MENTAL CAPACITY REPORT: HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

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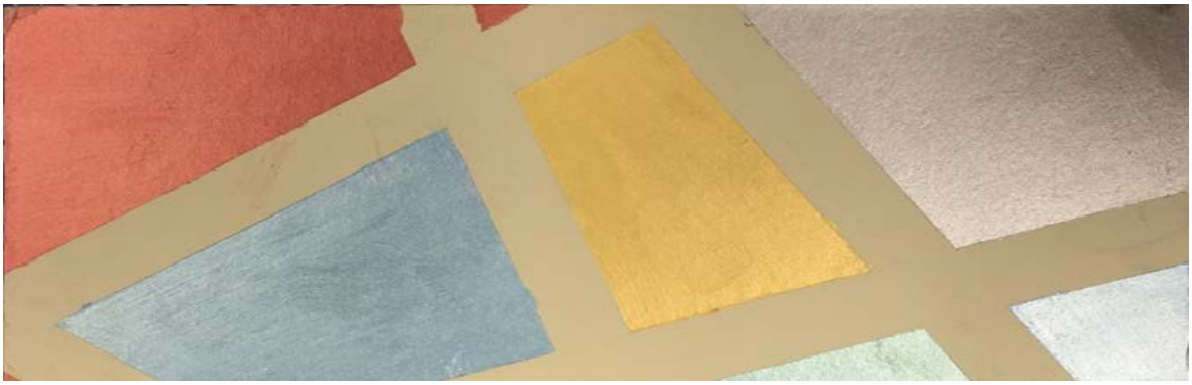

Welcome to the May 2023 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: LPS on the shelf; fluctuating capacity and the interface under the judicial spotlight;

(2) In the Property and Affairs Report: the new surety bonds structure and an update on the Powers of Attorney Bill;

(3) In the Practice and Procedure Report: reporting restrictions and the Court of Appeal, and costs in serious medical treatment cases;

(4) In the Wider Context Report: DNACPR notices and disability, litigation capacity, the new SCIE MCA database, and Ireland commences the 2015 Act;

(5) In the Scotland Report: problems of powers of attorney in different settings and a very difficult Article 5 choice.

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.

Contents

Liberty Protection Safeguards: implementation delayed "beyond the life of this Parliament"

The Government announced on 5 April 2023 that it would delay the implementation of the Mental Capacity (Amendment) Act 2019 until "beyond the life of this Parliament."

We set out the announcement in full below:

> *Update on implementation of the LPS*
>
> *Yesterday you will have seen the Government has set out its plans for adult social care reform in its publication of the Next steps to put People at the Heart of Care.*
>
> *To enable us to focus on these critical priorities, the Government has taken the difficult decision to delay the implementation of the Liberty Protection Safeguards beyond the life of this Parliament. This was one of a number of decisions taken as part of prioritising work on social care. More detail can be found on plans to reform and improve adult social care here.*
>
> *We recognise that this delay will be disappointing news for the people and organisations who have worked closely with us on the development of the LPS since the Mental Capacity (Amendment) Act was introduced in 2019. We would like to thank everyone who engaged with us on the development of the policy and during the consultation on the LPS. The detailed feedback we received has been invaluable.*
>
> *During the LPS consultation, we received detailed feedback from stakeholders across the health and social care, voluntary and legal sectors, and the people affected by it. Many of those who responded to the consultation expressed support for the LPS and agreed that there is a need for a more streamlined and person-centred system. Though some responses to the consultation also suggested changes to the proposals in a number of ways which have been considered during the consultation analysis phase.*
>
> *Although implementation of LPS has been delayed at this time, we plan to publish a summary of responses to the consultation in due course, which will set out further information about the feedback we received at consultation. We will update you via the LPS*

newsletter when the summary of responses is published.

In the meantime, the Deprivation of Liberty Safeguards remain an important system for authorising deprivations of liberty, and it is vital that health and social care providers continue to make applications in line with the Mental Capacity Act 2005 to ensure that the rights of those who may lack the relevant capacity are protected.

Changes to the LPS team

In line with the decision not to move forward with the LPS at this time, some members of the LPS team will begin moving to other areas of the Department in the coming weeks. In the short term, Laura Karan and Martin Teff will remain the key points of contact for the LPS and the DoLS. We will provide further updates on the future of the LPS team as soon as practicable.

As always, please do get in touch with us at lps.cop@dhsc.gov.uk with any queries or comments.

The most immediate effect that this has is that the Liberty Protection Safeguards are not going to come into force for the foreseeable future. There are also knock-on effects, including that the new version of s.4B will not come into force to provide much-needed 'cover' in emergency situations. And, at the time of writing, it is unclear what is going to happen in relation to those parts of the updated Mental Capacity Act Code of Practice that relate to the main body of the MCA and which are badly out of date (our informal attempt to highlight the most dangerous passages in the MCA Code, together with the DoLS Code, can be found here).[1]

As we were going to press, Helen Whateley MP and Michelle Dyson, Director General for Adult Social Care, Department of Health and Social Care, gave evidence to the Health and Social Committee, identifying that there was still a commitment to change the system, but that (in effect) it was too complex to do so at the moment. The relevant exchanges can be found from 15:49 here.

Schedule AA1 is dead; long live Schedule A1

The government's decision to dust-gather LPS on the lower priority shelf of policy will please some but frustrate most. Why the human rights of hundreds of thousands of people with disability have not been prioritised is difficult to fathom. But silver linings help to mediate the pain from change of policy. So what might DoLS 2.0 look like using a non-legislative approach (aka 'LPS')?

(i) Change the terminology!

Terminology matters. It matters to those with disability, to their family and friends, to care providers and to those practitioners responsible for acting lawfully. Neither the terms 'deprivation of liberty safeguards' nor 'liberty protection safeguards' are contained in legislation. They are in fact merely labels to describe a legal procedure. English law has always safeguarded the protection of liberty and the Mental Capacity Act 2005 already provides administrative and judicial liberty-protecting safeguards. You might say we already have "administrative LPS" (local authorities/ health boards safeguarding adults in hospitals and care homes) and "judicial LPS"

[1] Alex has also recorded a presentation about what to do now.

(Court of Protection judges safeguarding young people and adults in any care setting).

There is no legislative reason therefore why DoLS 2.0 could not be renamed as "LPS". Potential confusion could be addressed by updating the Code of Practice. After all, the work has already been done to improve the MCA-core content in the draft version. There is already a DoLS Code which, to reflect "administrative LPS", can at the touch of the CONTROL + H button easily replace 'deprivation of liberty' with 'liberty protection'. And it would not be that difficult to add new chapters for "judicial LPS". Given how much time and effort everyone has put into LPS, the least the government could do in this Parliament is to update the Codes of Practice.

(ii) Supply the demand

DoLS was not designed for the level of demand for legal safeguards that exploded onto its scene after the *Cheshire West* decision in 2014. In justified desperation, people will rightly call for more resources to try to make it work. We need more assessors, more authorisers, more advocates, more monitors of authorisation conditions (worth having if you have none), and more COP judges to reduce delays with COPDOL11 applications. But what other enhancements could also be made to help meet the demand?

Broadly speaking, there tends to be three types of case where liberty-protecting safeguards are required: 'the classic', 'the unhappy', and 'the stable'. The classic cases are where someone is being confined somewhere they really should not even be (e.g. in a care home rather at home with a care package). The unhappy are those situations where the person is in the 'right' type of place but changes to the arrangements are needed to make them happier. And the stable are those in the 'right' place with the 'right' arrangements but technically confined because "a gilded cage is still a cage".

With limited resources to supply the demand, the overriding objective in this DoLS 2.0 world we now face is, with a side-eye to the Court of Protection Rules, how to deal with all three cases justly and at proportionate cost, having regard to the MCA principles. Dealing with a case justly and at proportionate cost could be said to include, so far as is practicable:

(a) ensuring that it is dealt with expeditiously and fairly;

(b) ensuring that P's interests and position are properly considered;

(c) dealing with the case in ways which are proportionate to the nature, importance and complexity of the issues;

(d) ensuring that those involved are on an equal footing;

(e) saving expense;

(f) allotting to it an appropriate share of the supervisory body/Court of Protection resources, while taking account of the need to allot resources to other cases; and

(g) monitoring compliance with authorisation conditions, and reviewing recommendations.

After all, what is sauce for the Court of Protection goose is sauce for the supervisory body gander. For they both have the same responsibility to safeguard the protection of liberty, just in different care settings.

So what changes could be made to fulfil this new overriding objective of "administrative LPS"? The first is having the confidence to rely on good existing evidence for new authorisations. According to MCA Sch A1 para 49, an existing

assessment carried out within the last 12 months can be re-used as an 'equivalent assessment' if there is no reason why it may no longer be accurate. If I had dementia last time, chances are I still have it. If this was a care home last time, we do not need a medic to confirm that this is still a care home. Indeed, there is no need to reassess any of the six DoLS criteria (so-called 'qualifying requirements') if there is an accurate existing assessment.

Being able to identify when existing evidence can be relied upon for the next authorisation may be an art, but the current legislative option to do so provides a way to avoid unnecessary cost and ensure appropriate cases are dealt with expeditiously and fairly. This would certainly reduce the need for mental health assessors and no doubt an ADASS Form 4B could be created (if Lorraine Currie has not already written one!) to capture this to run alongside the existing Form 3B. And for those supervisory bodies that do not already use Form 3B, they may now well wish to consider doing so.

(iii) Improve the forms

Speaking of forms, those used for "administrative LPS" in the new DoLS 2.0 world can no doubt be speedily simplified and updated to reflect best practice and case law developments. And some thought could be given to the authorisation itself. In times gone by, only the most senior judges (Tier 3) dealt with judicial LPS cases. Nowadays, any nominated Court of Protection judge can do so and whether a case is scrutinised by a Tier 1, 2 or 3 judge depends upon the complexity of the issues. Conversely, most supervisory bodies no doubt still use some of their most senior staff to scrutinise assessments which can cause delay. Senior staff may still be justified for the 'classic' cases, but may not necessarily be for the 'unhappy' and 'stable' ones.

(iv) Expand the authorisers

There is nothing in law that determines who undertakes this role. Indeed, the role is not even mentioned in Schedule A1. It is the 'supervisory body' that gives a standard authorisation and it decides who does so. Clearly, they need to know their stuff to provide an appropriate level of scrutiny, and have a degree of independent thinking to reduce the risk of bias or conflict of interest. But no more than that. Advanced practitioners or best interests assessors, for example, could undertake the role. Not, of course, in relation to their own assessments but in those situations where they are able to think and act independently of the assessor.

(v) Embed periodic reviews

Changes could also be made to the standard authorisation without any legislative amendments. Its length (up to a 12-month maximum) is determined by the person's best interests. Rather than giving a shorter authorisation to ensure a BIA gets back on the scene, a longer authorisation could be given but with robust interim review arrangements. Authorisation conditions could, for example, require the managing authority to carry out a programme of care planning reviews, with recommendations targeted at the relevant health/social care professionals.

Effective monitoring of such conditions would provide the supervisory body/BIAs with greater confidence to go longer with the safeguards. Recommendations also need to be better communicated and checked because they can make a real difference. Fundamentally, a BIA may have more confidence to go long if the supervisory body's duty to monitor conditions is working effectively, there are interim reviews required, coupled with an efficient Part 8 review process to enable representatives to flag up 'problem cases' requiring attention. Such an

efficient and effective use of resources could provide more people with enhanced safeguards and reduce the need for legal proceedings. All these measures are already provided for; they just are not being used.

(vi) (Avoid?) advance consent

Finally, there is much learning from the draft Code of Practice that we can apply to "administrative LPS". Whether anyone will attempt to stretch the concept of advance consent to avoid Article 5 safeguards altogethzr remains to be seen. Only a capacitous forward-thinking care home resident or mental health patient and a test case would determine whether that is actually lawful.

(vii) Empower

Most people subject to DoLS we anticipate do not choose their own representative but should be better empowered to do so where possible. The draft Code suggests that the relevant information for this decision includes, but is not limited to:

- What a deprivation of liberty means and the impact on the person;
- The role of the RPR and what is expected from the individual who undertakes the role;
- How to carry out the role, such as meeting the person regularly and challenging decision makers;
- RPR's rights for support, including from an IMCA; and
- Information on the person and RPR's rights to challenge an authorisation and how to challenge.

This is certainly too demanding and more thought needs to be given to the salient details for this relatively simple decision. More people can no doubt be better-enabled to choose their own representative. And a renewed effort should be made to improve the giving of accessible information to people about their rights and safeguards.

(viii) Consider MHA 1983 s.17(3)

A little niche, but for those liable to be detained under the Mental Health Act 1983, the draft at paragraph 22.80 highlighted how the responsible clinician "should consider first whether it is possible for that deprivation of liberty to be authorised through the use of section 17(3)". Even had LPS been implemented, the interface with the MHA would have remained. But greater clarity like this on these sorts of issues could help now.

(ix) Acute hospitals

The same is particularly true in relation to acute hospitals where a significant demand for safeguards is made in circumstances where the patient is discharged before any assessors reach the scene. The current DoLS Code importantly states (emphasis added):

> *6.3 However, an urgent authorisation should not be used where there is no expectation that a standard deprivation of liberty authorisation will be needed.*
>
> *Where, for example:*
> - *a person who lacks capacity to make decisions about their care and treatment has developed a mental disorder as a result of a physical illness, and*
> - *the physical illness requires treatment in hospital in circumstances that amount to a deprivation of liberty, and*
> - *the treatment of that physical illness is expected to lead to rapid resolution of the mental disorder such that a standard deprivation of*

> *liberty authorisation would not be required,*
>
> *it would not be appropriate to give an urgent authorisation simply to legitimise the short-term deprivation of liberty.*
>
> *6.4 Similarly, an urgent deprivation of liberty authorisation should not be given when a person is, for example, in an accident and emergency unit or a care home, and it is anticipated that within a matter of a few hours or a few days the person will no longer be in that environment.*

Perhaps a significant number of patients in these acute physical ill-health scenarios are unlikely to be deprived of their liberty because of the *Ferreira* decision, which the draft Code describes as follows (emphasis added):

> *Medical treatment for physical health problems*
>
> *12.77 A deprivation of liberty will not occur if the person is treated for a physical illness and the treatment is given under arrangements that are the same as would have been in place for a person who did not have a mental disorder. In other words, the restrictions on the person are caused by physical health problems and the treatment being provided. The root cause of any loss of liberty is the physical condition, not any restrictions imposed by others (for instance health and care professionals). This approach should be applied to any form of medical treatment for physical health problems and in whatever setting the treatment is being delivered. It should not be limited to hospital settings, but could include any setting where medical treatment is being provided."*

One can well understand why acute hospitals are routinely triggering urgent authorisations to avoid the risk of legal liability. But if staff can develop the confidence to distinguish 'a *Ferreira*' (no safeguards required) from a 'DOL' (safeguards required), [2] that would avoid unnecessary requests being made.

The way forward

In conclusion, LPS-not-to-be would have provided more people with watered down safeguards whereas the LPS-as-is (aka DoLS 2.0) provides better safeguards but the challenge is enabling more people to secure them. They provide statutory time limits to prevent arbitrary detention. Everyone is entitled to an independent periodic check, whether from a BIA or a judge. The focus now should be on how best to deal with the demand justly and at proportionate cost. We should take our steer from the factors in the Court of Protection Rules and better enhance the use of current resources, whilst justifiably demanding more from the change in government priorities.

A capacity masterclass from MacDonald J (and an updated capacity guide from us)

North Bristol NHS Trust v R [2023] EWCOP 5 (MacDonald J)

Mental capacity – assessing capacity

Summary[3]

In 2015, in *Kings College Hospital NHS Foundation Trust v C and V* [2015] EWCOP 80, MacDonald J provided both the then-

[2] See in this regard, the 'Midnight Law' one-pager from the Faculty of Intensive Care Medicine on deprivation of liberty in intensive care.

[3] Note, we have also reported this case in 'headnoted' fashion in the first issue of the 39 Essex Chambers Mental Capacity Case Report series, available here.

authoritative summary of the principles to apply in assessing capacity, and a masterclass in the application of those principles to a complex case. In *North Bristol NHS Trust v R* [2023] EWCOP 5, MacDonald J has updated his authoritative summary to take account of the Supreme Court decision in *A Local Authority v JB* [2021] UKSC 52, and again provided a masterclass in the application of those principles.

The case concerned the question of the capacity and (if she lacked capacity in the relevant domains) the best interests of a woman as regards her birth arrangements. The woman, R, was a serving prisoner; she was a failed asylum contact and wished no contact with her mother who was understood to be present in England. She had had two previous children, both of whom had been removed from her care, one to adoption and one to placement with her mother. Little was known about the circumstances of her current pregnancy. She had had continued deterioration in the growth of her baby, and a number of other complications, which the clinicians involved considered meant that only a Caesarean section was consistent with recommended safe obstetric practice in this case. R had not said that she did not want a Caesarean section, but the clinicians were concerned as to whether she had capacity to make the decision. One doctor, a Doctor Q, considered that she had capacity to make decisions about her birth arrangements; none of the other clinicians considered this to be so. However, as MacDonald J observed at paragraph 44:

> […] *a difficulty in this case has been in identifying whether R is suffering from an impairment of, or a disturbance, in the functioning of the mind or brain. In particular, in circumstances where those who have assessed R are (with the possible exception of Dr Q) agreed that her presentation suggests that the functioning of her mind is impaired, but where they have not been able to arrive at any formal diagnosis for a presentation variously described as "unusual" and "baffling", this case has given rise to the question of whether a formal diagnosis in respect of R is necessary in order for the terms of s.2(1) of the 2005 Act to be satisfied.*

As MacDonald J had set out in the *C* case, but which usefully bear reproducing here, the 'cardinal principles' that must be followed are that

> *i) A person must be assumed to have capacity unless it is established that they lack capacity (Mental Capacity Act 2005 s. 1(2)). The burden of proof lies on the person or body asserting a lack of capacity, in this case the Trust, and the standard of proof is the balance of probabilities (Mental Capacity Act 2005 s. 2(4) and see KK v STC and Others [2012] EWHC 2136 (COP) at [18]);*[4]
>
> *ii) Determination of capacity under Part I of the Mental Capacity Act 2005 is always 'decision specific' having regard to the clear structure provided by ss 1 to 3 of the Act (see PC v City of York Council [2014] 2 WLR 1 at [35]). Thus, capacity is required to be assessed in relation to the specific decision at the time the decision needs to be made and not to a person's capacity to make decisions generally;*
>
> *iii) A person is not to be treated as unable to make a decision unless all*

[4] Note that the standard of proof strictly applies only in the court setting. Outside the court setting, in the context of care and treatment, the question is whether there is a reasonable belief that the person lacks capacity to make the decision (s.5).

practicable steps to help him to do so have been taken without success (Mental Capacity Act 2005 s. 1(3));
iv) A person is not to be treated as unable to make a decision merely because he or she makes a decision that is unwise (see Heart of England NHS Foundation Trust v JB [2014] EWHC 342 (COP) at [7]). The outcome of the decision made is not relevant to the question of whether the person taking the decision has capacity for the purposes of the Mental Capacity Act 2005 (see R v Cooper [2009] 1 WLR 1786 at [13] and York City Council v C [2014] 2 WLR 1 at [53] and [54]);[5]

v) Pursuant to s. 2(1) of the 2005 Act a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain. It does not matter whether the impairment or disturbance in the functioning of the mind or brain is permanent or temporary (Mental Capacity Act 2005 s. 2(2)). It is important to note that the question for the court is not whether the person's ability to take the decision is impaired by the impairment of, or disturbance in the functioning of, the mind or brain but rather whether the person is rendered unable to make the decision by reason thereof (see Re SB (A Patient: Capacity to Consent to Termination) [2013] EWHC 1417 (COP) at [38]);

vi) Pursuant to s. 3(1) of the 2005 Act a person is "unable to make a decision for himself" for the purposes of s.2(1) of the Act if he is unable (a) to understand the information relevant to decision, (b) to retain that information, (c) to use or weigh that information as part of the process of making the decision, or (d) to communicate his decision whether by talking, using sign language or any other means.
vii) An inability to undertake any one of these four aspects of the decision making process set out in s 3(1) of the 2005 Act will be sufficient for a finding of incapacity provided the inability is because of an impairment of, or a disturbance in the functioning of, the mind or brain (see RT and LT v A Local Authority [2010] EWHC 1910 (Fam) at [40]). For a person to be found to lack capacity there must be a causal connection between being unable to make a decision by reason of one or more of the functional elements set out in s. 3(1) of the Act and the diagnostic element of 'impairment of, or a disturbance in the functioning of, the mind or brain' required by s. 2(1) of the Act, i.e. for a person to lack capacity the former must result from the latter (York City Council v C [2014] 2 WLR 1 at [58] and [59]);

viii) The information relevant to the decision includes information about the reasonably foreseeable consequences of deciding one way or another (Mental Capacity Act 2005 s. 3(4)(a));

ix) The threshold for demonstrating capacity is not an unduly high one (see CC v KK & STCC [2012] EWHC 2136 (COP) at [69]).

In the *North Bristol* case, MacDonald J noted (at paragraph 43) that:

The foregoing authorities now fall to be read in light of the judgment of the Supreme Court in A Local Authority v JB [2022] AC 1322. The Supreme Court held that in order to determine whether a person lacks capacity in relation to "a matter" for the purposes of s. 2(1) of the

[5] Although, as the *Royal Bank of Scotland case* makes clear, that does not mean that the fact that the proposed decision appears unwise is irrelevant – it is a trigger to consider whether the person has capacity to make it:

> *Mental Capacity Act 2005, the court must first identify the correct formulation of "the matter" in respect of which it is required to evaluate whether P is unable to make a decision. Once the correct formulation of "the matter" has been arrived at, it is then that the court moves to identify the "information relevant to the decision" under section 3(1) of the 2005 Act. That latter task falls, as recognised by Cobb J in Re DD, to be undertaken on the specific facts of the case. Once the information relevant to the decision has been identified, the question for the court is whether P is unable to make a decision in relation to the matter and, if so, whether that inability is because of an impairment of, or a disturbance, in the functioning of the mind or brain.*

Applying these broad principles, MacDonald J turned to the specific question before him, identifying (at paragraph 57) that there were four questions he had to address:

> *First, what is the "matter", i.e. what is the decision that R has to make. Second, what is the information relevant to that decision. Third, is R unable to make a decision on the matter. Fourth, if R is unable to make a decision on the matter, is that inability caused by a disturbance in the functioning of her mind or brain.*

As to the first question, MacDonald J considered as being too broad the formulation advanced by the Official Solicitor, namely "whether to carry her baby to the point of natural childbirth or to have the baby delivered earlier and, if so, whether to do so by induction or Caesarean section." This was because:

> *59. In this context, in circumstances where R has had continual deterioration in growth of her baby from 28 weeks and that her abdominal circumference now well below the 5th centile, indicating a growth restricted, oligohydramniotic pregnancy, **the decision R is being asked to make is whether or not to undergo the procedure clinically indicated in those circumstances.** This does not mean that the option of carrying the baby to term followed by labour either induced or natural is irrelevant. But in light of the fact that R's treating team can now offer for decision only one clinically safe course, it is relevant as information to be retained, understood, weighed or used when deciding the matter, rather than as part of the proper formulation of the matter to be decided.* (emphasis added)

Turning then to the relevant information, MacDonald J reminded himself that the task had to be undertaken by reference to the specific facts of this case because:

> *61. Human decision making is not standardised and formulaic in nature in that we do not, at least consciously, break a decision down carefully into discrete component parts before taking that decision. In addition, decisions are always taken in a context, with the concomitant potential for a myriad of other factors, beyond the core elements of the decision, to influence the decision being taken. This has the potential to make the task of creating a definitive account of the information relevant to a particular decision a challenging one. This difficulty can be addressed however, by acknowledging that in order to demonstrate capacity, a person is not required or expected to consider every last piece of information in order to make a decision about the matter, but rather to have the broad, general understanding of the kind that is expected from the population at large (see Heart of England NHS Foundation Trust v JB [2014] EWHC 342 (COP) at [25]). Within this context, the Mental Capacity Act Code of Practice at [4.16] states relevant information includes "the*

> *nature of the decision", "the reason why the decision is needed" and "the likely effects of deciding one way or another, or making no decision at all".*

In the particular circumstances of R's case, this meant that:

> *62.* […] *the information relevant to the decision on the matter in this case can usefully be derived from the questions that might reasonably be anticipated upon a member of the population at large being told that their doctor is recommending an elective Caesarean section and being asked whether or not they consent to that course. Namely, why do you want to do a Caesarean section, what are the alternatives, what will happen when it is done, is it safe for me, is it safe for my unborn child, how long will I take to recover and what will happen if I decide not to do it. Within this context, I am satisfied information relevant to the matter requiring decision by R in this case can be articulated as follows:*
>
> > *i) The reason why an elective Caesarean section is being proposed, including that it is the clinically recommended option in R's circumstances.*
> > *ii) What the procedure for an elective Caesarean involves, including where it will be performed and by whom; its duration, the extent of the incision; the levels of discomfort during and after the procedure; the availability of, effectiveness of and risks of anaesthesia and pain relief; and the length and completeness of recovery.*
> > *iii) The benefits and risks (including the risk of complications arising out of the procedure) to R of an elective Caesarean section.*
> > *iv) The benefits and risks to R's unborn child of an elective Caesarean section.*
> > *v) The benefits and risks to R of choosing instead to carry the baby to term followed by natural or induced labour.*
> > *vi) The benefits and risks to R's unborn baby of carrying the baby to term followed by natural or induced labour.*

At paragraph 63, MacDonald J made clear that in relation to (iv) that R's child had no separate legal identity until born, but that:

> *that legal position does not prevent the impact on the unborn child of taking or not taking a decision being information relevant to the matter requiring decision. Indeed, I consider it a safe assumption that one of the foremost pieces of information a pregnant woman would consider relevant in deciding whether to undergo any medical procedure during pregnancy is that of the potential impact on her unborn child. On the evidence of Dr Jobson, in this case R has shown some preference for having a live, healthy baby, as inferred from her showing occasional interest in the baby by asking for scan photos, wanting baby clothes and speaking about going to see the baby from time to time.*

As to the third question, on the evidence before him, MacDonald J identified, first that:

> *65. There is some difficulty in this case in establishing the extent to which the relevant information was conveyed to R. This stems from the relative brevity of each of the documents recording the outcome of the various capacity assessments that have been undertaken on R. During the course of her oral evidence, Dr Zacharia noted, "we are not good at writing capacity*

> *verbatim" and that, especially where professionals differ, it would be very helpful to have more detail.*

MacDonald J made it clear that he agreed with those sentiments, and in a passage of broader application, continued:

> *Given the number of capacity assessments that are required to be carried out on a daily basis in multiple arenas, it would obviously be too onerous to require a highly detailed analysis in the document in which the capacity decision is recorded. However, a careful and succinct account of the formulation of the matter to be decided and the formulation of the relevant information in respect of that matter, together with a careful and concise account of how the relevant information was conveyed and with what result, would seem to me to be the minimum that is required.*

On the evidence before him, MacDonald J found that:

> *68.* […] *Whilst on occasion R may be able to understand in a limited way the information conveyed to her regarding the matter on which a decision is required (as demonstrated, for example, by R being able to verbalise to Dr Jobson that a Caesarean section is cutting open her tummy to deliver the baby), she is unable to retain that information for long enough to be able to use or weigh the information and communicate a decision and, in the circumstances, is unable to make a decision about whether or not her baby should be delivered pre-term by elective Caesarean section.*

As to the fourth question, the Official Solicitor had initially argued that, in identifying the impairment of the functioning of the mind or brain under s.2(1), the court must identify the underlying condition. This was position was moderated in argument, but MacDonald J helpfully set out why a formal diagnosis is not required:

> *46. In A Local Authority v JB at [65], the Supreme Court described s.2(1) as the core determinative provision within the statutory scheme for the assessment of whether P lacks capacity. The remaining provisions of ss 2 and 3, including the specific decision making elements within the decision making process described by s.3(1), were characterised as statutory descriptions and explanations in support of the core provision in s.2(1), which requires any inability to make a decision in relation to the matter to be because of an impairment of, or a disturbance in the functioning of, the mind or brain. Within this context, the Supreme Court noted that s.2(1) constitutes the single test for capacity, albeit that the test falls to be interpreted by applying the more detailed provisions around it in ss 2 and 3 of the Act. Again, once the matter has been formulated and the information relevant to the decision identified, the question for the court is whether P is unable to make a decision in relation to the matter and, if so, whether that inability is because of an impairment of, or a disturbance, in the functioning of the mind or brain.*
>
> *47. Once the case is before the court, the overall assessment of capacity under the single test is a matter for the judgment of the court (see Re SB (A Patient: Capacity to Consent to Termination) [2013] EWHC 1417 (COP) at [38]). In this context, the question of whether any inability of R to make a decision in relation to the matter in issue is because of an*

impairment of, or a disturbance in, the functioning of the mind or brain is a question of fact for the court to answer based on the evidence before it. In this context, the wording of s.2(1) itself does not require a formal diagnosis before the court can be satisfied that whether any inability of R to make a decision in relation to the matter in issue is because of an impairment of, or a disturbance, in the functioning of the mind or brain. The words "impairment of, or a disturbance in" are not further defined elsewhere in the Act. In these circumstances, there is no basis for interpreting the statutory language as requiring the words "impairment of, or disturbance in" to be tied to a specific diagnosis. Indeed, it would be undesirable to do so. To introduce such a requirement would constrain the application of the Act to an undesirable degree, having regard to the complexity of the mind and brain, to the range of factors that may act to impair their functioning and, most importantly, to the intricacies of the causal nexus between a lack of ability to take a decision and the impairment in question. In PC v City of York Council McFarlane LJ (as he then was) cautioned against using s.2(1) as a means "simply to collect the mental health element" of the test for capacity and thereby risk a loss or prominence of the requirement of a causative nexus created by the words "because of" in s.2(1). Reading s.2(1) as requiring a formal diagnosis would in my judgment significantly increase that risk.

48. In the foregoing circumstances, a formal diagnosis may constitute powerful evidence informing the answer to the second cardinal element of the single test of capacity, namely whether any inability of R to make a decision in relation to the matter in issue is because of an impairment of, or a disturbance, in the functioning of the mind or brain. However, I am satisfied that the court is not precluded from reaching a conclusion on that question in the absence of a formal diagnosis or, to address Mr Lawson's original proposition, in the absence of the court being able to formulate precisely the underlying condition or conditions. The question for the court remains whether, on the evidence available to it, the inability to make a decision in relation to the matter is because of an impairment of, or a disturbance in the functioning of, the mind or brain.

MacDonald J accepted the evidence of the consultant psychiatrist involved that even though there had been no formal diagnosis, on the balance of probabilities, R had a learning disability, which amounted to an impairment that disabled R from being able to make a decision about whether or not her baby should be delivered pre-term by elective Caesarean section, by preventing her from retaining information long enough to use and weigh it to make a decision. He also noted the psychiatrist's evidence that "*in circumstances where is an element of dissociation due to past trauma, R may also be at times choosing not to retain the information*" (paragraph 71, the word 'choosing' being an interesting one here).

As he had found that R lacked capacity to make the decision, MacDonald J had then to consider what course of action was in her best interests. As with considerations of capacity, and in line with previous case-law he found that the impact on R of any adverse impact on the unborn child of taking or not taking the decision *was* a legitimate factor to be taken into account when

assessing R's best interests (paragraph 79). On the evidence before him, and:

> *81.* […] *Given what I am satisfied is the would be the extremely traumatic experience for R of having to give birth to a dead child should the appreciable risk of the baby dying before natural or induced labour can occur become manifest, I am satisfied on balance that an elective Caesarean section is in R's best interests.*
>
> *82. I am further reinforced in my view that an elective Caesarean is in R's best interests by the, albeit limited, views she has expressed in respect of the same. Whilst I am satisfied that R does not have capacity to consent to an elective Caesarean section, it is relevant that she has never expressed an objection to such a procedure when it has been discussed with her. Lack of objection is not assent. However, I consider that this is nonetheless a further factor providing support for the court's conclusion as to best interests. As does the preference R has shown, on occasion for giving birth to a live, healthy baby.*

MacDonald J concluded by observing that:

> *84. As I have had cause to observe in another urgent case of this nature that came before me in the week I dealt with this matter, for the court to authorise a planned Caesarean section is a very serious interference in a woman's personal autonomy and Art 8 rights. As the Vice President noted in in Guys and St Thomas NHS Foundation Trust & Anor v R, Caesarean sections present particular challenges in circumstances where both the inviolability of a woman's body and her right to take decisions relating to her unborn child are facets of her fundamental freedoms. Against, this Parliament has conferred a jurisdiction on this court to authorise medical treatment where a person lacks capacity to decide whether to undergo that medical treatment and where the medical treatment is in the person's best interests. I am satisfied it is appropriate to exercise that jurisdiction in this case, for the reasons I have given.*

A postscript to the judgment confirmed that R had undergone an elective Caesarean section in accordance with the care plan, which proceeded smoothly. R's baby was born in good condition and was doing well for his gestation.

Comment

We have set out the reasoning of MacDonald J in some detail in relation to the elaboration of the capacity test as it applied to R because it shows (1) both the rigour of the steps required in a complex case; and (2) the consequent transparency of the decision reached. Whether or not one agrees with the outcome, it is entirely clear what MacDonald J considered to be the matter in question, what the information was that was relevant to that decision; how he reached the conclusion that R could not retain or use and weigh the information, and how that inability was caused by an impairment or disturbance in the functioning in her mind or brain. It is therefore precisely the sort of transparent and accountable, and therefore defensible, decision that we would suggest meets the demands of the CRPD (see further in this regard this article).

One point that is brought out by the transparency of the decision is that is possible and interesting to compare MacDonald J's list of relevant information with that set out in the Royal College of Gynaecologists and Obstetricians' August 2022 Planned Caesarean Birth consent guidance. The latter is said to be used for women over the age of 16 with mental capacity (and people under 16 years who are Gillick

competent). MacDonald J's list was draw up for purposes of deciding whether or not R had capacity. There are strong similarities, but not a direct overlap. This may be a function of the fact that the guidance was not before MacDonald J (there is no reference to it in the judgment), but it would have been interesting to see whether MacDonald J considered that the requirements of the RCOG guidance meshed with his own analysis of the position. It is certainly the case that, more broadly, there may be an insufficiently recognised tension between supporting people to make decisions for purposes of the MCA (which pushes towards a minimalist approach to the relevant information), and complying with the requirements of securing informed consent for purposes of the law of negligence (which pushes towards a maximalist approach).

MacDonald J's clear confirmation that a formal diagnosis is not required in order to reach a conclusion that a person lacks capacity to make a decision is helpfully crisp, as are his observations about the minimum requirements for recording assessments. We have updated our guidance note on assessing and recording capacity accordingly to reflect them (as well as to make a few other updates required by the passage of time since the last update).

Fluctuating capacity – making rights real and practical, not theoretical and illusory

A Local Authority v PG & Ors [2023] EWCOP 9 (Lieven J)

Mental capacity – assessing capacity

Summary[6]

This decision provides a very clear and helpful route map through the complexities of fluctuating capacity. The case concerned a 34 year old woman, PG, who had diagnoses of an intellectual disability in the moderate range, and autism spectrum disorder. She had also recently been diagnosed as having "trauma based mental illness with Emotionally Unstable Personality Disorder traits" (impulsivity, suicidal thoughts and emotional instability). As Lieven J noted (paragraph 4):

> *The parties agree that PG lacks capacity in the following respects – to conduct these proceedings and to enter into an occupancy agreement. The parties agree that she has capacity to make decisions about where she lives. However, the parties disagree about whether PG has capacity in respect of decisions about her care, including when she is within the home, when in the community, and at times of heightened anxiety. They also disagree as to whether she has capacity as to contact with others, including at times of heightened anxiety.*

Having set out a condensed list of the circumstances which gave rise to the concern of PG's local authority, Lieven J turned to the evidence of Dr Jordan King, Highly Specialist Clinical Psychologist at the Intensive Support Team of the Adult Neurodevelopmental Services for the relevant NHS Trust, was involved in PG's care between 2018 and the middle of 2022. He gave oral evidence to the Court and was cross examined. As Lieven J noted (paragraph 19):

> *It was clear from his evidence that this is a complex case in respect of PG's capacity and that the law's desire for clear lines as to both what decisions she does and does not have capacity to make, and in what circumstances she*

[6] Note, we have also reported this case in 'headnoted' fashion in the first issue of the 39 Essex Chambers Mental Capacity Case Report series, available here.

> *loses capacity, does not fit with the reality of PG's presentation. It might be said there was a lack of clarity in Dr King's reports, and perhaps shifts in his oral evidence. However, in my view that was not because of any lack of expertise or careful consideration by Dr King, but rather because of the complex interactions in PG's presentation and behaviours.*

Of significance, Lieven J continued:

> *It is important to note that Dr King had seen PG at times when she was in a heightened state, after some of the incidents referred to above. Therefore, his evidence was more based on actual observations of PG at critical moments, than is often the case with experts in these cases.*

Lieven J noted (at paragraph 30) that:

> *the Court of Protection has frequently had to consider the position of a person who has "fluctuating capacity" and such cases have been treated somewhat differently.*

In the circumstances, she found that:

> *36. I am really faced with a choice between making orders that follow the line of Sir Mark Hedley in PWK, and thus taking a "longitudinal view" of PG's presentation, and which closely relates to Newton J's "macro" decisions* [in *CDM*]*; or that of Cobb J in DN and making anticipatory declarations in respect of when PG has the equivalent of a "meltdown". Having analysed the facts of those cases, and considered those of PG, I do not think that one or other is the correct or indeed better approach. How an individual P's capacity is analysed will turn on their presentation, and how the loss of capacity arises and manifests itself. Both the decisions in issue here are ones that arise on a regular basis and often not in planned or controlled situations. That will influence how decisions about capacity are approached.*

Importantly, Lieven J reminded herself that:

> *37. In deciding this issue I must have regard to the importance of making orders that are workable and reflect the reality of PG's "lived experience", both for the sake of PG and those caring for her. This can be analysed in various difference ways. It is a fundamental principle of the European Convention on Human Rights and the Strasbourg jurisprudence that the Rights should be interpreted in a way which makes them real and practical, not theoretical and illusory. It is a principle of statutory construction that the Court must have regard to the "mischief" of the statute. One of the mischiefs of the MCA is to seek to preserve an individual's autonomy, but in a way that ensures that when they do not have capacity, their best interests are protected.*
>
> *38. My concern about making an anticipatory declaration in a case such as this, is that it would in practice be unworkable for those caring for PG. Unlike DN, PG does not have capacity in relation to decisions around her care, both when at home and in the community. Although when calm, she does at times make capacitous decisions within the meaning of section 3(1), I accept Dr King's evidence that even when at home, when she becomes anxious and emotionally dysregulated, she loses capacity. This seems to me to be a more fundamental part of her general presentation than was the case with DN.*

Whilst Lieven J noted that, it might well be that there were times when PG's decision making

was impacted by alcohol consumption, "*the evidence is clear that her decision making is impacted by her mental impairment under s.2(1) and not simply by consuming excessive alcohol*." Further:

> *41. It is not possible to disentangle the influence of alcohol from the impact of her mental impairment. If the evidence was that PG only lacked capacity at times when she is intoxicated then the position would be different, but that is not the evidence.*[7] *No party argued that the mental impairment has to be the sole cause for the person being unable to make a decision within the meaning of s.3(1).*
>
> *42. On the basis of Dr King's evidence, I conclude that the primary, though quite possibly not only reason, for PG not having capacity in relation to decisions about contact with others is her mental impairment.*

Lieven J therefore considered that the

> *43.* […] *the appropriate approach is to take the "longitudinal view". An anticipatory order would in practice be close to impossible for care workers to operate and would relate poorly to how her capacity fluctuates. The care workers would have to exercise a complicated decision making process in order to decide whether at any individual moment PG did or did not have capacity. This might well vary depending on the individual care worker, and how much of the particular episode they had witnessed or not. The result would fail to protect her, probably have minimal benefit in protecting her autonomy and in practice make the law unworkable.*
>
> *44. In my view, the more practical and realistic approach is to make a declaration that PG lacks capacity in the two key respects, but also make clear that when being helped by the care workers they should so far as possible protect her autonomy and interfere to the minimum degree necessary to keep her safe.*

Comment

Lieven J's observation that whatever orders she had made had to be workable, not just as a matter of pragmatism, but also so as actually satisfy the ECHR, is an important one. Further, her identification of the difficulties with making anticipatory declarations in PG's case resonates with the wider difficulty of seeking such anticipatory declarations, which in practice are only really workable if they relate to (1) a very obvious one-off, for instance giving birth; or (2) a situation where there are very clear, and obvious, external triggers for a person temporarily losing capacity to make a relevant decision. It is important to remember, however, that this is a difficulty solely for the court, which is fixed with the obligation to determine, at the point of making its decision, whether the person has or lacks the relevant capacity and – if possible – whether there are specific and identifiable circumstances under which they may do so. Outside the courtroom setting, the question is always whether those concerned with carrying out acts in connection with care and treatment reasonably believe that the person lacks capacity

[7] As a matter of law, a person can lack capacity for purposes of the MCA where alcohol has sufficiently impaired the functioning of their mind or brain (see paragraph 4.12 of the Code of Practice). However, a whole series of complexities would ensue in terms of seeking to establish a framework around someone with no apparent impairment, but who lacked capacity to make decisions about contact when intoxicated: not least, that such a framework could logically apply to anyone who might ever drink alcohol. In relation to addressing alcohol dependence, which raises distinct, and very difficult questions, see this guidance from Alcohol Change, and for a discussion about alcohol related brain damage and capacity, see this shedinar.

to give the relevant consent at the point that consent is required. In this regard, the guidance note we have done about fluctuating capacity in context may be of assistance (and also contains consistent and complementary observations about the operation of the ECHR to those contained in the current judgment).

Lieven J's emphasis on the importance of care workers protecting the autonomy of PG was an important ethical corollary to her willingness to declare PG to lack capacity in the relevant domains, and must always be remembered in any case where workably securing the person's interests may push towards a more 'longitudinal' approach to capacity. It also equally, if not more, important to remember that such situations are ones crying out for working with the individual to help them set out what they would like (or would not like) at points when they may in fact lack capacity.

Grasping the nettle of the interface

Manchester University Hospital NHS Foundation Trust v JS and Manchester City Council [2023] EWCOP 12 (HHJ Burrows, sitting also as a s.9 judge)

Mental Health Act 1983 – interface with MCA

This case concerned ineligibility for detention under the Mental Capacity Act under Schedule 1A MCA, and, in particular, the extent to which the court is bound to accept conclusions of the professionals involved.

The case related to a 17-year-old referred to the judgment as 'Jane' or 'JS,' who was represented by her mother, MS, as litigation friend. JS had diagnoses of autistic spectrum disorder, attention deficit hyperactivity disorder, a learning disability and an attachment disorder. She complex mental health needs and was agreed by all parties to be a danger to herself, and vulnerable to harm from others. There was no immediately effective plan for her care in the community.

In December 2022, JS was admitted a psychiatric inpatient in a specialist hospital for children and adolescents (the judgment records specifically that she had been admitted for the purposes of assessment and treatment of her mental disorders). She was assessed as having capacity to consent to an admission and was discharged home in January, but was quickly detained under s.136 MHA when she ran away from home and ran into traffic. She was assessed by the CAMHS gatekeeping service, but found not to be suitable for admission. She was again detained under s.136 a few days later after attempting suicide by overdose, followed by detention under s.2 MHA to a general adult acute (non-psychiatric) ward in a hospital to be treated for the physical consequences of the overdose.

Jane's s.2 MHA detention expired on 5 February, and while she had been physically fit for discharge for some time, she remained in hospital in the absence of any safe discharge destination. The court described the nature of Jane's care and treatment in hospital, which plainly amounted to a deprivation of liberty:

> 15. *A flavour of Jane's care and treatment at J6 is given in the statements and notes I read. According to one statement, there were many incidents during the currency of her s. 2 detention where she absconded or attempted to abscond. She tried to self-harm on a number of occasions, including by the use of sharp objects, attempting to swallow batteries, and claiming to have swallowed screws. She tried to lock herself in a toilet in order to carry out these acts of self-harm.*
>
> 16. *In order to try to manage Jane, the Hospital put in place a "Care Plan of*

Restrictions" for her. I summarise those restrictions:

(1) Jane is not to leave the ward.
(2) She is to be subject to "1:1 supervision (with a minimum of 2:1 assessed as necessary and appropriate by the ward staff during periods of escalation)".
(3) She is to be supervised when in the bathroom at all times by her care support worker and the bathroom door must not be locked.
*(4) Physical restraint and oral sedative medication **may** be used (as set out in the plan) if de-escalation techniques have been attempted but are unsuccessful.*
(5) Jane's room is "reviewed" by the Nurse in charge at least twice daily on shift handover "to remove any risky objects that Jane could use to cause herself or others harm"
(6) Jane's cubicle may be subject to additional searches if necessary and proportionate if there is a risk that she may have retained items she could later use to harm herself.

The records also detailed many 'incidents' in which Jane injured herself and others, and had to be restrained to prevent harm. HHJ Burrows noted that: "*it was anticipated on the expiry of MHA detention that the MCA would be used for exactly the same care plan, with exactly the same purpose namely to treat Jane's challenging and self-injurious behaviour, largely by physical containment and the use of restraint both by physical intervention and medication*" (paragraph 22) which included a number of psychotropic medications. HHJ Burrows observed that "[i]t seems entirely obvious to me those treating Jane considered her behaviour to be a manifestation of her mental disorder. This pharmacological treatment was intended to combat it" (paragraph 23).

There was no lawful authorisation for Jane's detention in hospital after the expiration of the s.2 MHA authorisation. The Trust took the clear view that JS did not need to be in hospital, but did not propose that she should be discharged in the absence of any safe destination. There was no option for her to either move to a Tier 4 CAMHS bed or have a community placement, and the local authority was continuing to work on a package of care to support Jane's return home (which was facilitated on 27 February, but was unsuccessful and Jane returned to hospital by 2 March, following the contested hearing). The Trust made an application to authorise JS's deprivation of liberty in hospital under the MCA, having refused to detain her under s.3 Mental Health Act 1983 (though she was subsequently detained under s.2 MHA after her March readmission which followed the contested hearing, she was again found not to be detainable under s.3 MHA).

HHJ Burrows that he had been the one to raise the concern as to whether the Court of Protection had the authority to detain Jane if she ought to be detained under the MHA; he also sat simultaneously in the High Court to cover all avenues. He also authorised Jane's detention in hospital on an interim basis pending full consideration of the issues in the case.

HHJ Burrows readily accepted evidence that Jane lacked capacity to make decisions regarding her residence and care. Similarly, in relation to best interests, HHJ Burrows accepted (with more hesitancy) that remaining where she was, despite it not being anything resembling an optimal environment, was the best available option for Jane while a robust care package to facilitate Jane's return to her mother's care was developed (it was hoped within a short timeframe after the hearing). Jane's remaining

in hospital was keeping her safe in the immediate short term, and it would not assist her to return home without a care package, which would very likely result in her return to hospital quickly (which ultimately occurred even though a care package was in place). The court noted the medical evidence that the doctor with responsibility for Jane's care "*was clear that he was not treating what is usually called the 'core condition' because such treatment was simply not available, but he was treating the manifestations of that condition, namely the behaviour outlined above in the incidents I have summarised*" (paragraph 42).

The crux of the court's judgment was in relation to whether Jane was ineligible for detention under Schedule 1A MCA, specifically under 'Case E', which applies where 'P is— (a) within the scope of the Mental Health Act, but (b) not subject to any of the mental health regimes.' (Paragraph 2 Schedule 1A MCA) The definition of 'within the scope of the Mental Health Act' is set out in paragraph 12 of Schedule 1A:

> *(1) P is within the scope of the Mental Health Act if-*
>
> *(a) an application in respect of P could be made under s.2 or s.3 of the Mental Health Act, and*
>
> *(b) P could be detained in a hospital in pursuance of such an application, were one made.*

After surveying the statutory provisions of both the MCA and MHA, HHJ Burrows proceeded on the basis that Jane could only be detained under s.3 MHA as she had very recently concluded a s.2 detention. In considering whether an application for detention under the MHA 'could' be made, HHJ Burrows made clear that "*the wording of the MCA places the Court in a similar position to the AMHP when determining whether P 'could' be detained*" (paragraph 65) as it is ultimately a question for the AMHP to make the application for admission if the medical recommendations are made. HHJ Burrows also observed that "[t]*o make the decision easier for the Court of Protection, or anyone else who has to decide, it is assumed for the purposes of Schedule 1A Para 1(12)(4) [MCA] that the medical recommendations for admission under s. 3(2) of the MHA have been made*" (paragraph 67). Finally, HHJ Burrows reminded himself of the definition of 'medical treatment' under s.145(4) MHA:

> *Any reference in this Act to medical treatment, in relation to mental disorder, shall be construed as a reference to medical treatment the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms of manifestations.*

HHJ Burrows considered that in this case it was:

> *69.* […] *immediately clear that the care plan for Jane on the ward was for medical treatment in this broad sense. It consisted in care, namely providing her with a safe place with nursing care. The purpose of that care plan, including the use of restraint both physical and chemical was to ensure that Jane did not harm herself, or that she absconded away from the care setting in order to do so.*

HHJ Burrows agreed that the treatment was not optimal, but that:

> *71* […] *in no meaningful sense could Jane's behaviours outlined above be described as anything other than manifestations of her mental disorder. Or put another way, Jane's mental disorder causes her to abscond from safe environments, such as her home or hospital. It causes her to place herself at*

> *great risk of danger. It causes her to injure herself using sharp objects or taking overdoses. She has done this with alarming regularity. Nothing that those responsible for her care have been able to do has prevented her from doing so. However, that is what they were trying to do, and their treatment was aimed at that.*

HHJ Burrows also noted that she was plainly objecting to being a mental health patient.

He went on to consider whether Jane 'could' have been detained under s.3 MHA. He considered that the issue was not simply whether the assessing professionals thought she could be detained under s.3, but whether the court, on the basis of the evidence before it, considered that she could. Considering *GJ v The Foundation Trust, a PCT & Secretary of State for Health* [2009] EWHC 2972 (Fam), HHJ Burrows reminded himself that Charles J had found that the MCA "*decision-maker should approach paragraph 12(1)(b) by asking himself whether in his view the criteria set by, or the grounds in, section 2 or section 3 of the 1983 Act are met (and if an application was made under them a hospital would detain P)*" (paragraph 80 of *GJ*). HHJ Burrows also noted that by the terms of Schedule 1A MCA, "*the decision-making process must be predicated on there being no available alternative under the MCA*" (paragraph 87).

HHJ Burrows found that Jane was within the scope of the MHA and found that she was ineligible for detention under the MCA. He summarised the reasons for his findings thus:

> *90. Firstly, that she was accommodated at the Hospital as a place of safety because there was nowhere else for her to go and, once the physical damage caused by her overdose was successfully treated, she needed no in patient medical treatment. The answer to that is: of course, she did. She was a danger to herself. She needed to be nursed safely and medicated to address the effects of her mental disorder (viz. to injure herself and abscond away for safety).*
>
> *91. It was submitted that although Jane suffers from a mental disorder it was not of a nature or degree to make it appropriate for her to receive medical treatment for that disorder in a hospital. This is clearly wrong. The medical treatment she did receive as a detained patient in hospital was necessary to keep her safe and to prevent her from absconding or harming herself. There was no readily available alternative when she was receiving it.*
>
> *92. It is submitted that the outcome of the MHA Assessments was that inpatient care for Jane's condition was neither available nor desirable because she could be treated in the community under the MCA. This too is plainly wrong. She could only be treated in the community once a suitable package of care was available for her. Until then she could not safely leave hospital. That was the situation with which I was confronted at the first hearing. At that point hospital was the only option.*
>
> *93. This is quite a familiar situation for those who practise mental health law. Patients who have been detained under the MHA (like Jane) can theoretically be discharged into the community with a suitable package of care, but only when that package is actually available. Many weeks or months can be spent putting such packages together (funding, placement, support etc) and in place. During which time patients remain detained. The whole s. 117 process is designed to speed that up so as to ensure detained patients get out and stay out of hospital. Of course, because Jane was never detained under s. 3 of*

the MHA, s. 117 aftercare was not available to her.

94. The hospital thought that utilising the MHA to detain Jane would be harmful to her mental health, as would her remaining in Hospital. This is an invalid argument which contains two fallacies. First, she was detained by her care plan which I have summarised above. What jurisdictional label is placed on the care plan is immaterial to its restrictive nature, whether that be MHA, MCA, "common law", the High Court's inherent jurisdiction is irrelevant to whether she was detained for treatment. That was the care plan's doing.

95. Secondly, keeping her in Hospital for a day longer than was necessary was also nothing to do with the regime she was subject to. Good clinical practice and the operation of Article 5 of the European Convention requires a patient to be detained only for so long as is necessary. The MHA does not prolong detention. In fact, as I have already said, proper use of s. 117 should reduce the overall time a patient spends in Hospital because professionals inside and out of Hospital concerned with health and social care should all work together to put together an effective discharge plan speedily.

96. There seems to be a belief, not just in this case but in others in which I have heard recently, that the decision to use the MHA should be viewed in isolation from what is available elsewhere at the time the decision to detain or not detain is taken. Ideally, a 17-year-old vulnerable young person would not be detained in a psychiatric facility, let alone a mixed adult general ward. However, where there is literally no option in which that young person will be safe, or as safe as possible in the circumstances, I cannot see how the MHA decision maker can avoid the decision I have had to make in this judgment. If the patient has to be detained for treatment for their mental disorder, and there is no alternative outside the hospital setting, and no other treatment plan available, then it seems clear to me the patient should not be detained under the MCA but rather under the MHA.

HHJ Burrows also rejected submissions that he should authorise the detention in the inherent jurisdiction in the alternative, finding that the MCA and MHA provided a legal structure for her detention.

Comment

This judgment grabs the nettle of a notoriously difficult issue under the MCA. In our view, it is also entirely correct.

The question of whether a person is detainable under the Mental Health Act is not an absolute one, but one which turns at least in part on whether the person could receive necessary care for a mental disorder outside of hospital. There are many people who are detained under s.3 Mental Health Act primarily because there are not yet any adequate arrangements for their care in the community: they 'need' to remain in hospital because there is simply nowhere else for them to receive appropriate treatment. We would further note that there are many people detained under the MHA who are being treated for symptoms of their disorder by way of medication or mental health nursing, and that 'treatment' is necessary for their health and safety.

There was no argument before the court that at the time of the hearing, Jane would be either safe or appropriately cared for if she left hospital. While the hospital was more appropriately understood as the 'least worst' option, it was plain that all other options were quite significantly worse and Jane would be at serious

risk of harm if she left. The care plan cannot be properly understood as anything other than one to treat symptoms of a mental disorder, and there was no proposal to change it. While the reasons the treating doctors refused to detain Jane are not entirely known, the court's logic as to why Jane could have been detained under the MHA is difficult to dispute. It is also very helpful that HHJ Burrows made clear that it is ultimately for the court to make the decision, rather than for the clinicians.

This judgment provides a thorough and welcome analysis which will likely be of assistance to other courts struggling with issues of Schedule 1A ineligibility.

Working through fluctuating capacity in the obstetric context

Wrightington, Wigan And Lee Teaching Hospitals NHS Foundation Trust v SM [2022] EWCOP 56 (Cobb J)

Mental capacity – best interests – medical treatment

Summary[8]

SM was 16 years old and a looked-after child under s.20 Children Act 1989. She resided in a supported living accommodation, and received regular care and support. She did not have a consistent relationship with her parents. She had a history of sexual exploitation, "*and suffer*[ed] *from a complex post-traumatic stress disorder as a result of childhood trauma, anxiety and emotional dysregulation. She has had multiple admissions to hospital as a result of her mental ill-health. She also has recorded instances of visual and auditory hallucinations, recalling a figure called 'Greg' who visits her. She is declining all psychotropic medications through fear she will become "like her brother", who it is said suffers from paranoid schizophrenia*" (paragraph 8).

At the time of the judgment, SM was 39 weeks pregnant. The Trust made an application for declarations that SM lacked capacity to make decisions regarding her obstetric care and treatment; that the Trust could proceed with a care plan which included delivery by caesarean section if necessary; and that SM could be deprived of her liberty to achieve the safe delivery of her child.

SM's antenatal care had been generally good, and she had been supported by a team which specialised in providing care to women with vulnerabilities. Most of her pregnancy had been uncomplicated, but she had become distressed and afraid when thinking about giving birth. This had caused her to, at times, self-harm and punch her stomach. She was briefly detained under s.5(2) MHA after stating she was a risk to herself.

During a routine scan on 10 November, an abnormality was noticed which indicated the foetus was at risk. The strong clinical opinion was that delivery should not be delayed to avoid a risk of stillbirth. SM agreed to be induced on 11 November, but then changed her mind and refused to carry on with the induction. Twice on 12 November and once on 14 November, SM agreed to an elective caesarean section but changed her mind at the stage of anesthesia being commenced due to severe anxieties. On 15 November, SM again agreed to a caesarean section, but again became severely anxious to the extent of running away from hospital grounds.

The case was brought on an urgent basis, and it was accepted by the Trust that the matter was "*complex and finely balanced*" (paragraph 3). The

[8] Note, although this case dates from 2022, it has only recently appeared on Bailii.

Official Solicitor declined to act, as it was agreed that SM had capacity to conduct proceedings; SM instructed her own solicitors to represent her.

Cobb J considered that SM had likely lacked capacity to make a decision about her treatment at the point at which the Caesarean section would become an immediate reality though did not consider that it was an 'inevitability' that she would do so. He accepted evidence that "*when calm she is able to recall the risks and benefits of proposed treatment, at that point she is not able to comply due to her health anxieties about different procedures involved in the treatment, such as anaesthetic, procedures, needles and medication*" (paragraph 29). Cobb J likened the case to that of *Re MB* [1997] EWCA Civ 3093:

> [i]*n that case, as in this, careful scrutiny of the evidence is necessary because fear of an operation can be a reasonable reason for refusing to undergo it. However, fear induced by panic may paralyse the will and thus destroy the capacity to make a decision. That is, in my judgment, this case* (paragraph 33)

Cobb J found that, if he was wrong on the issue of whether SM lacked capacity, he would exercise the High Court's parens patriae jurisdiction to make relevant order on the basis that SM was a vulnerable child.

In relation to best interests, at the time of the hearing, the clinical team considered that the only realistic option was a Caesarean section under general anaesthetic. The judgment set out that there was some lack of clarity as to the precise extent and timing of the risk of harm to the foetus. It also set out that SM's wish was to be able to deliver her baby with the least intervention practicable, and to be awake when her baby arrives. SM invited the court to make a decision "*to respect her autonomy and her ability today to make a capacitous decision in relation to this way forward*" (paragraph 24). She advanced as alternative submissions: (1) that she not be induced and should be allowed to go into labour naturally, with high levels of monitoring; or (2) to be vaginally induced and deliver vaginally. SM acknowledged that this had been attempted in the past and she had withdrawn her consent, but offered explanations that the process had been very painful and she had struggled to continue.

Cobb J adopted an approach which was a middle ground between the positions advanced by the respective parties: that SM should have one more opportunity for a vaginal induction, which if unsuccessful, would be followed by a Caesarean section under general anaesthetic if SM again lost capacity. Cobb J summarised his conclusion thus:

> 6. *…I am satisfied that the longer that the current situation goes on with this pregnancy at its extremely advanced stage, the greater is the risk of stillbirth of the baby, an outcome which would have a seriously deleterious effect on SM herself, particularly given her fragile mental health. I am further satisfied that ongoing distress for SM over the uncertainty of this current situation is not in her interests. I am also concerned about the situation that would arise should SM go into spontaneous labour in circumstances in which the medical support around her would not immediately be available. It is plainly in SM's best interests for a healthy baby to be born as soon as possible as the impact upon her psychological well-being, and the trauma that an unhealthy baby would create, would have a significantly detrimental and longer-term impact on both her and the baby. It is plainly in SM's best interests that she is able to exercise a high degree of autonomy over the manner in which her baby is born…I regard it as not only proportionate but also in SM's short and*

long-term best interests that the hospital attempts one final administration of vaginal induction of the baby. This should begin straightaway in order to give SM the best chance to deliver the baby vaginally and while she is alert and awake, something which she (and I understand this completely), wishes to achieve in her first experience of childbirth.

7. I am satisfied, however, from all that I have heard that there have been times in the last few days when SM has lost capacity in what has been described as "the heat of the moment", when anxiety and stress has overwhelmed her, and she has not been able to make a capacitous decision in relation to the appropriateness of submitting to Caesarean section. Should that situation arise in the hours ahead and if, in the opinion of the treating clinicians, she loses capacity again, as she has in the recent past and as described in the reports before me, and if the welfare of the mother or child is compromised or is likely to be compromised such that a caesarean section is indicated as an emergency, I confirm that it is in SM's best interests for the baby to be delivered by Caesarean section performed under general anaesthetic; it will accordingly be lawful for the hospital to perform that procedure in those circumstances. I recognise that this is not what the applicant NHS Trust wishes me to order in this particular case, at least in part, because they have assembled (no small feat) a dedicated and expert team this afternoon to perform the Caesarean section. However, with warning and due notice that the process of delivery of the baby is now to begin within the next few minutes or hours in the manner in which I have described, I very much hope that the clinical team that has been assembled can, either in its current form or in a substituted form, be on stand-by over the next few hours and days in the event that a Caesarean section is required.

The judgment included the welcome post-script that SM was induced after the hearing, safely delivered her daughter and was entirely compliant with medical advice during the delivery.

Analysis

This judgment is an interesting one on fluctuating capacity, particularly for its nuanced findings that SM likely had capacity at the time of the hearing, but repeatedly lost that capacity at the time when making a decision about a Caesarean section became an 'immediate reality.' However, as the postscript notes, on being given one further opportunity, it appears that SM had been able to make decisions despite her anxieties and the court was correct that her losing capacity was not 'inevitable.' Cobb J noted several times in the judgment that it was made on the specific facts of the case, but may be an interesting model for its careful and structured declarations on capacity and best interests in the event that SM again lost capacity to take a decision about her medical treatment (which ultimately were not required).

Short note: covert medication

A Local Authority v A & Ors (Re the Mental Capacity Act 2005) [2020] EWCOP 76 relates to the case of 'A', whose case was also discussed in the judgments of Poole J (*Re A (Covert Medication: Closed Proceedings)* [2022] EWCOP 44) and HHJ Moir (*The Local Authority v A & Ors* [2019] EWCOP 68 (18 June 2019)), which were covered in the November 2022 and December

2022 Mental Capacity Reports. A was a young woman with primary ovarian failure who was covertly medicated with hormone medication following orders to this effect by HHJ Moir in 2019. Neither A nor her mother had been told about the medication, due to concerns that her mother would seek to prevent A from taking the covertly-administered medication, which might result in either the administration of medication being ineffective and/or A ceasing to eat altogether.

This recently-reported 2020 judgment related to the decision to administer covert medication to A. The court noted that it had recently made an order that the substantive application to covertly medicate A not be served on B. The court noted its discomfort with considering such a significant application in the absence of B, who had been central in A's life. The consideration of the matter without B was supported by all other parties, including the Official Solicitor. HHJ Moir noted B's Article 6 rights and the importance of procedural fairness, but considered (at paragraph 11) that:

> *if she was aware of the plan B would seek to subvert the medical treatment. That view is based upon my knowledge of B's approach throughout these proceedings. I found in 2019 although B might say that she accepted the treatment should be undertaken that I had no confidence that she would encourage or support A to take the medication, or keep hospital appointments, and Dr X, consultant endocrinologist (to whom the judgment will refer to as Dr X), in their more recent report in, I think, March 2020, repeated their concerns about B's approach to A taking any medication. Therefore, I am satisfied that B should not be informed of the plan and therefore it is right that she should not have been notified of this hearing, or play a part within it.*

HHJ Moir identified that she would hear any opposing views to the application without B's presence, and considered that the scrutiny provided by the Official Solicitor and statutory bodies in weighing up the risks and benefits of the treatment would be appropriate. HHJ Moir considered that, 15 months after the original judgment concluding that it would be in A's best interests to have the medication, she had shown no willingness to take it; she was described as being 'completely against' the hormone medication, though willing to take other recommended medications. There had been no appeal to the court's substantive judgment that it was in A's best interests to have the medication, and further delay would only reduce the efficacy of the treatment. HHJ Moir reminded herself that the consequences of primary ovarian failure were profound, and included increased risk of death by cardiovascular disease by 30 to 40 years of age; by contrast, there were no meaningful physical risks to taking the medication. HHJ Moir accepted that there were disadvantages to A in going against her wishes and an interference with her Article 8 rights. However, HHJ Moir found that:

> *19. Balancing up the advantages and disadvantages it is clear that the advantages far outweigh the disadvantages, and the clear and significant advantages, set against the less concerning disadvantages, tell in favour of the covert medication being administered.* […]
>
> *20. Against the background of this case, it is clear that A and B would not willingly facilitate the administration of the medication for the primary ovarian failure, and that without that treatment the future for A will be significantly affected and even possibly life-limiting. If there was another way that the court could be satisfied that this treatment could be undertaken, then that would be*

considered. But the only mechanism by which the treatment can be administered is covertly. It is unarguable, unassailable, that the treatment is in A's best interests, and having considered the balance sheet it is difficult to see how A's best interests are not served by approving the application of the Trust, supported by the Local Authority and the Official Solicitor, that medication should be administered covertly, and in the circumstances I have set out, I am satisfied that any interference with Article 8 is justified, and is the only way forward to try to achieve what Dr X so graphically described in their oral evidence, and has set out in their written evidence, namely, that A should be given the opportunity to reach maturity and have a happy, fulfilling existence and, therefore, I am satisfied that the application should be granted.

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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.

Parishil Patel KC is speaking on Safeguarding Protected Parties from financial and relationship abuse at Irwin Mitchell's national Court of Protection conference on 29 June 2023 in Birmingham. For more details, and to book your free ticket, see here.

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

Advertising conferences and training events

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

Our next edition will be out in June. 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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