MENTAL CAPACITY REPORT:
HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

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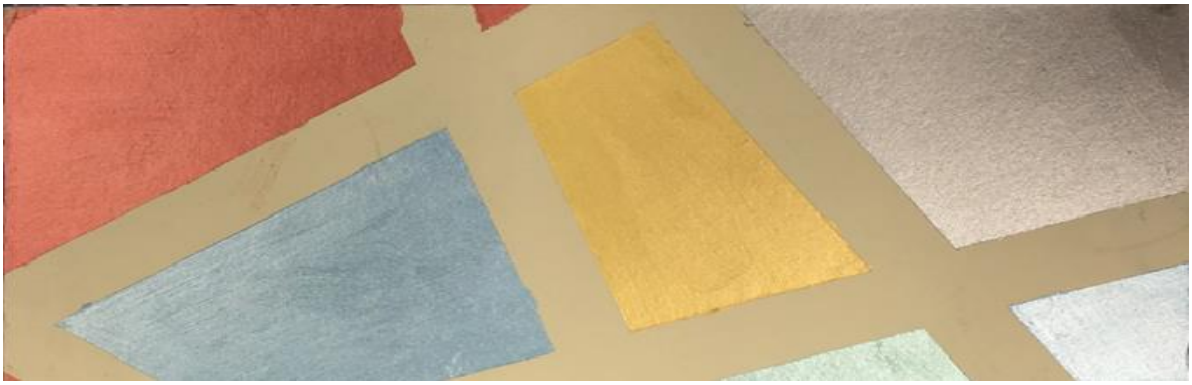

Welcome to the November 2017 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: the Court of Appeal considers parental consent to confinement, CANH withdrawal and the courts, and the latest DOLS figures;

(2) In the Property and Affairs Report: personal injury payouts and s.117 MHA 1983, calling in bonds and court approval of compromises through a human rights lens;

(2) In the Practice and Procedure Report: the Court of Protection Rules 2017 and what we can learn from the new Family Procedure Rules and PD concerning vulnerable witnesses;

(3) In the Wider Context Report: re-framing *Gillick* competence through MCA eyes, MHA changes coming into force, and CRPD developments and resources;

(4) In the Scotland Report: critical comments on practice rules, counter-proposals for guardians and parental consent to confinement from a Scottish perspective;

You can find all our past issues, our case summaries, and more on our dedicated sub-site here, and our one-pagers of key cases on the SCIE website. On our website, you can also find updated versions of our capacity and best interests guide, and new guide to without notice applications before the Court of Protection.

His fellow editors also take this opportunity to congratulate Neil on his very well-deserved nomination for the Bar Pro Bono award 2017.

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

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'Teen Bournewood' – the saga continues

In the matter of D (A Child) [2017] EWCA Civ 1695 (Court of Appeal (Sir James Munby P, Richards and Irwin LJJ))

Article 5 ECHR Deprivation of liberty – children and young persons

Summary[1]

This significant ruling by the Court of Appeal concerns the extent to which parents are able to consent to the confinement of their incapacitated children in light of *Cheshire West*. Previously, when he was 15, his parents had agreed to him being confined in a mental health hospital and Keehan J had held that such consent meant that he was not deprived of liberty: Re D (A Child) (Deprivation of Liberty) [2015] EWHC 922 (Fam). Subsequently discharged from hospital, D was confined in what was essentially a residential school with his parents' agreement under section 20 of the Children Act 1989. Keehan J had held that such parental consent could not be relied upon after he turned 16: [2016] EWCOP 8. It was this second decision that was the subject of the appeal.

Allowing the appeal, the outcome of the Court of Appeal's judgment is that there is no bright line at 16 so parents can continue to consent to such confinement up to the age of 18 if that is an appropriate exercise of their parental responsibility. As a result, although D satisfied the acid test, he was not deprived of liberty because there was valid consent from his parents. The corresponding judicial safeguards were therefore not required until he became an adult. Before analysing the judgment in detail, my understanding of the present position is that:

- For under 18s who are confined and unable to consent, parents can give valid consent if that is an appropriate exercise of parental responsibility.
- Those of any age under an interim/final care order who are confined and unable to consent require Article 5 safeguards.
- Those under 18 who are able to make the relevant decision and object to their

[1] Note, this summary and comment is prepared by Neil Allen, Alex and Tor both being instructed in the case.

confinement will require Article 5 safeguards.

The relationship between assessing capacity under the MCA and as per *Gillick* is discussed in the commentary below.

(a) Objective element: a nuanced acid test for under 18s?

The essential character of a deprivation of liberty (the so-called *Storck*-criteria) consists of:

(a) the objective component of confinement in a particular restricted place for a not negligible length of time;

(b) the subjective component of lack of valid consent; and

(c) the attribution of responsibility to the state.

The present case primarily concerned the second of these. But the local authority contended that the existing monitoring arrangements for looked after children meant that D was not deprived of liberty. This was rejected because these arrangements, such as the independent reviewing officer, did not afford the sufficiently independent safeguards and checks required by Article 5 (para 48).

Sir James Munby P (at paras 30-9) and Irwin LJ (at paras 158-9) both made observations in relation to the confinement of children, about which David Richards LJ preferred not to express a view (para 154). The President observed, "*Insofar as Cheshire West provides the answer, it is to be found in the judgment of Lord Kerr*," who used a comparator approach to confinement for those under 18 which involves:

> *77. … comparing the extent of your actual freedom with someone of your age and station whose freedom is not limited. Thus a teenager of the same age and familial background as MIG and MEG is the relevant comparator for them…*
>
> *79. … It is because they can – and must – now be compared to children of their own age and relative maturity who are free from disability and who have access (whether they have recourse to that or not) to a range of freedoms which MIG and MEG cannot have resort to that MIG and MEG are deprived of liberty.*

The President held:

> *39. Without deciding a point which is not before us, I am inclined to think that the effect of this is that, in Lord Kerr's view, the situation of the "young" or "very young" as he describes it does not involve a "confinement" for the purposes of Storck component (a), even though such a child is living in circumstances which plainly satisfy the Cheshire West "acid test." If this is so, though it is not something we need to decide for the purpose of disposing of this appeal and I express no concluded view, then the consequence, going back to my question, would be that the child living with foster-carers in their home is therefore not within the meaning of Article 5 being deprived of his or her liberty.*

Irwin LJ also noted:

> *158… Although it is not necessary for the decision in this case, I also agree with the President that the question whether there is "confinement" should be approached in the careful way analysed by Lord Kerr in Cheshire West, at paragraphs 77 to 79 …*

> *For all present purposes, "confinement" means not simply "confining" a young child to a playpen or by closing a door, but something more: an interruption or curtailment of the freedom of action normally to be ascribed to a child of that age and understanding.*

Furthermore, the Court expressly interpreted what had previously been implied, namely that in *Cheshire West,* the freedom to leave component of the acid test did "*not mean leaving for the purpose of some trip or outing approved by* [others]" but rather "*leaving in the sense of removing himself permanently in order to live where and with whom he chooses...*" (para 22).

(b) Subjective element: scope/zone of parental responsibility?

This was the crux of the appeal. The court fully endorsed the Strasbourg decision in *Nielsen v Denmark* (1988) 11 EHRR 175 – applying it to under 18s – and recognised the continued role of *Gillick* incapacity/incompetence beyond the age of 16. In short, the court held:

1. *Nielsen* was a case about the second limb of *Storck* (i.e. about consent, rather than about the objective element of confinement), and that this proposition had been endorsed by Lady Hale in *Cheshire West* (paras 26 and 37).

2. In line with *Nielsen*, there are circumstances where consent by a holder of parental authority (i.e. in domestic terms a person with parental responsibility) may provide valid consent to confinement (paras 37 and 95).

3. For these purposes, the relevant rights of a person with parental authority are determined by reference to domestic law (para 50) which provides that parental responsibility is in principle exercisable in relation to a 16- or 17-year-old who "*for, whatever reason, lacks 'Gillick capacity'*" (paras 84-85 and 128).

4. There was no 'magic' in the age of 16, so none of the statutory provisions relied upon by Keehan J to identify a dividing line between those under 16 and those aged 16+ had a bearing on the ambit and extent of parental responsibility established by the common law (para 125). Nor did the international conventions put before the court (paras 136-140) or arguments based upon discrimination (paras 141-146).

5. The "zone" of parental responsibility was to be ascertained by reference to general community standards in contemporary Britain, the standards of reasonable men and women. The question was whether the restrictions being imposed by the particular parent in the particular case fell "*within ordinary acceptable parental restrictions upon the movements of a child*" (para 84).

(c) State imputability

The court rejected the submission that the care arrangements were not imputable to the state for the reasons given at first instance (paras 41-46). Accordingly, it followed that although confined with state imputability, D was *not* deprived of his liberty for Article 5 purposes because there was valid consent to such confinement by his parents.

Comment

The Court of Appeal's endorsement of Lord

Kerr's more nuanced acid test is most welcome as it endorses a common-sense approach to Article 5 for those under 18. In my view, a typical 3- or 8-year-old child, for example, living in a family home or foster home at the same developmental stage as most children of that age would plainly *not* satisfy the acid test.

Where a child is confined, it is important for local authorities to ensure that parental consent to the *particular* circumstances giving rise to it is properly and thoroughly documented (para 150). Parents need to know what they are being asked to agree to where their child's liberty is at stake.

In terms of assessing the ability of someone under 18 to make decisions, it is important to stress that most of the MCA 2005 (except DoLS, statutory wills, LPAs, and advance decisions to refuse treatment) applies to those aged 16 and over. Some of it even applies to under 16s (criminal offences and financial deputyship). But, it is suggested, Parliament clearly intended that, at least insofar as those with mental impairments are concerned, the statutory capacity test ought to be used from the age of 16.

The capacity of those under 16 to make decisions is gauged by *Gillick* although, as recently seen in *Re S* [2017] EWHC 2729 (Fam) (discussed in the Wider Context section of this Report), the courts are sensibly fleshing out that common law test with the more comprehensive approach of the MCA where appropriate. But, in our view, the MCA does not completely oust *Gillick* at 16. There will be situations where a 16- or 17-year old does not have an impairment of the mind or brain but lacks the maturity or intelligence to make the decision. In that situation, it is suggested, there is a continued role for *Gillick* capacity. And, of course, even an under 18-year-old with MCA- and *Gillick*-capacity can lawfully have their decision overridden by the courts (as in *An NHS Foundation Hospital v P* [2014] EWHC 1650 (Fam)) as their views are important but not yet decisive until adulthood.

The judgment, and indeed *Nielsen*, recognises that parental rights are not unlimited. Would the situation be different, for example, if D was objecting to his confinement? In my view, it would. The (English) MHA Code of Practice (2015) at para 19.41 assists in determining the scope of parental responsibility by reference to, in summary, the following matters:

1. Is this a decision that a parent should reasonably be expected to make? Consider factors such as:
    - The type and invasiveness of proposed intervention.
    - The age, maturity and understanding of child or young person: parental role should diminish as the child develops greater independence.
    - Does it accord with the child or young person's current wishes or will they resist?
    - Have they expressed any previous views?
2. Are there any factors undermining the validity of parental consent?
    - Does the parent lack capacity to consent?
    - Is the parent not able to focus on what is in their child or young person's best

interests (eg due to an acrimonious divorce)?

- Is there significant distress/conflict between parents which means they are unable to decide what is best?
- Is there conflict between decisions of those with parental responsibility?

The more coercive the confinement needs to be, the more likely it is that the decision will fall outside the scope of parental responsibility in my opinion. For example, a *compulsory* admission to a psychiatric ward of an objecting incapacitated 16/17-year-old should not be attempted on the basis of parental consent. That would, it is suggested, be outside the scope and the young person would need Article 5 safeguards (of the MHA).

The judgment did not need to address the significant issue as to whether local authorities and parents can use shared parental responsibility to consent to confinement for those subject to interim or final care orders. But given the lack of dissent (at paras 109-110) on the issue, it is suggested that the prudent course is to assume that the law is unchanged. So there can be no valid consent where someone under a care order is confined according to the nuanced acid test. Local authorities involved in care proceedings may therefore want to continue to have cases listed before judges who can also exercise powers under the inherent jurisdiction so as to deal with deprivation of liberty authorisations.

There are a few other tangential but significant matters to be found in the judgment. Resource arguments cannot render nugatory the substantive and procedural protections of Article 5 (para 14). The court also, no doubt sensibly, avoided the international curve ball as to how Article 14(1)(b) of the UNCRPD – which prohibits detention on the grounds of disability – could be squared with Article 5(1)(e) ECHR (para 140). Finally, and with "*weary resignation*", the President observed (footnote 3) that the order in the court below was headed "*In the High Court of Justice Court of Protection*" and (noting that the responsibility for this appeared to lie with the court not the parties) said, '*The Court of Protection is not part of the High Court, so orders made by the Court of Protection should not be headed 'In the High Court of Justice': see section 45 of the 2005 Act. Is it too much to hope that, ten years after the Court of Protection came into being, this simple truth might be more widely understood and more generally given effect to.*"

Neil Allen

Contraception, safeguarding and best interests

The Hospital Trust v Miss V [2017] EWCOP 20 (Cobb J)

Best interests – contraception

Summary

Miss V was a 21 year old woman with a severe learning disability, cerebral palsy and epilepsy. She is described in the judgment as having the understanding of a 3-5 year old and to be entirely unable to identify situations that may pose a risk.

In 2016 Miss V presented to her GP as 28 weeks' pregnant, neither Miss V nor her mother apparently aware of her condition. All the professionals engaged in Miss V's care agreed

she did not have the capacity to consent to sexual intercourse.

Her baby was born by caesarean section following an order of the COP and immediately removed from her care. Both the fact of medical intervention and the removal of her baby are described as having caused Miss V great anguish: her social worker is noted in the judgment to observe that in 18 years of social work, she had never previously witnessed such extreme levels of distress.

An application was initially brought by the local Health Authority for an order for Miss V to be sterilised. This order was, however, abandoned in favour of an order for the prescription and application of a contraceptive patch.

Despite agreement as to the preferred method of contraception, the order was resisted by both Miss V's mother, Mrs W, and the Official Solicitor on the basis that even the least restrictive form of contraception has side effects and that it was not appropriate or in P's best interests for contraception to be administered "*just in case*": she was considered not to be sexually active and was the subject of extensive safeguarding and supervision, being in the constant company of a family member, albeit that evidence suggested that there were occasional unintentional lapses in her supervision.

On the matter of Miss V's capacity, the court found that she did have an ability to learn and could demonstrate a rudimentary understanding of some elements of contraception. However, applying the test as set down by Bodey J in *A Local Authority v Mr and Mrs A & Mr A* [2010] EWHC 1549 (COP) Cobb J held: "*in order to have capacity to make decisions about contraception, Miss V would need to be able to understand and weigh up the immediate medical issues including (a) the reason for contraception and what it does (which includes the likelihood of pregnancy if it is not in use during sexual intercourse); (b) the types available and how each is used; (c) the advantages and disadvantages of each type; (d) the possible side-effects of each and how they can be dealt with; (e) how easily each type can be changed; and (f) the generally accepted effectiveness of each.*" He determined, and it was agreed by all the parties, that Miss V lacked capacity to consent to sexual relations and to make decisions in relation to contraception. That having been said, Miss V was considered by those involved in her care to be capable of expressing views, and that although there was a limit on the weight which the court could reasonably attach to these views, given her lack of capacity, Cobb J was "*nonetheless satisfied that she has a reasonable awareness of the contraceptive patch and its function and has indicated no opposition to wearing it*" (paragraph 35).

In circumstances where the combined objective of the parties – endorsed by the court – to ensure that Miss V was protected from further harm, Cobb J went on to determine that contraception was in Miss V's best interests. To do, he considered he needed to ask – in sequence – the following series of interlinked questions (at paragraph 24):

i) *Is it in Miss V's best interests that she receives contraceptive protection?*

ii) *If so, what form of contraception is in her best interests, as the less restrictive option?*

iii) *If contraception is in her best interests, is it in her interests that such contraception is first trialled?*

iv) *Linked to (ii), are there some forms of contraception which are so invasive and restrictive that, even if contraception would generally be regarded as being in her best interests, the disadvantages or restrictions associated with these invasive forms of contraception would outweigh the benefit(s)?*

In determining whether the contraceptive patch should be administered, Cobb J endorsed the view that the safeguarding plan advanced by the local authority was as robust as it could be given the heavy reliance that it placed upon the continuous supervision of Miss V by her parents. He noted that the protection plan would be unaltered whether or not the contraception was administered. However, this did not mean – in his view – that there were:

> *43.* […] *not real advantages to Miss V in receiving contraception. The safeguarding plan is designed to reduce the risk of sexual exploitation particularly outside of the home; contraception is proposed to reduce the risk of pregnancy in the event that the plan fails. If this additional safeguard can be introduced without undue side effects, and is a safeguard which Miss V is not unwilling to accept, then the best interests balance tilts in favour of its use.*
>
> *44. The risk against which contraception is designed to guard is self-evidently a repeat pregnancy, delivery of the baby and probable removal, with its associated trauma; but pregnancy, even suspected pregnancy, usually brings with it a range of possible medical tests – the taking of weights, blood pressure and bloods, for instance. The very prospect of any medical intervention, even the simple task of being weighed and measured in a clinic, and of blood pressure being taken, has left Miss V 'petrified' in the recent past. It is incumbent on the court in the exercise of the discretion to reduce the need for such medical interventions, particularly since (and perhaps entirely predictably) Miss V displays a greater sense of mistrust of the professionals since the removal of the baby, and this adds another minor impediment to the effective monitoring of [the] plan.* (emphasis in the original)

Concerned, nonetheless, that the side-effects of the patch might be overly troublesome to Miss V, and that this could only be determined after a trial, Cobb J made a declaration that it was in her best interests for the contraceptive patch to be administered for a trial period of up to 6 months.

Comment

Cobb J was clearly aware of the sensitivity of the conclusion that he had reached. Confirming that his judgment was restricted to the facts of Miss V's specific case, he concluded: "*I wish to make clear that this decision is about Miss V, and her best interests; the decision is taken in the context of her unique situation. I wholly reject the submission on behalf of the Official Solicitor that by declaring contraception in Miss V's best interests I would in one way or another be setting a precedent for all incapacitous and vulnerable women.*" (paragraph 47).

We would echo this strongly, not least because the case should not be taken as a precedent for an approach to safeguarding which focuses on

the 'easier' course of directing measures at the potential victim of abuse (whether those being consenting to the administration of medication, as here, or removing them from their home), rather than the perpetrators of the abuse, not least as this is directly contrary to the very concept of making safeguarding personal.

CANH withdrawal and the courts

The withdrawal of clinically assisted nutrition and hydration ('CANH') has been featuring very heavily in recent court decisions, summarised here.[2]

PL

In *PL v Sutton CCG* [2017] EWCOP 22 , concerning potential CANH withdrawal from a woman who had "*suffered a catastrophic stroke which ha*[d] *left her very severely physically disabled, brain damaged, and significantly incapacitated*" (paragraph 1), Cobb J confirmed (at paragraph 29) that it would be wrong:

> *to conclude that where the patient is not diagnosed as MCS or VS, a significantly different approach to the determination of the case should be taken. Quite apart from anything else, as is well-recognised, the diagnosis is often difficult, and may indeed change over time. So just as it would not necessarily follow that someone who is in a 'vegetative state' would be bound to have life-sustaining treatment discontinued, the fact that someone retains consciousness and can answer questions is not in itself a reason not to consider discontinuance of life-sustaining treatment: see An NHS Trust v A [2006] 2 Lloyds Rep Med 29. It all depends, as I have indicated, on the individual facts, and every decision must ultimately be governed by what is in a patient's best interests.*

Cobb J confirmed (at paragraph 71) that the approach set down by Lady Hale at paragraph 39 of her judgment in Aintree:

> *reinforces the essentially limited value in considering previous case law otherwise than for general statements of principle or guidance. In any event, it is clear that the authorities to which I have been referred have concerned adults in MCS or VS. Adhering to the only authentic principle in cases of this kind – that the decision is taken in the best interests of P – ensures, so far as judicial ability and expertise permits, the right outcome.*

In determining whether it was in PL's best interests for CANH to be continued, Cobb J noted that:

> *76. I am conscious that in making the decision in relation to PL, I must not apply substituted judgment, even though there is a "strong element" of substituted judgment in the best interests' test. The Supreme Court in Aintree emphasised that while the court can, indeed should, accept that the preferences of the person concerned are an important component in deciding where her best interests lie, it is still a "best interests" test; see §24 of Aintree. As indicated above, Charles J in Briggs No.2 attached particular, even decisive, importance to the views of P, making the powerful point that someone*

[2] Note, Tor, Katie and Annabel have been involved in various of these cases (Tor in all of them), and Alex will be involved in the Y case if the Supreme Court hear it. Tor, Katie and Annabel have not contributed to the commentaries on their own cases; Alex has provided the neutral summary of the Y case.

with capacity could, through advance decision, displace the ordinary expectation of treatment in order to preserve life. This followed Lord Goff's comments in Bland to which I have also referred (§68 above: "a patient of sound mind may, if properly informed, require that life support should be discontinued"). On these facts, as I have made clear, I am satisfied that PL made her views about life-sustaining treatment well-known to her family and friends; I have accepted their evidence, and further accept that her views apply to her current situation. Had PL's views been specific to the provision of CANH, I would probably have regarded them as decisive of this application; as it is, her views weigh heavily in the balance.

77. I have weighed carefully the views of the family, to the extent that they wish me to do what they regard as the right thing, namely to authorise the discontinuance of treatment, not for themselves, but for PL.

78. So, I return to the fundamental question whether it is in PL's best interests to continue to receive CANH. I have reviewed and considered PL's welfare in the widest sense, and on balance I have concluded that it is not *in her best interests; it follows that the discontinuance of the CANH treatment is therefore lawful.*

Cobb J also confirmed, applying *Ferreira* and *Briggs*, that PL would not be deprived of her liberty when moved to the hospital where CANH withdrawal would take place, where she would be "*in a state of very low cognition and possibly consciousness, receiving palliative care, as her life ebbs away* […] *placed in a coma-like state to anaesthetise her from any distress associated with the discontinuance of treatment*" (paragraph 79).

Mrs P[3]

In *Salford Royal NHS Foundation Trust v Mrs P & Q* [2017] EWCOP 23, Hayden J was concerned with a woman in a minimally conscious state as a result of extensive widespread damage to the brain consistent with pre-existing cerebrovascular disease, the effects of hydrocephalus, and areas of focal cerebral infarction. The central issue in the case was the extent to which Mrs P's past wishes and feelings about life sustaining treatment could be ascertained. Both experts were of the view that her views would be determinative of the question of where her best interests lie, Hayden J agreed, endorsing the following "*uncontroversial*" principles to be taken from the "*evolving case law*:"

i. *The sanctity of life is not an absolute principle, and can be outweighed by the need to respect the personal autonomy and dignity of the patient: Aintree v James [2013] UKSC 6 at [35];*

ii. *There is no prohibition to conducting a best interests analysis of the continued provision of CANH even though MRS P is not in a vegetative state: W v M [2011] EWHC 2443 (Fam) at [102] per Baker J;*

[3] For a 'storify' of the case prepared by Celia and Jenny Kitzinger of the Coma and Disorders of Consciousness Research Centre, gathering together and adding to their live Tweets from the case, see here.

iii. *There can be no further guidance beyond the wording of s.4 other than that "decision makers must look at his welfare in the widest sense, not just medical but social and psychological; they must consider what the outcome of that treatment for the patient is likely to be; they must try and put themselves in the place of the individual patient and ask what his attitude to the treatment is or would be likely to be; and they must consult others who are looking after him or are interested in his welfare, in particular for their view of what his attitude would be." Aintree at [39] per Baroness Hale.*

iv. *Where the patient's condition may improve, a best interests decision may be based on the 'best case scenario' as advised by the relevant clinicians and experts: Briggs overview at (25) per Charles J;*

v. *It is incumbent on the court fully to investigate and consider the values and beliefs of the patient as well as any views the patient expressed when she had capacity that cast light on the likely choice the patient would have made and the factors that the patient would have considered relevant or important: M v N at [70] per Hayden J, Briggs at [54] per Charles J;*

vi. *Where the patient's views can be ascertained with sufficient certainty, they should generally be followed (Briggs at [62] per Charles J) or afforded great respect (M v N at [28] per Hayden J), though they are not automatically determinative. '...if the decision that P would have made, and so their wishes on such an intensely personal issue can be ascertained with sufficient certainty it should generally prevail over the very strong presumption in favour of preserving life. Briggs at [62ii] per Charles J.'...the 'sanctity of life' or the 'intrinsic value of life', can be rebutted (pursuant to statute) on the basis of a competent adult's cogently expressed wish. It follows, to my mind, by parity of analysis, that the importance of the wishes and feelings of an incapacitated adult, communicated to the court via family or friends but with similar cogency and authenticity, are to be afforded no less significance than those of the capacitous.' M v N at [32] per Hayden J;*

In Mrs P's case, Hayden J found that Mrs P would have found '*her present circumstances not only intolerable but humiliating. More than in any other sphere in her life she kept her health issues completely private. Her present high level of dependency and minimal awareness would, to her, have been 'a travesty of life', to adopt her own phase*.' He accordingly refused the Trust's application for a declaration that it was in her best interests for CANH to continue.

The judge was invited to give general guidance on a range of issues that had arisen in the case but declined. What he did say however (at paragraph 42) was that "*cases in the Court of Protection must always be driven by the needs of the patient and not by the exigencies of the litigation*." This is of course undoubtedly right!

Re Y

In *Re Y* [2017] EWHC 2866 (QB), O'Farrell J, applying the reasoning of Peter Jackson J in Re

M, declared that it was not mandatory to bring before the Court of Protection the withdrawal of CANH in the case of Mr Y, who has prolonged disorder of consciousness, in circumstances where the clinical team and Mr Y's family were agreed that it was not in his best interests to receive that treatment. The judgment is important because it is a judgment from the High Court, rather than the Court of Protection, making a declaration (under Part 8 CPR) as to the legal requirements. It is also important because the Official Solicitor was formally involved (as Mr Y's litigation friend). There is, in the circumstances, no question that the conclusions of the judge – which would apply in other, similar, cases – are obiter, unlike the question mark that has been placed by some over the conclusions of Peter Jackson J in *Re M.*

O'Farrell J certified the case as fit for the Official Solicitor to "leapfrog" to seek permission to appeal from the Supreme Court to appeal her decision, as well as for expedition. If the Supreme Court grants permission, it is likely, therefore, that the issue of whether, when and why cases of CANH withdrawal[4] need to come to court will be considered by the highest court in the land in the very near future.

DOLS applications continuing to rise

NHS Digital has now published its DOLS report for England for 2016-17 (also available in whizzy interactive form here). Headline statistics include:

- There were 217,235 applications received during 2016/17; an increase of 11% on 2015/16.
- The number of applications that were completed increased by 45% to 151,970 during the same period.
- The reported backlog of cases that were not completed as at year end increased by 7% to 108,545 over the year.
- Four new applications were being made for every three being completed.
- The average number of days from applications being received to being completed across England was 120 days.

For enthusiasts wishing to dig further into the statistics, it is important to emphasise that it is not straightforward (or indeed, often possible) to make comparisons between statistics relating to individual authorities, because of the widely differing approaches that have been taken amongst local authorities to addressing both the backlog and new DOLS applications. Differences between two apparently comparable local authorities should therefore be taken as a starting point to ask more questions, rather than a simple measure of which local authority is doing better or worse.

[4] And, indeed, life-sustaining treatment more broadly, the logic of the Official Solicitor's argument not being limited to CANH.

Interim Government response to Law Commission's Mental Capacity and Deprivation of Liberty report

Jackie Doyle-Price (Parliamentary Under-Secretary of State for Health), set out in a written statement on 30 October the Government's Interim Response to the Law Commission's MCD report as follows:

> *I am today announcing the publication of the Government's interim response to the Law Commission's report on Mental Capacity and Deprivation of Liberty, a copy of which is attached. In England, around 2 million people with conditions such as dementia, learning disability or an acquired brain injury may be unable to always make decisions about their care or treatment, including where they live, because they lack mental capacity. In 2007, the Government amended the Mental Capacity Act to introduce the deprivation of liberty safeguards (DoLS), which provide a legal framework for such decisions. However, the framework has been subsequently criticised in both Houses, as well as by charities, Local Authorities and families. The current regime is inflexible and complex and the system is bureaucratic and unwieldly meaning that it is unnecessarily cumbersome to ensure that vulnerable people are afforded the rights and protections to which they are entitled. The current system does not always empower people or place them at the heart of decision making about their care as set out by the Care Act 2016.*
>
> *The Commission were asked to conduct a fundamental review of the Deprivation of Liberty Safeguards provisions which are rooted in the Mental Capacity Act and integrated into healthcare practices for joined-up person-centred care. Our expressed priority at the time was that any new scheme delivers real tangible benefits for individuals and their families, and this remains the case. Any new scheme must improve the quality of care for people, improve access to safeguards and be cost-effective.*
>
> *I welcome the publication of the Law Commission's report which we are carefully considering and thank them for their careful and considered work. We will now engage with a range of stakeholders to understand in greater detail how these changes can be implemented. We will also consider what enabling actions need to be taken to support the Mental Capacity Act ethos of greater empowerment and care centred around people, their wishes and aspirations.*
>
> *This Government is committed to take action to reform mental health and transforming care for people with conditions such as dementia, learning difficulties and autism. Action to reform the current Deprivation of Liberty Safeguards regime is an important contribution towards achieving these aims including effectively protecting some of the most vulnerable people in our society.*
>
> *The Government will provide its final response on the Law Commission report to the House in Spring 2018.*

The fuller response is available here, in which the Minister notes also that:

As you are aware, the government has committed to reform of mental health legislation and ensuring that parity of esteem is at the heart of treatment. We will ensure that our work on deprivation of liberty for the purpose of care and treatment is undertaken in consideration of our work reforming mental health.

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Conferences

Conferences at which editors/contributors are speaking

Deprivation of Liberty in the Community

Alex is delivering a day's training in London on 1 December for Edge Training on judicial authorisation of deprivation of liberty. For more details, and to book see here.

Deprivation of Liberty Safeguards: The Implications of the 2017 Law Commission Report

Alex is chairing and speaking at this conference in London on 8 December which looks both at the present and potential future state of the law in this area. For more details, see here.

Advertising conferences and training events

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

Our last report of 2017 will be out in December. Please email us with any judgments or other news items which you think should be included. If you do not wish to receive this Report in the future please contact: marketing@39essex.com.

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