E was a justifiable violation of her Article 3 and 8 rights, in circumstances where the evidence was that she had a 20-30 % chance of success if maintained for 12 months in a specialist unit where she would be forced fed by naso gastric tube, either by sedation or physical restraint. It has to be said that the prognosis for successful treatment in that case was strikingly different to the facts presented in this case. In Re L [2012] Eleanor King J (as she then was) found herself confronted by circumstances where treatment was assessed as futile, given L's frailty and the likelihood of treatment itself causing death. That strikes me as a similar risk matrix to that which confronts me here but, that said, I have reached my conclusions in this case on its specific facts and not by way of a

> *comparative analysis with the case law. The case law has been helpful only to the extent that it confirms the way in which the decision should be approached.*

Drawing the threads together, Hayden J held as follows:

> *19. In a recent case: Betsi Cadwaladr University Local Health Board v Miss W [2016] EWCOP 13, Peter Jackson J agreed with the medical evidence which advised ceasing coercive treatment and discharging W home to her parents with community support (§21, §48). Though he did not consider that any further admissions would prolong W's life, he took the view that it was "the least worst option" for her (§48). It does not really matter how option 3 here is characterised, it is ultimately the only proposal which carries any vestige of hope and most effectively preserves Z's dignity and autonomy.*

As a procedural point, Hayden J noted that whilst the effect of s.28 MCA 2005 would on its face prohibit the making of a declaration concerning coercive treatment within the scope of Part IV to the MHA 1983, he did not need to determine the point given the way that he had determined the case. Further, "*given this application is heard in the Court of Protection, sitting in the High Court, I would have had the scope to make the declarations under the Inherent Jurisdiction and so the debate seems to me to be arid.*"

Hayden J, finally, noted that it had been possible to bring the case on from first hearing on 19 December to final hearing on 30 December (including the instruction of Dr Glover), and that "*the avoidance of delay should be regarded as a facet of Article 6 (i.e. a fair trial) in these cases. In this respect the Courts must play their parts too and ensure that case management centres upon the needs of the patient which cannot be derailed by administrative pressures faced by Trusts or the Courts.*"

Comment

As with *Ms X*'s case (a case which we understand was cited to the court but not referred to by the judge), and Miss W's case, Ms Z's case leaves one with a strong impression not just of the challenges facing the individuals in question (including the clinicians) but also of the fact that, silently, the courts are developing a form of therapeutic jurisdiction in this area in which they go to careful lengths to emphasise the extent to which they are handing back control of the ultimate decision as to whether to accept or refuse food to the person at the heart of the proceedings, so as to give the best chance that the person will, in fact, make the "right" decision and accept food. Whilst it might be possible from some standpoints to contend that such represents collusion between the professionals (including the Official Solicitor) and the court, for our part we have not the slightest problem with this collusion. It must, at a minimum, be preferable to the extraordinary levels of coercion that would have been involved in option 1 in this case (and the scarcely lower levels in option 2); it can also, it seems to us, to be characterised as an entirely proper and CRPD-supportive way in which to seek to support individuals with anorexia to bring into alignment what is often, as in this case, identified as being their will to live with their clashing preference not to eat.

NPM report on deprivation of liberty

The National Preventative Mechanism was established in March 2009 after the UK ratified the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) in December 2003. It is made up of 21 statutory bodies that independently monitor places of detention. Its 7th annual report, for 2015-16, touches glancingly on DOLS and on the prospects for reform in this area. It does not though comment upon such twiddly matters as whether deprivation of liberty for purposes of OPCAT can take place outside institutions.

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

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Conferences

Conferences at which editors/contributors are speaking

Royal Faculty of Procurators in Glasgow

Adrian will be speaking on adults with incapacity at the RFPG Spring Private Law Conference on 1 March 2017. For more details, and to book, see here.

Seminar on Childbirth and the Court of Protection

39 Essex Chambers is hosting a seminar in conjunction with the charity Birthrights about caesarean-section cases in the Court of Protection. The seminar aims to take a critical look at these cases, with a distinguished multi-disciplinary panel. The seminar is at 5pm-7pm on 8 March 2017, and places can be reserved by emailing beth.williams@39essex.com.

Hugh James Brain Injury conference

Alex will be speaking at this conference aimed at healthcare professionals working with individuals with brain injuries and their families on 14 March. For more details, and to book, see here.

Scottish Paralegal Association Conference

Adrian will be speaking on adults with incapacity this conference in Glasgow on 20 April 2017. For more 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 Mind in return for postings for English and Welsh events. For Scottish events, we are inviting donations to Alzheimer Scotland Action on Dementia.

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

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