MENTAL CAPACITY REPORT: HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

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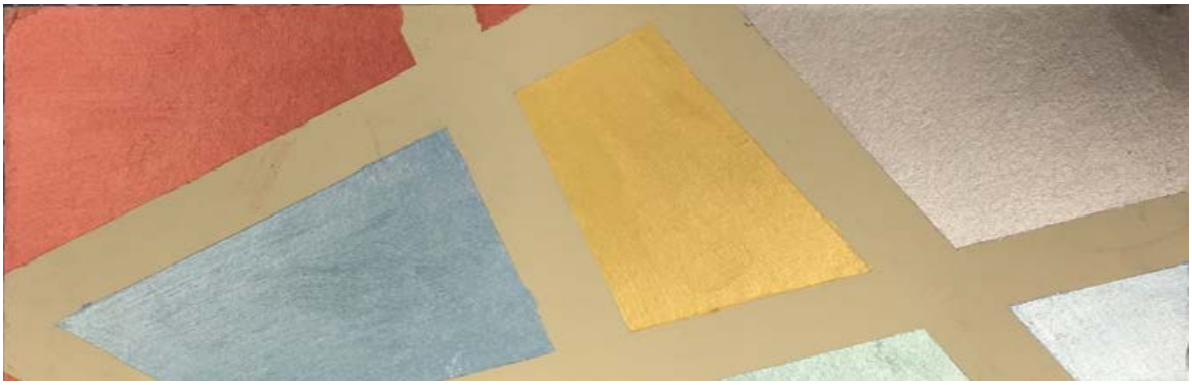

Welcome to the July 2023 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: an Anglo-Welsh LPS update and cases covering contingency planning, executive capacity, decision-specificity and restraining the detained patient;

(2) In the Property and Affairs Report: Hayden J takes on common LPA problems, an MOJ toolkit and a rather startling assertion about the position of professional solicitor deputies;

(3) In the Practice and Procedure Report: habitual residence under the spotlight, contempt and the Court of Appeal and the most recent Court of Protection statistics;

(4) In the Wider Context Report: the LGSCO ombudsman and deprivation of liberty, Article 2 and DoLs, visiting in care homes, and a report from our new Irish correspondents;

(5) In the Scotland Report: AWI masterclasses and the Scottish Government respondents to the Scott Report.

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

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

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LPS UPDATES

The DHSC and MOJ

The Joint Committee on Human Rights wrote on 28 May 2023 to the Minister of State for Social Care to express its view that the "*delay* [to implementation] *is deeply concerning, given the serious problems with the DoLS system that we reported on last year*," and to ask three questions. The Minister, Helen Whately MP, has responded by letter dated 14 May 2023 (published by the JCHR on 23 May 2023). The letter is available on the JCHR website here, but as it requires a bit of navigation to get to it, we reproduce the material parts.

The decision to delay implementation of the Liberty Protection Safeguards (LPS) was taken after careful consideration of any implications it may have. I know that many people and organisations did an incredible amount of work in preparing for the introduction of these safeguards and the decision to delay their implementation beyond the lifetime of this Parliament was not taken lightly.

As you are aware, the Deprivation of Liberty safeguards (DoLS) set out in the Mental Capacity Act 2005 (MCA), is the system that provides for the lawful deprivation of liberty, of adults who lack the relevant capacity in hospitals and care homes, in accordance with article 5 of the European Convention on Human Rights. It is important that everyone concerned upholds this system. I do, however, recognise the challenges facing this system following the Supreme Court judgment in 2014 in the 'Cheshire West' case which increased the number of people considered as deprived of their liberty. The introduction of LPS was intended to address these challenges and although the Government has decided that now is not the right time to introduce this reform, I understand these challenges continue to pose practical problems

for those affected by and applying the DoLS including those highlighted in your letter. I have responded to each of your points in turn.

Does the Government still believe that the system of DoLS is in need of reform? If so, given the delay in the implementation of the LPS, are any reforms of the system currently planned in the interim?

The Government still accepts the need for change and we are pleased that we have made progress towards introducing the LPS. There was clear support for implementing the LPS to replace DoLS at consultation, which will be a matter for a future government to consider.

The decision to delay the implementation of the LPS will enable us to focus on our priority of ensuring that everyone can access the right care, in the right place, at the right time. To achieve this goal, we are providing an historic funding uplift to the sector and taking forward the reforms set out in the Next Steps to Put People at the Heart of Care plan, which include investment in the workforce, technology and support for unpaid carers. Although these wider reforms will not alter the DoLS system, they will improve the lives of people who draw on, work in or provide care and support.

With respect to plans to reform DoLS in the interim, we recognise the importance of updates to the Mental Capacity Act Code of Practice (MCA Code) being taken forward irrespective of LPS to ensure all those practicing in this space have accurate and up-to-date guidance. Since the MCA came into force in 2007, the MCA Code has played an important role in shaping the practical application of the MCA. The Department of Health and Social Care and the Ministry of Justice (MoJ) intend to work together to consider the feedback and publish a response to the 2022 consultation on changes to the MCA Code, with the aim of publishing a revised MCA Code that supports understanding and the application of the MCA which is essential to the application of DoLS. Further details on the timing of this work will be shared with the sector in due course.

Finally, I recently met with the Chief Executive of Social Work England and our officials continue to work together on launching a consultation on refreshed standards for Best Interest Assessor Training to ensure the ongoing quality of all those carrying out this important role under DoLS.

What steps are being taken to address the delays to the processing and completion of DoLS applications, with the aim of ensuring that no one is unlawfully deprived of their liberty in a care setting?

The Government has made it clear that all individuals and bodies with legal duties under the DoLS must continue to apply these important safeguards to ensure the rights of people without the relevant mental capacity are protected.

Local authorities have a duty to make sure that they are processing all cases under DoLS and receive specific funding to process cases in the NHS through the Local Government Community Voices Grant. Annual data on the DoLS clearly shows wide variation in how local authorities are processing and completing their DoLS applications. Many local authorities already use a prioritisation tool to manage DoLS cases, such as that developed by ADASS following the Cheshire West ruling in 2014.

The Government has made available up to £7.5 billion of additional funding over two years to support adult social care and discharge – with up to £2.8 billion available in 2023/24 and up to £4.7 billion in 2024/25. Local authorities have flexibility about how to use this funding to meet local needs.

Will the availability of non-means-tested legal aid be extended to include those who may be subject to deprivation of liberty in care settings without an authorisation in place?

From 15 March 2022 to 7 June 2022, the Government consulted on detailed policy proposals published under the Legal Aid Means Test Review. The MoJ published the Government Response to the consultation exercise on 25 May 2023 which set out the detailed policy decisions underpinning the new means-testing arrangements.

As part of the recent Legal Aid Means Test Review covering England and Wales, the Government considered whether certain specified civil legal aid proceedings should no longer be subject to means testing arrangements. These proposals did not extend to the removal of legal aid means testing for individuals subject to deprivation of liberty in care settings where no authorisation was in place or in cases where the Court of Protection needs to make a deprivation of liberty order, and, therefore, this position remains unchanged. However, if the application to the Court of Protection is made on behalf of an under 18-year-old, the applicant will benefit from the decision to introduce non-means tested civil legal aid representation for all under 18s.

What steps are being taken to ensure that those involved in making DoLS decisions receive adequate human rights training, and fully understand the operation of DoLS?

It is vital that those involved in DoLS decisions receive the right training. Training and learning on DoLS, which is free to access, is available through Health Education England's e-learning for health platform as well as the Social Care Institute for Excellence's website.

It is also essential that all those involved in DoLS decisions have sufficient understanding of the MCA which underpins the safeguards. In addition to updating the MCA Code, the Government continues to support the National Mental Capacity Forum whose purpose is to raise awareness and understanding of the MCA across the health and social care sectors. The Department has sponsored this Forum jointly with the MoJ since 2015, bringing together stakeholders from a range of sectors where the MCA applies. Furthermore, MoJ continue to deliver wider MCA-awareness raising work on aspects of the MCA that do not directly relate to DoLS but are important for the proper application of the MCA which underpins the DoLS. This includes the publication of an MCA toolkit this month which provides guidance on the MCA and the legal steps for parents and carer to access funds on a young person's behalf.

I appreciate all the ongoing efforts of the sector to ensure the rights of those deprived of their liberty are upheld and I welcome the Committee's ongoing interest in this important issue.

In the most recent DOLS Newsletter published on 20 June 2023, the DoLS and Mental Capacity team at the DHSC made clear that:

> *remain committed to publishing a response to the consultation, which we hope to publish later this year. This response will summarise the valuable feedback we received, including the main themes we identified during our analysis of the responses.*
>
> *We would also like to take this opportunity to update you on the work to review and update the Mental Capacity Act 2005 Code of Practice (MCA Code) jointly with the Ministry of Justice (MoJ). We would like to assure you that both MoJ and DHSC remain committed to updating the MCA Code, to ensure that changes in case law and good practice since its publication in 2007 are incorporated, and to reflect the feedback stakeholders have provided both before and during consultation.*
>
> *As such, we are currently planning to work with the MoJ to revise the MCA Code, considering references on the Deprivation of Liberty Safeguards*

> *(DoLS) where appropriate, with the aim of ensuring all those who work with the Act and those who are affected by it have up-to-date statutory guidance. We will continue to work closely with stakeholders and further details on this work will be shared with you in due course.*[1]

The newsletter continues:

> *The Deprivation of Liberty Safeguards remain an important system for authorising deprivations of liberty. It is vital that health and social care providers continue to make applications in line with the Mental Capacity Act (MCA) 2005, and that Supervisory Bodies continue to fulfil their responsibilities with respect to authorising DoLS applications under the MCA to ensure that the rights of those who lack the relevant capacity are protected.*

Editorially, we are duty bound to note that unfortunate that neither in the letter from the Care Minister nor the DHSC Newsletter is it made clear how supervisory bodies can discharge their obligations (or public bodies make necessary applications to court) when it is clearly proving impossible for them to do with the resources currently available to them.

Welsh Government

A Welsh Government consultation was held between 17 March 2022 and 14 July 2022 on four sets of draft Regulations to support the implementation of the LPS in Wales The Welsh Government also consulted on supporting Impact Assessments, and a draft National Minimum Data Set for the LPS.

A summary of the consultation responses was published on 14 June 2023. The introduction sets out a number of key messages that were repeated across responses in relation to more than one of the consultation questions. These included:

- The need for further clarification on how the Regulations will work in practice and concerns that the Regulations are not supporting the intended reforms, particularly around reducing bureaucracy; embedding the principles of the MCA across care, support and treatment planning; and supporting the rights of the person.
- Questions around cross-border issues and associated practicalities around implementation, workforce, and monitoring and reporting.
- Concern that the Regulatory Impact Assessment underestimates costs associated with undertaking assessments, determinations and pre-authorisation reviews; the role of the AMCP; the role of the IMCA; plans for monitoring and reporting; and plans for workforce development and training.
- Concern over the definition of a deprivation of liberty included in the draft Mental Capacity Act Code of Practice (published for consultation by the UK Government, alongside draft Regulations for England) and associated impacts on the

[1] Whilst we wait for the revised Code, it may be worth remembering that there is an unofficial update prepared by Alex and others at 39 Essex Chambers highlighting the passages that are dangerous in the current Code. It also worth reading the update carefully – it does not sound as if there is the intention to update the DOLS code, as opposed to the main Code.

implementation of the safeguards in Wales.

- Welsh Language: Support for the active offer and the needing to strengthen commitments regarding preferred language, and build workforce capacity.

Picking up for present purposes on the penultimate bullet point, it is interesting to note (from page 59), under the heading "Concerns regarding the Code of Practice and how this is does not protect the rights of the cared for person" the following:

- Specific concerns raised in relation to the definition of a deprivation, set out in Chapter 12 of the Code of Practice.
- The rights of the person and service users can only be protected when there is a clear definition of what is classed as a deprivation of liberty. Respondents "not convinced we have achieved that within the proposed legislation".
- The Acid Test appears to be altered which questions if the safeguards will be at a level required or as Cheshire West intended.
- The new interpretation[2] of the Acid Test takes many vulnerable people who lack capacity out of the reach of Article 5, yet still allows for intensely restrictive care with no right to appeal or independent scrutiny.
- Concerns raised that some people will not come under LPS (whereas they would come under DoLS). This means they will not be offered the same right to appeal and have their case heard in court.
- Concerns raised in relation to people who may not meet the "threshold" which would result in a deprivation of liberty being authorised. Greater clarity needed on this as there may still be restrictive practice taking place.

Whilst we wait for further news from DHSC as to how they intend to proceed in England & Wales – including the equivalent summary of consultation responses (and a response to the letter from the Joint Committee on Human Rights), it is perhaps worth setting out the concluding section of the Welsh Government consultation response document in full:

> *107. The UK Government has recently announced their decision not to implement the LPS within this Parliament. Welsh Government has issued a Written Statement expressing disappointment at this decision.*
>
> *108. The consultation responses from stakeholders in Wales on the draft Regulations and supporting impact assessments have provided a wealth of information that will help inform future policy decisions, when any planned implementation of the LPS is confirmed by the UK Government. It may be necessary to undertake a further consultation on the Regulations following any decision by UK Government to progress with the LPS in the future.*
>
> *109. We all share the goal to continue to integrate and embed the principles of*

[2] It is nerdily important to point out that a Code of Practice cannot create law, as opposed to amplifying what the law is (and, here, the law relating to deprivation of liberty is as set down by the courts). Although it is perhaps telling here that the Michelle Dyson, Director General for Adult Social Care at the Department of Health and Social Care, told the Joint Committee on Human Rights in May 2022: "We are looking at a new definition of what should constitute a deprivation of liberty – we have consulted on that and will wait to see what comes back…."

the Mental Capacity Act 2005 and the Mental Capacity (Amendment) Act 2019 into everyday care, support or treatment arrangements to avoid unnecessary duplication and bureaucracy for individuals and their families, and equally for practitioners, enabling them to share and use information legally and appropriately. Despite the recent decision of the UK Government, this remains our goal and our ambition for the people of Wales. As highlighted in the recent Written Statement, the views and the work of everyone who helped us develop and shape the consultation products, as well as everyone who offered views on the consultation, are not wasted. They have been recorded and retained to support us to protect and enhance people's rights.

110. It has been widely recognised that there are number of challenges associated with the current DoLS system, particularly in light of the increases in the number of DoLS applications – which have been seen across England and Wales.

111. In light of the UK Government decision, we will need to consider how we strengthen the current DoLS system in Wales and continue to protect and promote the human rights of those people who lack mental capacity. Stakeholders in Wales have provided significant evidence and support to help us shape the LPS for Wales. Welsh Government will be re-engaging with stakeholders so that we can listen and hear what we can do now to address some of the current challenges within DoLS. This will support the current application of DoLS, and strengthen the position that Wales will be in to transition to the LPS in the future.

112. It is imperative that the momentum generated through the contributions of stakeholders in Wales is not lost. Welsh Government will continue to work with stakeholders to improve services for those who lack mental capacity, whilst preparing for any future decision by UK Government to implement the necessary reforms identified in the Mental Capacity (Amendment) Act 2019.

KEY RECENT CASES

Contingency planning (1)

The Shrewsbury and Telford Hospital NHS Trust v T and Midlands Partnership NHS Foundation Trust [2023] EWCOP 20 (Lieven J)

Best interests – medical treatment – practice and procedure (Court of Protection) – other

Summary[3]

This judgment (which Lieven J notes was prepared approximately nine months after the application was determined) related to an application by the applicant Trust on 1 August 2022 for an anticipatory declaration in respect of the obstetric care for 'T.' T was 39 weeks pregnant, and had a diagnosis of Persistent Delusion Disorder. She had been detained under s.2 Mental Health Act 1983 approximately two and a half months prior to the application, and was recorded as not being compliant with medication. T was described as having "*something of a chaotic lifestyle*" (paragraph 4), but on 14 July 2022, had been assessed by her treating obstetrician as having capacity to make decisions about her obstetric care.

However, "*[i]n late July, T called her midwife and sounded very distressed, angry and delusional*"

[3] Steph David, having been involved in the case, has not contributed to this summary.

(paragraph 6). T's obstetrician reconsidered her view on capacity, and felt that T had fluctuating capacity, and specifically, "*may lose capacity due to the stress and pain of labour and the effects of drugs, which may cause her to have delusional thoughts which mean she cannot discuss her delivery options and obstetric care at the time. T has been known to focus on her delusional thoughts to the extent that it is not possible to discuss her pregnancy, and if this were to occur during labour it could place her and her baby at significant risk of harm"* (paragraph 7).

T's obstetrician felt that there was a small risk that she would become so focused on delusional thoughts during labour that she would be unable to make decisions regarding her care. T's midwife took the same view.

Lieven J criticised the timing of the Trust's application at paragraph 10:

> *…it is of some note that the first time that the Official Solicitor was notified of the intention to make an application was Tuesday 26 July and she was sent the Application bundle on Friday 29 July. At that stage the plan was to induce labour on Tuesday 2 August, i.e. 2 working days after the bundle was sent. This was in circumstances where the Trust had been aware of T's mental health condition since at least 19 May. As Ms Watson pointed out, the need for the application should have been apparent since at least 24 June when T's midwife was unable to complete a full antenatal check.*

When the Official Solicitor's representative spoke to T on 29 July, he found her "very lucid" (paragraph 11). When the matter was heard in court, *"the Midlands Partnership Trust, which was responsible for T's mental health care, had declined to carry out a capacity assessment*" (paragraph 12). T was supported to make an advance statement of her wishes and feelings on 31 July 2022.

Citing *University Lincolnshire Hospitals NHS Trust v CD* [2019] EWCOP 24, Lieven J considered that there was 'no doubt' the court "*has the power to make anticipatory declarations where P has fluctuating capacity, and there is a real risk that they will lose capacity in respect of an important decision, pursuant to s.15(1)(c) Mental Capacity Act 2005 ("MCA")*" (paragraph 14). Lieven J also noted that, as per *NHS Trust 1 and NHS Trust 2 v FG* [2014] EWCOP 30, "*there is very clear guidance from the court about the timing of applications concerning obstetric care where capacity is an issue*" (paragraph 16). The guidance in *FG* "*states that an application should be made "at the earliest opportunity" … and no later than four weeks before the expected delivery date."* Lieven J echoed Keehan J's observations in *FG* "*that a late application '…seriously undermines the role that the Official Solicitor can and should properly play in the proceedings' and prevents the court from giving directions for further evidence, if necessary*" (paragraph 17).

Lieven J stated that the application should have been made much earlier to allow consideration by the Official Solicitor and court. She also stated that T's entering into an 'advanced declaration about medical treatment' was *"a far more appropriate way to deal with a potential loss of capacity, rather than engaging the Court in making an invasive and draconian order. Such an approach protects the woman's autonomy, in a way that an anticipatory declaration does not* do" (paragraph 23). The court also sounded a note of caution about anticipatory declarations more generally *'unless the evidence clearly supports it.'* [24]

> *24.* […] *In the present case the Court did not have evidence that T did not have capacity at the time of the hearing and was in reality doing no more than*

speculating as to whether she might lose it. The evidence was that there was nothing more than a "small risk" that she might lose capacity, and in my judgment that is insufficient to justify an anticipatory declaration in a case such as this. There is a serious risk in a case such as this that a woman's autonomy will be overridden at such an important time, because of an assumption that she has lost capacity.

25. In this case there are other ways of managing the situation, apart from taking the draconian and properly exceptional step, of making an anticipatory declaration in respect of a woman who at the present time has capacity. Firstly, she could be invited to enter into an advance statement of her wishes and feelings in respect of her obstetric care during birth. It was clear that T was prepared to enter into such an advanced declaration. Secondly, if there was a true emergency, then the clinicians can use the doctrine of necessity to protect the mother. There needs to be some caution about turning what are in truth medical decisions into legal ones.

Comment

The observations about the impact of T's entering into an 'advanced declaration about medical treatment' perhaps need a little unpacking. A person may create an Advance[4] Decision to Refuse Treatment (ADRT) if the requirements are met, but this can only relate to a refusal of treatment.[5] An advance statement, as T was supported to make in July 2022, can cover both 'negatives' and 'positives.' A clear and specific statement of T's wishes and feelings at a time when she had capacity would clearly be of considerable relevance for any best interests decisions which would need to be taken if T were to lose capacity in the future.

However, it appears that the Trust's concern was that it might need to force treatment on T in an emergency situation for her own safety and that of her child. While it is not explicit from the judgment, it would appear likely that the Trust anticipated that some restraint or deprivation of liberty might be required, and was seeking the declarations for this purpose. Despite the Government's assertion that this is already the law,[6] no court has ever held, and we strongly doubt, that an advance statement could serve as valid consent to confinement, occurring in the indefinite future, on unknown facts and on the assumption that T would lose capacity.

We would also consider that the criticisms given of the timing of the application perhaps give short shrift to the Trust's need to respond to the factual picture as it emerged. While it appeared that T was having difficulties with her mental state, the Trust had considered her capacity in an assessment on 14 July and concluded that she had capacity. It would be difficult to see on what basis the Trust would have made an application in respect of a person who it had assessed as

[4] Pedantically, it is 'Advance' not 'Advanced,' both because it is happening in advance, and also because there may not be very anything 'advanced' all about the decision.

[5] And an interesting question (as yet untested question) arises as to whether a woman can refuse a Caesarean section by way of an ADRT. Logic suggests that she must be able to, even if the consequences may prove challenging.

[6] See pages 64-5 of the January 2021 White Paper Reforming the Mental Health Act (publishing.service.gov.uk), and also paragraphs 12.55-12.71 of the draft Code of Practice to the Mental Capacity Act 2005 published in 2021. The draft Mental Health Bill put before Parliament in 2022 made no reference to advance consent (nor did the accompanying impact assessment or explanatory notes). The report of the Joint Committee convened to consider the draft bill did not address the issue of advance consent.

having capacity, and surely an application is not warranted in any case where there is some concern regarding the mental health of an expectant mother, or a reluctance to engage in all care interventions. Even by the time of the application, the Trust did not consider there was an overwhelming risk T would lose capacity, but only a 'small risk,' which the court did not consider warranted an anticipatory declaration. However, we would note in *Glass v United Kingdom* [2004] ECHR 103, an Article 8 ECHR violation was found where a Trust had treated a patient without consent on an emergency basis without seeking a court order to do so. At paragraph 79, the ECtHR considered that the "*onus was on the Trust to take the initiative and to defuse the situation in anticipation of a further emergency*." Trusts thus find themselves in the unenviable position of being criticised for bringing applications where there is only a small risk the emergency may occur, or being criticised for waiting too long by applying once it is relatively clear a court order is required.

Contingency planning (2)

Somerset NHS Foundation Trust v Amira [2023] EWCOP 25 (Mostyn J)

Best interests – medical treatment – mental capacity – litigation – medical treatment

Summary

This judgment concerned an application made on 26 May 2023 by the applicant trust for anticipatory declarations that in the event 'Amira' lost capacity during the delivery of her child it would be in her best interests to implement an obstetric care plan with progressively more invasive interventions. Amira was 25 and was pregnant with her first child. The matter was heard on 8 June 2023, which was Amira's due date.

Amira had a diagnosis of hebephrenic schizophrenia, which appears to have been responsive to medication, but prone to relapse if she ceased taking that medication. She had been transferred from prison to hospital in January 2023 with an index offence of ABH against her mother. She had previously been a psychiatric inpatient for approximately two years between 2020 and 2022.

While Amira was considered to have capacity when the application was made, *"it was apprehended that as the delivery approached she would lose capacity*" both to make treatment decisions and to conduct litigation (paragraph 3). Amira had made a good recovery since her January 2023 admission, and her mental state had improved considerably until two days prior to the 8 June 2023 hearing. From 6 June 2023, Amira had begun to experience paranoia, anxiety and distress, and had been unable to understand information put to her about her obstetric treatment. Treating clinicians considered that her deteriorating mental state was partly due to being told the local authority's plan for her child (which would presumably have been to apply for her child to be taken into care). Amira's capacity was assessed on 7 June 2023, and the Trust's evidence was that she had lost capacity by that time. The application was reconstituted to seek declarations of current incapacity and orders on that basis, rather than anticipatory declarations.

The Trust's obstetric care plan had been written with Amira's involvement at a time she was considered to have capacity. It set out options for delivery in Amira's order of preference, with the final option being an emergency caesarean section if required.

The Official Solicitor submitted that the Trust should have brought its application at the earliest opportunity after 8 March 2023, arguing that if it had been made in a timely manner, Amira would have had capacity to conduct these proceedings

herself. The court noted that had this been the case, she would also have not lacked substantive capacity, and in the view of the court, "*there would not have been any valid issue for the Court of Protection to decide*" (paragraph 17).

After surveying existing case law on anticipatory declarations, Mostyn J set out his own perspective on their lawfulness; as Amira had been found to currently lack capacity by the time of the court's consideration, this discussion was obiter dicta (i.e. it did not form a part of the actual, binding, decision).

Mostyn J considered that ss.4A(3) and (4) MCA only permit a deprivation of liberty where an order has been made under s.16(2)(a) and a "declaration under s.15 will not suffice" (paragraph 25). Mostyn J considered that in any event, the proposed anticipatory declarations "*do not state how, or by whom, the future loss of capacity foreshadowed in each of these declarations is to be determined. This seems to me to be a fundamental flaw in the logos of the concept*" (paragraph 26). Mostyn J considered that Part 1 MCA did not permit anticipatory declarations, but applied only to people who lacked capacity at the time the decision was to be taken. He considered that that ss.5 and 6 MCA "*put on a statutory footing the common law doctrine of necessity as it applies to the care or treatment of persons who are believed to lack capacity*" (paragraph 30). He concluded that in emergency situations "*and only in such an emergency situation, Part 1 of the Act will apply to someone who may yet be shown not to lack capacity at the time that the act in question was done in relation to his or her care or treatment. But that is the only circumstance where someone who is in fact capacitous falls within the terms of Part 1 of the Act*" (paragraph 31, emphasis in the original).

Mostyn J went on to consider the powers of the Court of Protection under s.15 MCA. In further obiter observations, Mostyn J made clear his view that the court was not able to make a best interests declaration in the event of future incapacity, and that the High Court had no power to authorise the deprivation of liberty of a capacitous person. Mostyn J made clear that he considered that anticipatory declarations were unworkable in practice, as there was no clear line as to when a person could be said to have lost capacity. He observed that, to the extent that the obstetric team had clear evidence that Amira had lost capacity during labour by receiving the contemporaneous opinion of her treating psychiatrist, "*such an opinion would unquestionably satisfy the terms of s. 5(1) and 6 (and if the restraint amounted to a deprivation of liberty, s.4B also) thereby giving the obstetric team a complete defence to any later complaint by Amira that she had been the victim of battery or trespass to the person*" (paragraph 40). The court stated that it was "*at a loss as to why the ss 4B, 5 and 6 route to obtain immunity from a later complaint by P about an act done in connection with her care or treatment is not routinely used. It is specifically legislated for in the Act. In contrast, the device of a proleptic declaration under s. 15(1)(c) is in my judgment directly contrary not only to the wording of the Act, but also to its essential scheme*" (paragraph 41).

Mostyn J returned to the application before him, which was grounded in the Trust's evidence that by the time of the hearing, Amira had lost capacity to make decisions about her treatment (which was not challenged by the Official Solicitor).

Mostyn J concluded that Amira lacked capacity for the purposes of a s.15 MCA declaration, but before doing so, observed (again obiter) that the court may not have power to authorise a deprivation of liberty if it is making interim orders pursuant to s.48 MCA, but considered (at paragraph 52) that:

> *…In my opinion, in an emergency, provided that the court is satisfied that there is reason to believe that P lacks capacity, the court can lawfully authorise a temporary deprivation of liberty under the inherent jurisdiction to endure for a very short period until the question of capacity can be finally determined, and, if capacity is found to have been lost, an order made under s.16(2)(a), which in turn triggers s.4A(3) and (4).*

Mostyn J readily found that the birthing care plan, which had been developed with Amira's input, was in her best interests, as it would work to protect her own health and safety and that of her unborn child. Mostyn J authorised restraint in the implementation of that care plan.

Comment

It is worth emphasising that all of the more controversial statements in what we hope we can call a characteristically contrarian judgment were obiter dicta; Mostyn J did not appear to struggle to accept either that Amira had, by the time of the hearing, lost capacity to make decisions regarding her obstetric care, or that the graduated plan of interventions which she had contributed to was in her best interests.

While being cognisant that these comments were not part of the ratio of Mostyn J's decision, we would not agree with his observation at paragraph 30 that ss.5 and 6 MCA address only emergencies. We would note the findings of the Supreme Court in *N v ACCG* [2017] UKSC 22 at [38], which offers no such limitation to the powers of s.5 MCA:

> *Section 5 of the 2005 Act gives a general authority, to act in relation to the care or treatment of P, to those caring for him who reasonably believe both that P lacks capacity in relation to the matter and that it will be in P's best interests for the act to be done. This will usually suffice, unless the decision is so serious that the court itself has said it must be taken to court.*

We would also note that the power to make anticipatory declarations under s.15 MCA has been repeatedly considered and found to exist; a comprehensive summary of the case law was recently conducted by Lieven J in *The Shrewsbury and Telford Hospital NHS Trust v T and Midlands Partnership NHS Foundation Trust* [2023] EWCOP 20.

Finally, Mostyn J's obiter observation that s.4B can be relied upon absent a court application having been made has a certain pragmatic appeal, but may come as a surprise to all of those making and determining so-called 'Community DoL' applications. In that context, s.4B doing all the 'heavy lifting' legally in terms of providing protection to those depriving individuals of their liberty in the community pending consideration of the application by the court.[7]

Further, we would suggest that Mostyn J's interpretation has two fundamental problems.

The first, is, as Mostyn J himself makes clear in footnote 1 to his judgment, his approach depends on rewording s.4B(2) from "there is a question about whether D is authorised to deprive P of his liberty under section 4A" to mean "there will be a question to be decided by the court whether D should be authorised." His reason for adopting this interpretation is:

> *because s. 4A(3) and (4) provide that D may deprive P of his liberty if, by doing*

[7] And, nb, pending any judicial consideration, so there is no question of a court making an order under s.48.

> *so, D is giving effect to a decision made by an order under section 16(2)(a) in relation to a matter concerning P's personal welfare. If such an order has already been made there could never be a "question" whether D "is authorised" to deprive P of his liberty under section 4A. The authorisation in the order will be plain on its face and there could be no question about it. Therefore s. 4B(2) must be seen as stipulating a requirement that D intends, after the emergency is over, to obtain an order authorising the deprivation of liberty of P. The other, more literal interpretation, makes no sense to me.*

However, this overlooks the fact that s.4A does not just apply to situations where a court order is made under s.16(2)(a). It also applies to situations where the deprivation of liberty is to be authorised under Schedule A1. An example of a situation where there is genuine doubt about whether a situation can be authorised by a DoLS authorisation is where there is a dispute about whether the person is eligible for DoLS, or whether the MHA 1983 has to be used. In such a situation, an application is required so that the court can decide which regime is in play (as per the *JS* case, the appeal against which is to be heard by Theis J on 20-21 July). Between the application being made and determined, the person is in the Schrodinger's cat position of being both within the scope of DoLS (and hence s.4A) and outside its scope. The unglossed wording of s.4B(2) therefore makes entire sense within this context.

The second problem is that it drives a coach and horses through the approach to deprivation of liberty currently provided for in the MCA 2005. As also discussed in *Norfolk and Suffolk NHS Foundation Trust v HJ* [2023] EWFC 92 (see further below in this Report), where the line is crossed from restraint – restriction upon – liberty to deprivation of liberty, formal authority is required. On Mostyn J's approach, a person could be deprived of their liberty with no formal authority, on the basis that there is an understanding that an application will be made in due course. But what happens where – as is all too likely to be the case – the emergency passes, and no application is in fact made. Does this invalidate the lawfulness of the steps taken if the person taking them at the time (who may not be the person in charge of deciding to make the application) genuinely, but mistakenly considers that an application is to be made?

Put briefly, s.4B is not contingent on a reasonable belief that an application is to be made, but on the basis that a decision **is** being sought from the court, which we suggest makes clear that active steps are being taken – not just proposed – to obtain such a decision.

Ironically, the approach advocated for by Mostyn J is, in some ways, mirrored in the proposed amendments to s.4B that were contained in the Mental Capacity (Amendment) Act 2019. These would have provided for authority to deprive a person of their liberty in an emergency without further formal authority, on clearly defined grounds. Unfortunately, they are another victim of the decision not to implement the 2019 Act.

What should happen where it appears impossible to engage the person? A high-stakes question for the Court of Protection

Nottingham University Hospitals NHS Trust & Anor v RL & Ors [2023] EWCOP 22 (Sir Jonathan Cohen)

Mental capacity – assessing capacity

In a decision handed down in February 2023, but only published in June 2023, Sir Jonathan Cohen grappled with a dilemma that occurs relatively often in practice, but has been curiously under-considered by the courts: namely what

'communication' means for purposes of s.3(1)(d) MCA 2005. Along the way, he had also to consider how to proceed where everyone involved appeared to face insuperable challenges in engaging him.

The case concerned a man, RL, in his 30s, serving a sentence of life imprisonment for murder. His mental health having given rise to concern, he went back and forth between prison and hospital until February 2023, at which point he was selectively mute, refusing food (whether 'conventionally' or by way of nasogastric feeding), and anti-psychotic medication. He was severely malnourished, and in the view of one of his treating doctors, "*if we do not give sustained feed to RL now, we will precipitate a life-threatening scenario which could occur at any time*." It was the view of the treating team that it would be deeply undesirable to delay and that the risk grew exponentially the longer he was not fed or did not receive the appropriate medication.

The treating Trust brought an urgent application for authorisation of a nasogastric feeding tube for the treatment for malnutrition and also for his mental health condition and, in addition, as became apparent during the hearing, the treatment of his thyroid condition. The Official Solicitor, having considered the matter carefully, acting on behalf of the man, accepted the urgency of the situation and did not seek an adjournment, as is often the case, in order to obtain further information or third-party expert opinion.

The first question was as to RL's capacity to make the relevant decisions. The case was advanced on the basis that, whilst RL could understand and retain the relevant information, he could not weigh it or communicate his decision. The evidence before the court included that of his treating consultant psychiatrist, who considered that he was "*suffering from depression, and described him as virtually stuporous and mute. When she last saw him, he did not even flicker his eyes when she put papers in front of him and was not willing to communicate his wishes in any way at all. She described him as presenting as 'quite shutdown'*" (paragraph 10). RL was described by his mother as being a completely changed person from the son that she knew and that he had very much deteriorated over the course of recent times. The evidence was that he was not engaging with the family either, contrary to the way that he used to. When the Official Solicitor's representative went to see him, Sir Jonathan Cohen explained that "*he literally was not able to do so because RL would not come out from under the bedclothes; he remained completely invisible and would not engage in any way whatsoever*" (paragraph 11).

Sir Jonathan Cohen concluded (at paragraph 12):

> *The evidence which I accept is that, on the balance of probabilities, he is indeed unable to weigh up the information as part of the process of making a decision or to communicate his decision in the words of the statute "whether by talking, using sign language or any other means." He simply has made it impossible for anyone to know what his wishes are because he will not express them himself. He does not give any indication of understanding the link between receiving food and treatment and life and death.*

Before moving to best interests, Sir Jonathan Cohen noted that, the morning of the hearing, the treating team had inserted a nasogastric tube. As he noted, "*I think it is fairer to describe what happened this morning as an absence of any resistance by RL rather than a sudden piece of insight into his condition. He did not in any way try to interrupt the process; he was awake and conscious, but he said and did nothing*."

Sir Jonathan Cohen therefore made a declaration as to RL's lack of capacity to make the relevant decisions under s.15 MCA 2005, noting that it was more appropriate for him to use this rather than the 'interim' provisions of s.48, as he had the evidence before him to enable him to make the declaration and that, if RL's capacity returned, he would fall outside the statutory framework of the MCA.

As to best interests, Sir Jonathan Cohen identified that it was very difficult to assess RL's views. He had been recorded as having said in late January whilst in A&E that he was trying to kill himself, but Sir Jonathan Cohen did not find that this constituted a "*clear and settled wish to end life*." He would not communicate with the Official Solicitor's representative, but Sir Jonathan Cohen noted that his mother had been very clear that her son's current presentation was "*out of character. She believes – and she knows him better than anyone else in this case – that he would want treatment if he was well*" (paragraph 18).

Sir Jonathan Cohen therefore found that there was a very strong balance in favour of the administration of medication, including by way of restraint. However, he indicated that the matter should come back within a week because "*within five to seven days there should be at least some indication as to whether or not the feeding issue is beginning to be resolved, even though the time for knowing whether the medication for his psychosis is assisting will be much longer. Since the court order includes the power to use restraint in order to address the issues of nutrition and hydration, it is appropriate that the matter should come back sooner rather than later*" (paragraph 19) (at the time of writing this, no further judgment is available in relation to RL's case).

Comment

We address in our guidance note on assessing and recording capacity the need to distinguish between a situation where a person is unwilling to take part in a capacity assessment, and the one where they are unable to take part. It is interesting to contrast this case with *Re QJ* [2020] EWCOP 3 where Hayden J considered that – on the facts of that case – there was a "good deal of evidence" that the person's reluctance to answer questions meant that they were unable to do so. Here, by contrast, it appeared to be clear to those involved that, to the extent that RL was being selectively mute, it was not a matter over which he could be said to have any conscious control.

As regards the consequences, this case fits squarely within the research that we referred to in our guidance note which suggests that, although the 'communication' limb of s.3 was intended to cover only a very narrow category of cases (such as locked in syndrome), it has been broadened to cover the situation where the person is unable to express a stable – or, here – any preference. As we put it in at paragraph 45 of our guidance note, "*in such a situation, the assessor does not have access to the person's real choice*."

In this regard, it is perhaps of note that Sir Jonathan Cohen appears at paragraph 12 to have proceeded on the basis that not only could RL not use and weigh the relevant information, he appeared also not to be able to understand that information either. Indeed, logically, if the end result is that everyone is having to proceed on the basis that the decision-making is taking place within an entirely impenetrable black box, it is difficult to see how any conclusions could be drawn (either way) as to the person's ability to retain the information either.

Disentangling decisions – and do they even need to be taken?

Wiltshire County Council v RB & Ors [2023] EWCOP 26 (Peel J)

Mental capacity – assessing capacity – residence

Summary

RB was a 29 year old woman diagnosed with Autism Spectrum Disorder. Since 2015 she had been selectively mute, and chose to communicate in writing or by pointing to words on an alphabet board. She had rheumatoid arthritis and was found in 2021 to have capacity to decline medical treatment for that condition, as a result of which her mobility was severely impaired. Since entering sixth form she had had several admissions under the MHA 1983. She has been in a number of placements which have been unsuccessful. In June 2020, she was found to have capacity to decide where to live after leaving a community placement. In August 2020, she was detained in a psychiatric hospital for over 2 years. On 3 January 2023, she was discharged to a bungalow with a 24/7 package of 2:1 care. She was clearly deeply unhappy there, partly as a result of being transported against her will and subject to physical restraint. Over two days, she undertook several acts of deliberate self-harm including attempts to strangle herself. At first instance, the court received evidence from the expert consultant psychiatrist that "….. a return would be likely to cause her real physical, emotional and psychological injury that has the potential to be lifelong". On 5 January 2023, the woman herself emailed the Court of Protection seeking the court's assistance. She also contacted the emergency services as did her carers. She was admitted to a general hospital on 7 January 2023. She was medically fit for discharge but had consistently said that she did not want to return to the bungalow, nor did she agree to return there.

At first instance, HHJ Cronin found that RB lacked capacity to decide to consent to be discharged from the hospital to live at the bungalow. Acting by her litigation friend, the Official Solicitor, RB appealed. The appeal was not opposed by the Local Authority or the ICB. Save in one respect, it was opposed by the Health Trust responsible for the area where RB was currently hospitalised.

As Peel J noted at paragraph 5:

> *It is common ground that the hospital ward is not an appropriate environment for RB, and her presence allocates resources away from other requirements. The Hospital Trust is in the uncomfortable position of effectively housing RB until these proceedings resolve her future. It does strike me that the Trust's position in the litigation is somewhat peripheral. Its interest at a practical level is to secure the departure of RB from the hospital. The outcome of capacity and best interests assessments is only of relevance to the Trust in terms of potential delay. In saying this, I am not in any way downplaying the Trusts' commitment to the wellbeing of RB.*

Peel J noted that the decision was a difficult one, but zeroed in on the fact that there appeared to be some confusion as to precisely what capacity issue required adjudication. The declaration made by HHJ Cronin directly linked discharge from hospital to a return to the bungalow. But, as he identified, the specific decision included two components: (1) discharge from hospital; and (2) return to the bungalow. Peel J considered that:

> *22. By eliding discharge and accommodation at the bungalow, it seems me that the judge may have unwittingly fallen into an "outcome approach" which is inconsistent with autonomy and the subjective patient's*

> *individuality, and does not form part of the framework of the Act; para 13 of R v Cooper [2009] 1 WLR 1786.*
>
> *23. This is demonstrated vividly by RB herself who, in* [a letter to the court]*, clearly thought that she was being presented with one option. She was being presented with a decision which to her mind was whether to return to the bungalow or not; essentially a fait accompli. Dr Camden-Smith* [the independent expert] *refers to this in her report: "[RB] is aware that the hospital wishes to discharge her, and that currently the only option available to her is the bungalow". That was a stark option with no nuances and, what is more, one that is, on the evidence of the expert, likely to expose her to grave physical, psychological and emotional harm.*
>
> *24. Dr Camden-Smith's report at para 35 says: "I told [RB] in the email that she cannot stay in hospital and that she will end up being discharged to the bungalow if she cannot make a decision". Given that the judge, understandably, paid particular attention to the evidence of Dr Camden-Smith, my sense is that as a result she was led away from a focus on discharge to a focus on living arrangements. That is reinforced by the tenor of her judgment in which she said: "The decision the court is ultimately asked to make, if RB cannot, is a decision about: first, where RB should live on her discharge from hospital".*

Peel J considered that:

> 26. […] there *were, or should have been, two separate issues, and two separate capacity decisions, to consider, namely:*
>
> *i) Did RB have capacity to consent to hospital discharge? That evaluation depended upon, inter alia, the information recorded in the order of 21 February 2023. Inevitably, that includes a possible return to the bungalow (it would be unrealistic to separate this out) but that was not the only possible option, nor the only factor to be taken into account. Others included the Local Authority continuing searches for alternative placements, or RB simply refusing to leave hospital and accepting the potential consequence of a forced departure which might include living in a hotel or living rough (as she has done before). The latter might be deemed an unwise decision, but by s1(4) of the MCA 2005 that is not of itself indicative of lack of capacity. Moreover, as Dr Camden-Smith said, it is not irrational to refuse to leave hospital if the only alternative put to her is somewhere she adamantly refuses to go to because of previous traumatic experiences.*
>
> *ii) Does she have capacity to consent to going to the bungalow? That, it seems to me, would also need to be considered in the light of other relevant information such as alternative placements (as identified by Dr Camden-Smith, concrete options are required) and a full understanding of what caused her so much distress at the bungalow in the first place.*

Whilst expressing sympathy for the difficult decision faced by the judge, Peel J concluded that she was wrong to elide the declaration in the way that she had done.

In terms of the actual assessment of RB's capacity, Peel J identified that:

> *37. It is not for RB to establish capacity or justify her autonomous wishes; she is presumed to be capacitous. To interpret a refusal to contemplate returning to the*

> *bungalow as indicative of lack of capacity, or causative of lack of capacity, as the expert seems to do, should be weighed against an alternative explanation that she was simply expressing a capacitous wish not to go there again after her prior experiences. In my judgment, the judge did not adequately weigh up these competing factors in circumstances where by any measure a strongly held wish not to return to the bungalow, with clearly stated reasons, was understandable. This ground of appeal is allowed.*

In other words, the specific decision upon which the judge determined lack of capacity included two components: (i) discharge from hospital and (ii) return to the bungalow. That is how it appeared in the final version of the order, albeit not in the first version drafted by the judge.

Peel J also agreed that the judge had not undertaken any substantive analysis of the question of RB's capacity to decide upon care, which seemed not to have been referred to in the judgment but added upon a request for clarification.

Whilst allowing the appeal, Peel J emphasised that:

> *Although I have concluded that in the end the judge fell into error, I am not convinced that the case was presented to her as clearly as it might have been, identifying the issues accurately and clearly. No order before the hearing set out with clarity the issues to be decided and as a result the elision of discharge and best interests was allowed to develop unchecked.*

In remitting the case for rehearing, Peel J suggested that the capacity issues to be considered were, in this order:

> *i) Does RB have litigation capacity?*
> *ii) Does RB have capacity to consent to hospital discharge?*
> *In considering this the court should direct itself to the relevant factors identified in the order of 21 February 2023 and should in particular consider the position if the bungalow is a residence option or, in the alternative, is not a residence option.*
> *iii) Does RB have capacity to decide where she should live?*
> *iv) Does RB have capacity to make decisions about personal care?*

Peel J identified, finally, that he could and should:

> *45.* […] *make a general comment about the bungalow. I appreciate the complexities of this case which is challenging to all involved. I appreciate also the immense pressure on resources. Nevertheless, from what I have seen and heard, for RB to return to the bungalow risks causing her profound harm. What happened during her time there is shocking. The expert's view about the potential impact on her physically, emotionally and psychologically is compelling. Transportation would almost certainly take place against her will, and require physical restraint. It seems to me that alternative options simply have to be sourced. The expert says that RB should be given a viable alternative that is not the bungalow, and I agree. If the bungalow is removed from the equation, it is possible (indeed, I suspect, likely), that capacity and best interests issues may well resolve themselves.*

Comment

Peel J's dissection of the actual decisions in play is important for illuminating the consequences of imprecision – but his concluding observation about the potential for the issues to resolve themselves if alternatives are found is equally

important. More broadly, the decision is also helpful for shedding light on an area which causes inordinate difficulty in practice: i.e. discharge decisions in the situation where a person has impaired decision-making capacity. Part of the complexity, as alluded to by Peel J, is that there are likely to be multiple organisations involved. Alex has previously sought to undertake the exercise of disentangling who, precisely, is responsible for what, and – in consequence – what capacity questions actually arise, in a presentation available here. He is somewhat reassured to see that Peel J's analysis matched his own, even if Alex might not talk about 'consenting' to hospital discharge, as opposed to 'deciding to leave hospital,' to match the language that would be used in relation to a person whose decision-making capacity is not in question.

Executive capacity – clinical and legal realities

Warrington Borough Council v Y & Ors [2023] EWCOP 27 (Hayden J)

Mental capacity – assessing capacity – residence

Summary

This application concerned Y, who was in her early twenties. Y had been diagnosed with autistic spectrum disorder as a child. Her education records reveal difficulties with learning but she remained in mainstream education and was provided with support. In consequence of a road traffic accident, she had serious injuries, including brain injuries. She was cared under care arrangements commissioned by her deputies and managed by a case manager. A question of no doubt vital importance to Y, namely as to her capacity to decide to take cross-sex hormones, was resolved without the need for judicial determination, as was the question of whether she had capacity to access the internet. Hayden J had to resolve the question of Y had capacity to take decisions in relation to her care and residence. Opinion on this was divided between Dr Janet Grace, Consultant Neuropsychiatrist, and Dr David Todd, Consultant Neuropsychologist. Whilst there were areas of common ground, helpfully teased out in an experts' meeting, Dr Todd was "very clear" that Y lacked capacity to make decisions as to where she resided and the care and support she required. Dr Grace "forcefully" articulated the opposite opinion.

In essence, Dr Todd considered that Y presented with Dysexecutive Syndrome, consequent on traumatic brain injury, and highlighted the operation of "the frontal lobe paradox," that those with frontal lobe damage can perform well in interview and test settings, despite marked impairments in everyday life. By contrast, Dr Grace considered that, whilst Y was "*impulsive, difficult to contain and risk taking*," this was largely confined to occasions in which she was "*clearly hyper-aroused*." Dr Grace considered that that these patterns of behaviour were present pre-injury and believed that they are not a consequence of the brain injury but due to a combination of anxiety and autistic spectrum disorder (ASD) traits. Dr Grace's evidence was that "*in common with the rest of the population, she is at risk of making decisions that are potentially harmful when she is anxious or angry*."

Much of the judgment of Hayden J consisted of an analysis of the views of the two experts, in circumstances where he considered it was important that "*this is not a case where the two experts have been sucked into an ideological battle in which both have retreated to a defence of their amour propre. There is a genuine difference of opinion in which both have engaged in an intellectually honest dialectic*" (paragraph 35). Of wider relevance, perhaps were Hayden J's observation at paragraph 45 that:

> *Executive dysfunction and frontal lobe paradox is, as Ms Butler-Cole correctly submits, not to be regarded as synonymous with the functional test for mental capacity. The former derives from clinical practice, the latter is the test prescribed by MCA. Neither is 'insight' to be viewed as equating to or synonymous with capacity. To elide those two would be to derogate from personal autonomy, every adult from time-to-time lacks insight into an issue or indeed into themselves.*

On the facts of the case, Hayden J considered that Dr Todd had not fallen into these "rudimentary errors:"

> *It must be emphasised that severe traumatic brain injury has been identified neuroradiologically in this case and that this is not challenged. Dr Todd considers that Y has cognitive, emotional and behavioural manifestations which are not confined to periods of heightened arousal but are pervasive and reductive of capacity for problem solving. These, he considers are frequently associated with frontal lobe damage. Again, whilst recognising the variability of these behaviours, I do not understand this central premise to be in dispute. The consequence, Dr Todd contends, is to impair the ability to think consequentially and ultimately, to be able satisfactorily to understand, retain or weigh information in order to make a decision about care needs and accommodation. To my mind, that establishes both the functional and diagnostic test. Moreover, for the reasons I have already explained, I consider that the accounts given by F very much reinforce Dr Todd's views and do not sit as comfortably with those expressed by Dr Grace. It is Dr Todd's opinion which unifies most of (though by no means all) the features of what is undoubtedly a complex evidential matrix.*

Ultimately, therefore, Hayden J considered that Dr Todd's opinion was to be preferred, although he made clear that he was "*particularly alert to* [Dr Grace's] *entirely proper warning that a dissociation between knowing or understanding and a failure to follow through or convert to action, is not, axiomatically, pathological*."

Returning to a familiar theme, Hayden J concluded that:

> 47. *The presumption of capacity is the central tenet of the MCA. It is a powerful safeguard of civil liberty. It requires to be rebutted on cogent evidence, nothing else will ever do. The principle was well embodied in the case law that preceded the MCA. It is both a guard against the power of the state and a gateway to State support where needed. It is woven into the professional DNA of practitioners and Judges in this important and evolving sphere of the law. I feel confident that every Judge, evaluating a question of capacity, approaches the test with a resolve to find that an individual has capacity and arrives at a contrary conclusion only when the evidence demands it.*

In this spirit, Hayden J continued:

> *Having concluded that Y lacks capacity to make decisions relating to her care and accommodation, it is important always to remember that the MCA constructs an ongoing obligation to promote capacity, in effect, to build a pathway to capacity where there is a prospect of it. There is evidence that Y is making progress cognitively and more broadly. That evidence, at present, has a degree of fragility which causes me to draw back from any more confident assertion. What it indicates, however, is the importance of the obligation to provide a scaffolding of support for Y in order that she is availed of the very best opportunity to reassert her autonomy in*

> *these two very important spheres of decision taking. It may well be that in the months to come, the landscape might change and require my decision to be revisited. I suspect, though I may be entirely wrong, that some of Dr Grace's reservations may also reflect my own sense from the evidence that Y's situation remains an evolving one.*

Comment

The considered and thoughtful disagreement between Drs Grace and Todd set out in the judgment is one which repays careful scrutiny by those working in this area. Hayden J's clear reminder that the clinical phenomenon of executive dysfunction needs to be addressed by reference to the specific criteria of the MCA 2005 in relation to the facts of any individual case is of wider importance. For those who want to get a further – interdisciplinary – insight into the issues, we recommend this webinar from the National Mental Capacity Forum.

Restraint, physical health and the detained patient: the rights in play

Norfolk and Suffolk NHS Foundation Trust v HJ [2023] EWFC 92 (High Court (Family Division) (David Lock KC (Sitting as a Deputy High Court Judge)

Article 5 – deprivation of liberty – best interests – medical treatment

Summary

This case concerned the question of whether specific authorisation is required to administer physical health treatment under conditions of restraint to a person detained under the Mental Health Act 1983 who lacks the capacity to consent to the treatment. This is a question that had been considered in some detail by Baker J (as he then was) in *NHS Trust v Dr A* [2013] EWHC 2442 (COP), including the legal quirk that it was necessary to have recourse to the inherent jurisdiction to authorise such additional deprivation of liberty as might arise even in the case of a person lacking the relevant decision-making capacity.[8]

The facts of Dr A's case – concerning a detained patient on hunger strike – were very stark. The facts of HJ's case might be said to be much more 'routine' (although the outcome of no less importance to HJ herself). In summary, HJ had a range of physical and cognitive impairments, and required enemas to treat her for constipation. The process of providing HJ with an enema was described in some detail in the judgment by a Nurse O thus:

> *She explained that when staff consider that HJ is suffering signs of distress and an enema may be needed, she is guided or physically escorted from the "pod area" towards her bed and placed in the prone position and rolled onto her left side. Staff will then go on either side of the bed and hold her arms for reassurance. Once HJ is on the bed, nursing staff explain to her that they need to administer an enema. At this time HJ will typically either attempt to pull at staff clothing or grip onto staff hands or body parts. The administration of the enema itself requires 4 people to assist with the physical restraint required; one person on each side to restrain arms, one to administer the enema and a fourth person to hold both legs and prevent HJ from kicking staff. A fifth person is also required to open doors entering her room, support her head if needed and monitor her physical state during the restraint. HJ will continue to be loud and verbally*

[8] Incidentally, another casualty of the decision not to implement the Mental Capacity (Amendment) Act 2019 is that s.16A MCA will not be being repealed, the provision which caused the problem in *Dr A*.

aggressive towards staff throughout this process.

12. Nurse O further explained that:

(i) The typical duration of physical restraint when administering the enema with HJ on the bed is approximately "3-5 minutes in length";
(ii) It may take between "30 seconds to 5 minutes" for HJ to be physically escorted from the pod area to her bedroom. This escort may require some form of physical restraint (such as holding her forearms), although hand holding can be used more often than not;
(iii) HJ has had other forms of treatment provided via the same restraint procedure including: (i) administration of depot medication once per week (although this has not been required since March 2023); (ii) administration of rapid tranquilisation by intra-muscular injection on a PRN basis; (iii) taking blood samples; (iv) the administration of skin ointment (although she could not recall when this was last needed); and (v) transfers to an acute hospital for medical treatment;
(iv) The provision of enemas under restraint is reported to take "slightly more time" than other forms of treatment;
(v) HJ can remain agitated and/or distressed for up to an hour after the administration of an enema, although sometimes this can also resolve within a few minutes;
(vi) If HJ is not provided with an enema and has no bowel movement, it can become very painful for her in the short-term in addition to the serious longer-term risk of bowel perforation;
(vii) Two other service users within the ward also require physical restraint to deliver treatment, although not to the same extent, frequency or durations as HJ;
(viii) A record is kept in HJ's medical notes whenever physical restraint is used;
(ix) HJ's ongoing care and treatment is discussed and reviewed during MDT meetings on a weekly basis, although there is no formal review of the restraint plan; and
(x) Staff would be prepared to undertake a more structured review of HJ's restraint plan on a periodic basis, including consideration about whether this method of delivery remains necessary and proportionate and whether any less restrictive measures could be used.

HJ's constipation was a physical disorder not caused by her mental disorder, such that treatment – including potential restraint – could not be administered under Part 4 MHA 1983. The Trust caring for her therefore applied for a determination (presumably under the inherent jurisdiction) that it was lawful to deprive her of her liberty whilst administering the enemas; the Official Solicitor acting on her behalf agreed both that such authority was required, and that granting it was in her best interests. David Lock KC, sitting as a Deputy High Court judge, took a different view – namely that no formal authority was required.

David Lock KC started with s.5 MCA 2005, outlining how it provides a codified defence of necessity. In passing, it is clear from his analysis, applying that of Lady Black in *NHS Trust v Y* [2018] UKSC 46, that s.5 is not limited to emergency situations as suggested, obiter, by Mostyn J in *Somerset NHS Foundation Trust v Amira* [2023] EWCOP 25. David Lock KC then turned to s.6, outlining how its "broad effect" is

that, where such treatment is reasonably believed to be in P's best interests, restraint short of a deprivation of liberty can lawfully be imposed on P without any further authorisation where it is reasonably believed by those providing the care that it is necessary to prevent harm and the restraint used is proportionate to the likelihood and seriousness of that harm.

On the facts of HJ's case, David Lock KC agreed that, given that only "proportionate restraint" was used to administer the enemas, the Trust clinicians could, in principle, bring themselves within the terms of s.6 MCA 2005, such that, "*if matters had stopped at that point, there would have been no need for the Trust to come to court because the legal approvals needed under these procedures of the MCA do not require court oversight*" (paragraph 22).

The Trust, however, had been concerned that the process of administering enemas to HJ was depriving her of her liberty (it is not entirely clear from the judgment precisely what gave rise to the Trust's concern that the line was crossed from restriction upon liberty to deprivation of liberty). It was that concern – initially shared by the Official Solicitor – that David Lock KC questioned, and which led ultimately to the parties agreeing that, in fact, no deprivation of liberty was taking place, an agreement endorsed by the court. At paragraph 32 he set out his conclusion, reached after an analysis of the relevant domestic and Strasbourg case-law as to the principles to apply when deciding whether medical treatment provided to someone in lawful detention amounts to a further deprivation of their liberty, requiring specific authorisation:

> *a) the starting point should be that it will only be in exceptional cases (see Bollan/Munjaz) where something that happens to a person who has already been lawfully deprived of their liberty will amount to a further deprivation of that person's residual liberty;*
> *(b) Article 5 will only arise in an exceptional case because the usual position is that "Article 5(1)(e) is not in principle concerned with suitable treatment or conditions" (Ashingdane); and*
> *(c) the acid test for the engagement of article 5 in any case involving an alleged deprivation of residual liberty is whether there is an unacceptable element of arbitrariness in the actions which are taken by a state body and which are said to deprive a person of their residual liberty (see Idira).*

Applying those principles, therefore:

> *32.* […] *it must follow that, save in exceptional circumstances, any proper and lawful exercise of clinical judgment by clinicians in administering medical treatment to a detained person will not amount to a deprivation of the person's residual liberty because there is no element of arbitrariness in the actions of the clinical staff. If restraint is imposed in order to enable treatment to be administered for a physical health condition for a person who lacks capacity to consent under the MCA, the tests for the lawfulness of that restraint are set out in section 6 MCA. If those conditions are satisfied, the usual consequence will be that there will be no independent breach of the patient's rights under article 5 ECHR. Part of the reason that, in my judgment, there will be no breach of article 5 rights in such circumstances is that the Trust owes a common law duty of care to HJ. That duty means that, whilst she is detained in hospital, Trust staff are required to provide her with appropriate medical treatment to meet her physical and psychological needs. The Trust discharge that duty by administering medical treatment to her, including enemas as described above, and there is*

> *nothing arbitrary about their application in HJ's case. On the contrary, as set out above, this is a carefully thought-out treatment plan which is designed to meet her medical needs in a lawful and proportionate manner. I do not consider that acts taken by clinical staff to discharge that duty are capable of amounting to the type of exceptional circumstances which could lead to a further deprivation of HJ's residual liberty. In my judgment, HJ cannot be deprived of her liberty as a result of actions of Trust staff that, to discharge their duty of care to HJ, they are required to take. I therefore consider that the revised position adopted by the Trust was correct and that the Official Solicitor was also correct to make the concession that HJ was not being deprived of her liberty when she was being administered enemas.*

Importantly, David Lock KC also went on to consider HJ's Article 8 ECHR rights, engaged by decisions made to apply enemas and the accompanying decisions to use restraint to enable the treatment to be administered. There was no dispute, as he noted, that Article 8 ECHR contains procedural as well as substantive obligations. In general terms, and echoing (although not expressly referring to, the decision of the ECtHR in *AM-V v Finland* [2017] ECHR 273), he found that:

> *35. The process leading up to the administration of enemas is required by section 4 MCA to fully take into account HJ's views, albeit they are not decisive. Overall, the sections 4 and 6 MCA decision making process is a process mandated by statute and, if followed, in my judgment satisfies the requirements of fairness and properly respects a patient's article 8 rights.*

He also noted that, as restraint which was applied to HJ was to take place within a mental health unit, there were the additional procedural obligations imposed by the Mental Health Units (Use of Force) Act 2018, and that the Trust:

> *36. […] has explained how it is complying with the terms of the 2018 Act. It has appointed a responsible person or suitable seniority, adopted a policy regarding the use of force on patients by staff who work in its mental health units and is providing appropriate training. None of the steps taken by the Trust to implement the terms of the 2018 Act have been criticised by the Official Solicitor and it appears to me that the evidence provided about the way restraint is applied to HJ is consistent with the Trust policy and the recording of the use of restraint follows (if not exceeds) the requirements of the 2018 Act. I also note that the requirements of the 2018 Act supplement the duty on the Trust to have regard to the Statutory Code of Practice published under the MHA.*

David Lock KC continued:

> *37. In J Council v GU & Ors Mostyn J considered that the procedural requirements under article 8 required an additional degree of oversight because restraint was taking place outside of mental health detention and was thus occurring in a setting where there were "no equivalent detailed procedures and safeguards stipulated anywhere for persons detained pursuant to orders made under the Mental Capacity Act 2005": see judgment at paragraph 14. This case is different because (a) it takes place within the legal framework applying to patients who are detained under the MHA and (b) the procedural requirements of the 2018 Act are required to be followed and, on the evidence, are being followed. In those circumstances, I do not accept that the existing legal obligations on the Trust*

> *need to be supplemented in order to ensure compliance with HJ's article 8 rights. On the contrary, it seems to me that the requirements on the Trust to continue to comply with the best interests decision making processes under section 4 MCA, the need to ensure that any level of restraint is justified under section 6 MCA and the additional procedural requirements imposed on the Trust by a combination of the MHA framework and the 2018 Act provide an entirely adequate procedural framework to protect HJ's article 8 rights. I therefore do not accept that it is either necessary or appropriate to supplement these obligations with provisions within a court order.*

Nonetheless, and presumably because the matter was, in fact, before the court, David Lock KC indicated that he was prepared to make a declaration under s.15 MCA 2005 that the Trust was acting lawfully in administering enemas to HJ in accordance with the protocols described in the evidence in this case. However, he made clear that no declaration was needed under the inherent jurisdiction because he was satisfied that the MCA 2005 provided a sufficient framework for governing the lawfulness of the actions of the Trust and clinical staff employed by the Trust.

Comment

Substantively, it is important to see a Trust discharging its obligations to secure against the risks of constipation, a problem which is too often ignored, not just in cases such as HJ's but also – and perhaps especially – in the context of those learning disabilities. One would hope that the consideration given to the steps required would have been equally careful had HJ not been detained in the community.

Procedurally, the case raises two interesting questions. The first is as to whether, had HJ not been subject to the MHA 1983 (or a DoLS authorisation), it would have been legitimate simply to rely upon ss.5-6 MCA 2005. On one view, it is perhaps a non-question, because any care plan which contained that level of planned restriction in relation to medical interventions would almost inevitably contain sufficient restrictions upon the person's physical liberty more generally that they would need to be detained under either the MHA 1983 or under the MCA 2005. However, paragraph 22 of David Lock KC's judgment could be read as suggesting that restrictions of those being used to secure HJ's treatment could be imposed without requiring formal authorisation. With respect, Alex would suggest that, for a person who is not detained, ss.5-6 would only give the thinnest of legal ice under the feet of professionals drawing up and implementing a care plan of the kind in play for HJ given not just the nature of the restrictions but, in particular, their frequency – no matter how benignly intended.

The second question is as to whether the answer given by David Lock KC to the question of whether HJ was subject to a deprivation of her residual liberty is entirely convincing viewed through the prism of the ECHR. His essential answer rested upon the fact that the clinicians were doing that which they were required to do so to discharge their common law duty of care to her, such that the consequences of their action could not give rise to a deprivation of her residual liberty. The European Court of Human Rights in the *Bournewood* case held that reliance upon the common law doctrine necessity was not an answer to the charge that HL had been arbitrarily deprived of his liberty for purposes of Article 5 ECHR (see paragraphs 118-119). David Lock's analysis also comes close to the approach of the Courts of Appeal in the *Cheshire West* cases in conflating why steps are being taken to confine the person with what the consequences of those steps are: an approach strongly deprecated by

the majority of the Supreme Court. That having been said, it is perhaps appropriate to note that the ECtHR in the *Munjaz* case did seem to elide the two in precisely that way in holding that Col. Munjaz was not deprived of his residual liberty by being subject to sustained periods of segregation, noting that the periods were "*foremost a matter of clinical judgment*," and "*could only continue for as long as those responsible for [his] care judged it necessary*" (paragraph 71).

Whether or not the answer to the Article 5 question was entirely convincing (and, indeed, whether or not the Strasbourg case-law is entirely coherent), it is important that all concerned recognised that matters did not stop at Article 5, but that Article 8 was just as important. Indeed, in *Munjaz*, the ECtHR emphasised that "*the importance of the notion of personal autonomy to Article 8 and the need for a practical and effective interpretation of private life demand that, when a person's personal autonomy is already restricted, greater scrutiny be given to measures which remove the little personal autonomy that is left*" (paragraph 80, emphasis added). In this regard, it is of no little interest to note the emphasis placed upon the Mental Health Units (Use of Force) Act 2018 (incidentally, the first time that it has featured in a judgment).

The Mental Health Units (Use of Force) Law – commonly known as Seni's Law – was introduced to respond to what might be thought to be a very different problem, that of force being used as a response to behaviours identified as challenging. But the breadth of the 2018 Act's definition of force[9] means that – rightly – the provisions designed to secure greater accountability and transparency should apply to situations such as that of HJ, at least when they are detained in a mental health unit. Some might well ask why equivalent provisions should not apply in relation to those subject to deprivations of liberty in other settings which are, to all intents and purposes, identical.

'Deprived of her liberty': My experience of the court procedure for my mum

One of the many useful blogs on the website of the Open Justice Court of Protection Project, which has recently turned 3 (Happy Birthday!) is a blog published by 'Anna,' which makes both important and salutary reading for anyone working in the deprivation of liberty zone.

[9] Although note that its definition is not the same as that of 'restraint' for purposes of the MCA 2005. Restraint for purposes of the MCA 2005 arises where a person "(a)uses, or threatens to use, force to secure the doing of an act which P resists, or (b)restricts P's liberty of movement, whether or not P resists" (s.6((4)). Force for purposes of the 2018 Act involves "(a) the use of physical, mechanical or chemical restraint on a patient, or (b) the isolation of a patient."

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Conferences

Members of the Court of Protection team regularly present at seminars and webinars arranged both by Chambers and by others.

Alex is leading a masterclass on approaching complex capacity assessment with Dr Gareth Owen in London on 1 November 2023 as part of the Maudsley Learning programme of events. For more details, and to book (with an early bird price available until 31 July 2023), 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 September. 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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