MENTAL CAPACITY REPORT:
HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

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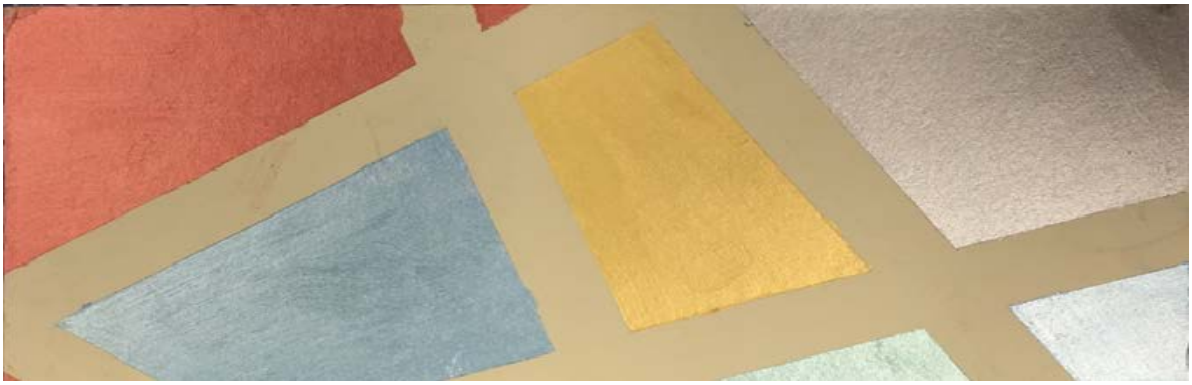

Welcome to the February 2024 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: medical treatment dilemmas of different hues, how risky can the court be, and capacity in context;

(2) In the Property and Affairs Report: useful guides for those creating LPAs and an Australian take on balancing risk and (false) hope in the context of scamming;

(3) In the Practice and Procedure Report: medical evidence, mental disorder and deprivation of liberty, and the approach to propensity evidence;

(4) In the (new) Mental Health Matters Report: medical evidence, mental disorder and deprivation of liberty, and the approach to propensity evidence;

(4) In the Wider Context Report: the new framework for care home visiting in England, an important consultation on capacity in civil litigation, new core ethics guidance from the BMA, and the Circuit Court rolls up its sleeves in Ireland;

(5) In the Scotland Report: discrimination narrowly avoided, and a case posing questions about compensation for unlawful detention.

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.

Finally, we should note March 2024 contains three ten year anniversaries. One is national – indeed international – significance: the decision in *Cheshire West*; one is of national significance: the House of Lords Select Committee post-legislative scrutiny report on the MCA 2005; and the third is of personal significance to Alex: the launch of his website.

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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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Mental capacity – sexual relations

Summary

Poole J is rapidly becoming the specialist sexual capacity judge at the Court of Protection. Following his decisions in *Hull City Council v KF* [2022] EWCOP 33, and *Re PN (Capacity: Sexual Relations and Disclosure)* [2023] EWCOP 44, we now have a further decision from him. This case concerned a 31 year old woman who wanted to become pregnant and have a baby; her capacity to engage in sexual relations, to decide about contact with others, and to make decisions about contraception, were all in issue and required the court's determination.

The parties agreed that EE had capacity to make decisions to engage in sexual relations and lacked capacity to make decisions about contact with others. The applicant local authority submits that EE lacks capacity to "make decisions about whether to use contraception." The Official Solicitor submitted that EE has capacity to make "decisions about contraception." As Poole J noted at paragraph 3:

> *The fact that the parties used different formulations for the matter in respect of which the court must evaluate P's capacity to make a decision for herself concerning contraception, points to an important issue for the court to address, namely what is the matter in relation to contraception which EE has to decide.*

Sexual relations and contact

Poole J's analysis of the position is sufficiently nuanced and detailed that it requires to be set out in full.

First, as regards sexual relations:

> *24. Dr Todd has advised, and the parties agree, that EE has capacity to make decisions to engage in sexual relations. I am not bound so to find. I have regard to the legal framework set out earlier in this judgment and, crucially, the authority of JB. Baker LJ's formulation of the information relevant to a decision to engage in sexual relations included "that a reasonably foreseeable consequence of sexual intercourse between a man and woman is that the woman will become pregnant." He did not include information about the possible consequences to P, or, if P is male, to P's female sexual partner, of becoming pregnant to P or the possible risks to the baby if conceived. However, the "specific factual context", including the existence of "serious or grave consequences" of a decision, or not making the decision, needs to be considered and Baker LJ did not purport*

to give an exhaustive or exclusive list of relevant information that would apply in every case. If a woman of child-bearing age were to have a high risk of suffering serious or grave complications of pregnancy of the kind to which P in DD was vulnerable, then it is arguable that the information relevant to her decisions to engage in sexual relations would include not only the prospect of her becoming pregnant but also that consequently she and her baby would be at a high risk of grave harm. These kinds of reasonably foreseeable consequences were not addressed by Lord Stephens in JB, but he was concerned with a man not a woman, and in any event it would not have been possible for him to have addressed every kind of information that would be relevant to every potentially incapacitous person's decisions to engage in sexual relations. Instead, he set down the general requirement for the court to consider the specific factual context of each case.

25. However, having noted that it is at least arguable that in some cases where there are serious or grave risks of harm consequent on a pregnancy, the information relevant to engagement in sexual relations might include those risks, it is right to note that Lord Stephens warned that there were "practical limits" on what P should be expected to envisage as the "reasonably foreseeable consequences" of a decision or failing to make a decision. A line must be drawn so as to avoid imposing too high a requirement on persons who may potentially lack capacity to make a particular decision.

26. In the present case, I consider that in the context of decision-making about engaging in sexual relations it would exceed the practical limits to require EE to envisage the risks to her or her baby should she become pregnant following intercourse. Firstly, the evidence does not establish that she or her baby would be at serious or grave risk of harm were she to become pregnant. The evidence suggests that there would be some risks to her, but they are not of a direct and severe kind. I address this more fully below. Secondly, many women will put their physical or mental health at risk by becoming pregnant. Some may consider those risks before engaging in sexual relations, some might not. To require EE to understand and weigh or use information about risks to her health during pregnancy or labour, in particular risks which were not grave, would stray beyond the practical limits to which Lord Stephens referred and would set the bar too high. Thirdly, and similarly, many women will engage in sexual relations with a view to conceiving when there is a risk that their baby will suffer harm in utero or be born with a congenital disability. Again, some women will consider those risks in advance of engaging in sexual relations, some will not: the bar should not be set too high for EE. Finally, these matters – risks consequent to pregnancy – have not featured significantly or at all in the case law regarding the information relevant to decisions about sexual relations including older authorities about capacity to consent to sexual relations. I proceed on the basis that it would only be in cases where there was a clearly identified, high risk of grave harm consequent on pregnancy or childbirth, that information about that might have to be envisaged by P and be included in the list of relevant information.

27. I have found it necessary to address the question of information relevant to decisions to engage in sexual relations, notwithstanding the agreement of the parties as to EE's capacity in that respect, because it is necessary to consider the consistency between the

> *determinations of capacity I have to make.*

On the facts of EE's case, Poole J considered that:

> *28. In my judgment the information relevant to EE's decisions to engage in sexual relations is that set out by Baker LJ in JB and I do not consider that any further relevant information should be added in this case. Dr Todd's written reports correctly address EE's ability to understand, retain, and weigh or use the relevant information. EE's responses in interviews with Dr Todd are conspicuous for the detailed understanding and ability to weigh and use information that she demonstrates. As Dr Todd said to the court, EE offered the information she knew and her opinions about decision making, largely unprompted. I have no hesitation in finding that she has capacity to decide to engage in sexual relations as Dr Todd and the parties have agreed.*

Second, as regards contact, the primary reason EE lacked capacity regarding contact was her inability to use or weigh the risks that others posed to her. Poole J noted that he should comment briefly on whether the agreed positions regarding capacity to make decisions about sexual relations and about contact with others were consistent with each other, especially in light of his observation in *Hull City Council v KF* that it was difficult to see how a person who lacked capacity to decide to have contact with a specific person could have capacity to decide to engage in sexual relations with that person. Poole J continued:

> *30.* […] *However, in PN […] I was concerned with determining capacity to engage in sexual relations generally, not with a specific person and I found that PN lacked capacity to make decisions about contact with others but had capacity to engage in sexual relations with others. For the reasons set out in that judgment, in particular at [28], I did not consider those determinations to be inconsistent. Likewise, in the present case, I am content to find that EE lacks capacity to decide on contact with others, specifically those with whom she is not already familiar, but has capacity to decide to engage in sexual relations with others. EE's carers have devised and adopted a care plan which has been based on those positions in relation to capacity. It follows an approach of the kind set out by Baker J in A Local Authority v TZ [2014] EWHC 973 (COP) and discussed in his oral evidence by Dr Todd when he referred to "positive risk taking". The approach involves encouraging EE to consider the risks and benefits of meeting any particular person and the form of contact with them but ultimately to make best interest decisions to protect her from harm, or the risk of harm from contact with a person with whom she is unfamiliar, and to allow for interventions by a carer. However, once she has familiarity with a person and wishes to have sexual relations with them, her capacity to make that decision would have to be respected. The fact that JB had been found to lack capacity to make decisions relating to contact with others did not preclude the Court of Appeal and the Supreme Court from considering whether he lacked capacity to engage in sexual relations. The courts were clearly prepared, in principle, to find that he had capacity to engage in sexual relations notwithstanding that he lacked capacity to decide to have contact with others.*

Contraception and conception

When the expert was asked about contraception, he had questions put to him as if "contraception" included two questions: (1) deciding to conceive;

and (2) to make decisions in relation to contraception. Poole J therefore considered "whether it is appropriate to consider EE's capacity to decide to conceive or to become pregnant alongside decisions about her capacity to make decisions about engaging in sexual relations and the use of contraception" (paragraph 31). At paragraph 34 he asked himself:

> *Ought the court to be even considering the question of EE's capacity to make decisions about conception given its determination that EE has capacity to decide to engage in sexual relations and that it will determine her capacity to decide on the use of contraception? In JB no distinction was made between decisions about engaging in sexual relations with a view to trying to conceive, and decisions about sexual relations which are not for any reproductive purpose. It is sufficient for P to understand, retain, and weigh or use information that sex might result in pregnancy. There was no suggestion in JB that the relevant information concerning pregnancy differs according to whether P and their consenting sexual partner wish to have sex without contraception. Furthermore, the non-exclusive list of information relevant to decisions to engage in sexual relations set out in JB does not include the risks consequent on pregnancy or childbirth to P or, if P is a man, to a woman with whom P has sex, or to a conceived child. Such information was not included within the "practical limits" of what needs to be envisaged. In the present case I have found that those matters were not part of the information relevant to EE's decision to engage in sexual relations. The freedom to make decisions about conceiving and having children, subject to the unavoidable restrictions imposed by biology, is a fundamental part of anyone's Article 8 right to respect for their private and family life and, in my judgment, it would be irrational, unnecessary, and an unjustified interference with EE's Article 8 rights, to find that she has no capacity to make decisions about conception on the grounds that she cannot understand, retain, or weigh or use that same information. Dr Todd and the Applicant have, I believe, fallen into that error.*
>
> *35. Clearly there is some overlap between decisions about contraception and decisions about conception, but they are different. Without needing to decide the matter, there may be cases, for example where P wishes to undergo IVF, in which P's capacity to make a decision about conception has to be determined. But in most cases, including EE's case, those specific considerations will not apply. EE has capacity to engage in sexual relations and that means she has capacity to engage in sexual relations with a view to becoming pregnant. I shall also consider her capacity to make decisions about the use of contraception. In the circumstances, no separate consideration of capacity to decide about conceiving or conception is required or justified.*

Poole J therefore found that it was not necessary or appropriate to frame the matter for decision as being about "conceiving/getting pregnant" as Dr Todd expressed it, or about conception at all. Rather:

> *36.* […] *In relation to the issue of contraception, in my judgment the appropriate formulation of "the matter" in respect of which the court must evaluate whether EE is unable to make a decision for herself, is "the use of contraception".*

As to contraception, Poole J reminded himself that in order to identify the information relevant

to the decision in question, he had to consider the particular factual context within which EE would make such decisions. She was currently prescribed anti-anxiety medication, sleeping tablets, and an anti-psychotic. The probable advice to EE would be to continue with each of these during pregnancy. EE had said that that is what she would do. She had been compliant with her medication for some time and had not suffered a psychotic episode for a while. The medical evidence was that, if EE were to continue her medication throughout pregnancy, then at birth the baby might initially have to be cared for in the neonatal intensive care unit to monitor for signs of withdrawal from the anti-psychotic medication. Poole J noted (at paragraph 37) that there was no evidence that EE did not understand this information or was unable to weigh or use it.

Poole J noted that Dr Todd had concluded that "[EE] *does not have the mental capacity to make an informed decision whether to use contraception to prevent the risks associated with pregnancy to her mental health and the risks to her baby of a mental health relapse and the use of psychotropic medication during pregnancy*." At paragraph 3.2 of the report, he explained his reasoning:

> *She stated that it is her right to have a child and all her physical and mental problems will go away once she has a child. This strongly held belief, in combination with her lack of insight into her care and support needs, leads her to be unable to use and weigh the risks to her mental health of becoming pregnant and being a new mother and the impact of the baby on her mental health and the risks to her baby of a mental health relapse and the use of psychotropic medication during pregnancy. In terms of pregnancy and the risks to her mental health, EE believed that she would be able to manage regardless of any impact on her mental health. In terms of pregnancy and the risks to her baby, she believed her mental health would have no impact on the child and any risks caused by psychotropic medication were not significant and, even in the worst case, she would be able to manage the impact on the baby.*

In his oral evidence, Dr Todd focused on the risk of EE suffering from a deterioration in her mental health or psychological state due to the combination of her autism and learning disability, and the stress of pregnancy and/or birth. However, as Poole J noted: "[h]*e had not specifically addressed that issue in his written evidence. More importantly, he had not addressed it with EE, so that there was a lack of evidence before me of what she might have said about the risk of a general deterioration in her mental or psychological condition*," such that:

> *40. I have virtually no evidence of the likelihood, nature, or severity of any deterioration in her mental or psychological state that EE might suffer as a consequent of pregnancy. Dr Alex does not comment on those matters in his report, Dr Todd does not give such evidence in his written reports, and he did not provide any specific evidence at the hearing, only referring to having dealt with a patient, whom I did not understand was pregnant at the material time, who had suffered what he called "an autistic meltdown". I do not doubt that as a woman with autism and learning disability, EE will have some difficulties adapting to the physical and emotional changes caused by pregnancy, but I have no evidence beyond Dr Todd's implication, that EE is especially vulnerable to suffering a severe crisis of the kind he described should she become pregnant.*

As Poole J identified, a relevant aspect of the case that EE had previously been pregnant, and

that there was evidence that she experienced an autistic "meltdown" or other deterioration, although he had been given very little information about her previous pregnancy save that it ended with a termination. He continued (at paragraph 41): "[it] *cannot be known exactly what support EE would have were she to find that a pregnancy was exacerbating her mental or psychological health. The father might or might not support her, but she would be highly likely to have the support of care staff and therapists*." Further, and whilst it was clearly material to Dr Todd's oral evidence about EE's capacity to make decisions about contraception, that he had found (and no-one disputed) that EE lacked capacity to make decisions about her care, and that, "*his view appeared to be that because she lacks capacity to make decisions about care, EE cannot understand, or use or weigh, information about her care needs in the event of a deterioration in her mental or psychological health during pregnancy*." However, Poole J did not accept that reasoning: "Dr Todd's interview with EE about care and support focused on her independence and ability to live without day to day support and care, not on medical treatment or support in the particular circumstances of a crisis or deterioration in her mental health or psychological condition caused by pregnancy" (paragraph 43).

As Poole J identified:

> *43. There are reasons to avoid setting the bar too high for capacity to make decisions about the use of contraception. As noted, at [75] of his judgment in JB, Lord Stephens adopted the caution expressed in In re M (An Adult) (Capacity: Consent to Sexual Relations) [2014] EWCA Civ 37, namely that the notional decision-making process attributed to P should not "become divorced from the actual decision-making process carried out in that regard on a daily basis by persons of full capacity". Daily, in GP surgeries and clinics, women make decisions about contraception without considering the risks to them or to the health of their baby if they were to get pregnant. The risk of becoming pregnant following intercourse is a core piece of relevant information, but not all the many and varied risks which may be consequent on becoming pregnant. Some may envisage all manner of risks, others will not do so.*
>
> *44. Nevertheless, for some women, there may be certain risks arising from pregnancy that would be highly relevant to their decisions about the use of contraception. Following paragraph 4.19 of the Code of Practice (above), and Cobb J's judgment in DD (above), serious or grave consequences of pregnancy to which P would be particularly vulnerable, might be considered to be part of the relevant information. In my judgment, this approach would be consistent with the approach to decision-making about engagement in sexual relations set out by Lord Stephens in JB as I have tried to describe earlier in this judgment. The information relevant to a decision is dependent on the specific factual context of each case but must be kept within practical limits so that the bar is not set too high and the requirements on a person who might lack capacity are not divorced from the realities of decision-making for capacitous persons.*
>
> *45. More remote consequences of pregnancy, labour and birth, such as the impact on the child of being born to a mother with mental health problems, physical illness, or disability, are not part of the relevant information (for a number of reasons including that they are not within practical limits or, as it was put by Bodey J in A Local Authority v Mrs A and Mr A (above) they are not proximate medical considerations).*

Therefore, considering the evidence in the case, the specific factual context in which EE might make decisions about contraception,, including whether to use contraception at all, and the need to respect practical limits when determining what reasonably foreseeable consequences should be included, Poole J decided to adopt the list of relevant information given by Bodey J in *A Local Authority v Mrs A and Mr A* [2010] EWHC 1549 (Fam), with no additions or subtractions, i.e. (i) the reason for contraception and what it does (which includes the likelihood of pregnancy if it is not in use during sexual intercourse); (ii) the types available and how each is used; (iii) the advantages and disadvantages of each type; (iv) the possible side-effects of each and how they can be dealt with; (v) how easily each type can be changed; and (vi) the generally accepted effectiveness of each.

Poole J was also at pains to explain why he had excluded certain information, at paragraph 47:

> *a. The risks and benefits to EE of continuing with anti-psychotic and other medication during pregnancy. I am not persuaded that serious or grave consequences to EE are brought into consideration. Moreover, I believe that these risks and benefits are not sufficiently proximate to the decision about contraception. The risk of thromboembolic disease which was pertinent to decision making in DD would arise directly from a pregnancy. Here, the risks of continuing or discontinuing medication are a secondary consequence of the pregnancy – they arise from a decision that has to be made in the event of the pregnancy. They are therefore further removed from the decision about contraception. If I am wrong and should have included this information, then I am quite satisfied that EE can understand, retain, and weigh or use the information. Dr Todd focused his discussions with EE much more on the potential impact of continuing the medication on any baby she might carry in the future, rather than on the impact to EE herself of ceasing medication, but he went through Dr Alex's report with her and EE appears to have aligned herself with Dr Alex's evidence and his opinion that EE ought to continue taking her current medication during any future pregnancy. I am satisfied that she did so having weighed and used the information provided. To underline my conclusion, EE's ability to weigh and use information in relation to the medical issues regarding the use of different forms of contraception shows her functional abilities in these areas.*
>
> *b. The risks of a deterioration in EE's mental health or psychological condition due to pregnancy or labour. There is no, or no sufficient, evidence before me that this is a serious or grave consequence in the case of EE. I would accept that in principle serious or grave risks might be included as reasonably foreseeable consequences of deciding not to use contraception, but in the specific context of this case, the evidence does not justify treating these risks as serious or grave or as matters which any woman in EE's position would have to consider when making decisions about contraception. Aside from Dr Todd's comments during his oral evidence about the risk of "autistic meltdown", which were not backed up by any references or reliable experience, only by an anecdotal reference to a single case that did not relate to a pregnancy, no other evidence was provided that was relevant to EE's case. If, contrary to my determination, this should be regarded as relevant information then I would need to consider allowing for a further interview with EE in order to afford her an opportunity to address it and thereby to give the court evidence as to her ability*

to understand, retain, and weigh or use that information. This information has not been discussed with her. I do not need to decide whether I would indeed allow for further evidence to be adduced but I note that the onus is on the Applicant to establish that EE lacks capacity. Whilst the Court of Protection adopts an inquisitorial approach, it does not follow that if, after sufficient time has been given to gather relevant evidence, a party is unable to establish a case, then proceedings must be adjourned to enable more evidence to be obtained.

c. The potential effects on EE's baby of her continuing to take anti-psychotic and her other current medication during any pregnancy. Dr Alex's evidence is that,

> *"Use of aripiprazole [which EE takes] and other antipsychotics throughout pregnancy or near delivery has been associated with withdrawal symptoms in the neonate and/or poor neonatal adaptation syndrome (PNAS). These symptoms are likely to be more severe in infants exposed in utero to more than one CNS acting drug. Delivery should therefore be planned in a unit with neonatal intensive care facilities."*

Dr Alex has not said that withdrawal symptoms or PNAS would be a severe or grave condition for the baby. Care must be taken not to insist on P needing to envisage a wider range of risks than a capacitous woman might be expected to envisage, including women taking prescribed or other medication which might affect a baby if they became pregnant.

d. The effect of EE's mental or psychological health on her newborn baby, the difficulties she might have caring for a baby or coping with the peri-natal period, or the prospects of a child being made the subject of protective orders by the court. Those issues are not "proximate medical issues" and are not within "practical limits" of what needs to be envisaged (JB at [75]).

Having regard to the relevant information, Poole J had "no hesitation" in finding that EE had capacity to make decisions about the use of contraception.

Poole J, who had met with EE prior to the hearing, agreed with EE that he would write a letter to her explaining his decision. He noted that:

> *50*. […] *With respect to her, although she has thought the matter through, many would think it unwise for her to try to conceive, but it is not for me to advise her, and it is certainly not the role of the Court of Protection to intervene in the autonomous decision-making of an adult who has capacity to make decisions about sex or the use of contraception, however unwise the court may consider the proposed decisions are. Many capacitous people make unwise decisions about sex and contraception, sometimes with awful consequences for themselves and others, but however strong is the impulse to protect, the follies of the capacitous are not the business of the Court of Protection.*

Comment

As might be expected, the ramifications of the decision in JB continue to make themselves felt, especially as to the vital importance of focusing on the information that is actually relevant to the decision in question. This, in turn, involves the recognition that determination of mental capacity has a clear element of social construction to it. For the avoidance of doubt, we are suggesting by this that this means that it is a

concept that lacks validity, but rather that it is a concept that requires to be considered in a transparent fashion in exactly the way that Poole J has done here.

Poole J's analysis of the interrelationship between conception and contraception is also very helpful in terms of clarifying a matter which can otherwise cause undue complication, his clear-eyed analysis of the need for actual evidence of risk if such risk is to be asserted to be relevant both made all the difference on the facts of the case and is of wider relevance.

Care, residence and contraception – getting the calibration right

Re CLF (Capacity: Sexual Relations and Contraception) [2024] EWCOP 11 (Poole J)

Mental capacity – sexual relations – care – residence

Summary

In this case, Poole J had to consider the capacity of woman to make decisions about: (1) the conduct of the proceedings; (2) residence; (3) care; (4) contact with others; (5) use of the internet and social media; (6) engagement in sexual relations; and (7) the use of contraception. He accepted the unchallenged expert evidence that CLF lacked capacity to make decisions about conducting the proceedings, care, contact and the use of internet and social media. He therefore focused on residence, engagement in sexual relations, and the use of contraception.

On residence, Poole J was troubled by the attempt to pull part care and residence on the facts of the case:

> *36. Dr Rippon's evidence as set out at paragraphs [10] and [11] of this judgment is that CLF is able to make a decision as between two options for her residence but only if adequate care was arranged at each one. CLF does not have capacity to make decisions about her care but, as I understand Dr Rippon's evidence, she can describe her care – she understands what care is and what kind of care she is receiving. Hence, she could not make a decision about residence if it involved an assessment of the appropriate level of care in each place available for her. But if the provision of care was decided for her, she would be able to understand, retain, and weigh or use the other information relevant to a decision about residence – see LBX at [43] (above). Mr Karim KC for the Local Authority submitted that the court should not accept the distinction that Dr Rippon had adopted but should apply LBX, avoid the trap identified in Re B, and find that CLF lacks capacity to make decisions about residence. Mr O'Brien KC, for the Official Solicitor for CLF, submitted that the danger of considering decision-making in silos, as identified in Re B, was that it may result in a situation that would be "practically impossible" for the Local Authority to implement – Re B at [63] (above). Here, it would not be practically impossible for the Local Authority to make decisions about the care provision CLF requires, make arrangements for that to be put in place at residence A and residence B, and then allow CLF to make a choice about which residence to live in. Where possible, her autonomy should be respected and protected.*
>
> *37. There is a risk, in my judgement, in dissecting areas of decision-making such that it becomes practically impossible for those caring for P to implement the assessments of capacity made. It would make it difficult for a Local Authority to implement a care plan if it had been determined that P had capacity to make decisions on, for instance, eight aspects of her care, but*

> *not on five others. Furthermore, the process of assessing capacity might become unwieldy. However, in this instance, Dr Rippon's evidence is that CLF would have capacity to make decisions about her residence but for the element of choosing the right level of care within those places. I can see that if care decisions could be removed from decision-making about residence, then a declaration that CLF had capacity to make decisions about residence provided that the care arrangements for each available residential option were made for her, would not necessarily be incompatible with a declaration that she lacks capacity to make decisions about her care. However, my concern is that the position is more complex than Dr Rippon has assumed. As well as compatibility with the declaration of incapacity to make decisions about care, I also have to consider compatibility with my finding that CLF lacks capacity to make decisions about contact with others and to use the internet and social media. When considering the practical implications of the declaration regarding residence decision-making sought on CLF 's behalf by the Official Solicitor, I do not see how a declaration of even conditional capacity to make decisions about residence, is compatible with declarations of incapacity that I make. What might seem an attractive solution in theory, could not be possibly to put into practice. Much of the information relevant to a decision about residence, even with a care package determined for her, will be relevant to care, contact with others and the use of the internet and social media. A choice about whether to live in house A or house B will involve information about access to activities and the community which entails questions about risk; about the neighbours and any risks of conflict with them, or harm from them; about the layout of the house or flat, the ability to monitor CLF within the accommodation, including her use of social media and the internet. Care is not simply a "given": the choice of residence will itself determine the level and kind of care required. Similarly, decisions about contact with others will be contingent upon where CLF lives. Whilst wishing to protect CLF's autonomy as much as is possible, I cannot see a way in which to divorce her decision-making about residence from other decision-making in relation to which it is agreed, and I have found, CLF lacks capacity.*

Poole J therefore found that CLF did not have capacity to make the decision about residence, although, importantly, noted that *"it does not follow that CLF may not take any part in decision-making. Clearly, her views about residence should be sought and she should be supported to be able to express her opinions and take into account relevant information*" (paragraph 38).

As to sexual relations, he noted the clear and consistent evidence of the expert that CLF had such capacity. He rejected the submission that her belief that the withdrawal method was a wholly effective method of avoiding pregnancy, such that she engaged in unprotected sex, meant that she lacked capacity to decide to engage in sexual relations. That might go to the question of contraception, Poole J considered, but not to sex:

> *41. CLF clearly understands that sex may result in pregnancy. She understands and can weigh or use the other relevant information identified by Baker LJ and the Supreme Court in JB (above). On the basis of the evidence before me, including Dr Rippon's opinion evidence, I find that CLF has capacity to make decisions about engagement in sexual relations. As explained below, I find that she presently lacks capacity to make decisions about the use of*

> *contraception. I do not consider that these two findings are incompatible. The bar should not be set too high for capacity in relation to sex. There are practical limits on what should be envisaged by the individual concerned. There is a danger in imposing requirements on their decision-making that are higher than those attained by many capacitous people making the same decisions. A lack of understanding about a particular method of contraception or birth control, should not deprive a person of being found to have capacity to engage in sexual relations. It is unhelpful to break down decision-making in relation to a particular area, here sexual relations, into sub-divisions such as the decision to engage in sex whilst relying on the man withdrawing before ejaculation to avoid pregnancy. Firstly, that route will often lead to a result that is "practical impossible" to manage: how can anyone manage a situation in which a person has capacity to engage in sex using a condom but not have capacity to engage in sex using the withdrawal method? Secondly, many otherwise capacitous individuals might be found to lack capacity to make very specific decisions. Thirdly, and related to the second objection, the more one breaks down an area of decision-making into sub-divisions, the more complex the relevant information within that area becomes, and the more difficult it will be for people with a learning disability or other cognitive impairments, to avoid conclusions that they lack capacity. The MCA 2005 directs those assessing capacity to support people to make decisions for themselves. Framing decisions with ever more precision risks undermining that purpose of the Act.*

Poole J did not consider that his conclusion that CLF had capacity to make decisions about engaging in sexual relations with the finding that CLF lacks capacity to make decisions about contact with others, expressly adopting the reasoning in the earlier decisions in *Re PN (Capacity: Sexual Relations and Disclosure)* [2023] EWCOP 44, we now have *Re EE (Capacity: Contraception and Conception)* [2024] EWCOP 4.

Finally, as to contraception, Poole J noted that Dr Rippon had been clear that CLF did not understand, and could not weigh or use, information about different forms of contraception, their effects, side-effects, and effectiveness. This is primarily because she understood that contraception involving medication or a device (not condoms) will render her permanently infertile. Her inability to do so was because of her Learning Disability and Autism Spectrum Disorder. In the circumstances, he concluded, as was accepted by all the parties, that CLF lacked capacity to make decisions about the use of contraception.

He noted, though, that:

> *46. CLF also told Dr Rippon that she believed that the withdrawal method was wholly reliable to prevent her from becoming pregnant. I recognise the sensitivity of referring to the withdrawal method as a form of contraception. It might better be described as a form of birth control. I would not accept any argument that faith in the withdrawal method as a form of birth control was in itself proof of a lack of capacity to make decisions about the use of contraception (or birth control). It is practised by many millions of people. However, I accept that in CLF's case, she does not understand, and is unable to weigh or use, information about birth control, including the withdrawal method, because of her Learning Disability and Autism Spectrum Disorder. Even if I am wrong, she clearly lacks capacity in that area for the reasons referred to in the previous paragraph of this judgment.*

Importantly, Poole J did not make a final declaration in respect of CLF's capacity but only an interim one, because there was evidence that a focused educational programme could lead to CLF gaining capacity in this area.

Comment

Whilst appreciating that care and residence are distinct questions, this case adds to others (including the characteristically clear decision of Sir Mark Hedley in *Re CMW* [2021] EWCOP 50) suggesting that, in the context of someone with needs for care, attempting to take the two together represents salami-slicing leading to problems.

In relation to the approach to contraception, by contrast (and with thanks to Ian Brownhill for making this point) it might be thought that the decision could have been broken down further. Putting aside the withdrawal method, and noting Poole J's observation on whether to characterise it as a method of contraception, this was a situation where it might be thought necessary to consider separately CLF's capacity to make decisions about (a) contraception where (in effect) reliance was being placed on the partner to use a condom; and (b) contraception reliant upon her either taking medication or using a device such as an IUD. Given that Poole J only made an interim declaration in relation to CLF's capacity, it may be that this is a matter which still falls to be considered by him in due course.

Birth arrangements under a careful microscope

A Hospital Trust v CP [2024] EWCOP 7 (Henke J)

Best interests – medical treatment

Summary

This case concerned the obstetric treatment of CP, a 30 year old woman with a diagnosis of schizophrenia who was detained pursuant to s.3 MHA 1983 The acute Trust sought declarations and orders allowing it to provide a planned caesarean section to CP.

The capacity evidence (as is commonly the case in such cases) was provided jointly by CP's Responsible Clinician under the MHA (employed by the Mental Health Trust) and a clinician from the Acute Trust. It appears from the judgment that this issue was not the subject of challenge.

The best interests evidence appears to have been tested by the Official Solicitor (albeit there was by the conclusion of the hearing, no disagreement between the parties). In carrying out the best interests evaluation, the Court factored in the evidence of CP's parents that she "*is not good at handling pain and would find a natural delivery a very difficult experience. According to them, she becomes distressed when she has a headache*," together with their evidence that she "*would be unlikely to be able to cope with a normal labour of 12-16 hours duration*" and that CP would find that traumatic. The Court accepted that if CP were to have a vaginal delivery there was a real likelihood that medical intervention would be required in crisis and that CP would need to be restrained. This, the judge considered, would be likely to impact negatively on her mental health. Henke J factored in both CP's previously expressed wish for a vaginal delivery and her views as expressed to the Court, that she wanted a caesarean section. The Court concluded that the proposed planned caesarean section was in CP's best interests.

Henke J also considered, separately, what form of anaesthetic should be used – spinal block or general anaesthetic, concluding on the facts before her a spinal block was in CP's best interests.

Comment

There are three aspects of this case that make it worthy of comment.

The first is the fact that (increasingly rarely), the Trust's obstetric plan was to move straight to a caesarean section. There were sound reasons for this, not least as set out above, that is what CP herself wanted (or at least that was the case by the time the matter was before the court). However, it is more common to see care plans that provide for vaginal delivery to be tried first, with authority to provide a caesarean section as a last resort.

The second is that, reflecting the evidence before the court, there was a rather clearer recognition in the judgment than in some others that vaginal delivery "*has the best clinical outcome for a medically low risk of primigravida. Recovery time is quicker than after a caesarean, there is no uterine or abdominal scar, there are less use of lines and thus less likelihood of wounds and infections*" (paragraph 59).

The third aspect is the decision by Henke J not to join CP's parents as parties to the application. Henke J considered COPR 2017 9.13(2) which provides: "*The Court may order a person to be joined as a party if it considers that it is desirable to do so for the purpose of dealing with the application*." At paragraph 22, Henke J observed that "[d]*esirability in this context means that their joinder would enable the court to better deal with the substantive application*." In circumstances where the parents themselves stated that they simply wanted to observe the proceedings, where their views (in particular about CP's inability to deal with pain), had been taken on board by the Trust witnesses and reflected in the Trust's evidence and decision making, and where the parents agreed with the application, had not filed any witness evidence, or sought to cross examine any of the witnesses, Henke J held that joinder would not enable the court to better deal with the substantive application. Part of the Henke J's reasoning for not joining the parents also included (i) that CP herself did not want them joined as parties, and (ii) the fractured nature of the relationship between CP and her parents. We can quite see why these factors were in Henke J's mind, and it is clear that she did not fall into error and consider the question of joinder to be a best interests decision as opposed to a case management decision. The views of P have been taken into account in deciding whether to remove a person as a party (see *London Borough of Southwark v P & Ors* [2021] EWCOP 46 at paragraph 42) this is the first reported case we are aware of where they have been taken into account in deciding not to join someone.

DoLS and the 'nuclear option'

Northern Ireland Health and Social Care Trust, Re Application for Judicial Review [2023] NIKB 78 is a decision of the High Court in Northern Ireland from June 2023, but which only appeared on Bailii at the start of 2024. It reinforces, by analogy, how nuclear are the options (1) not granting a DoLS authorisation; and (2) discharging an authorisation. The Review Tribunal (charged with oversight of the Northern Irish DoLS regime) discharged an authorisation relating to a person in a care home, on the basis that it did not consider that it was proportionate. In doing so, it understood that there would be a care package in place for her when she returned home, at least on a trial basis, but that it would not be in place immediately upon discharge of the authorisation. The Trust responsible for the woman's care challenged the decision of the Tribunal by way of judicial review. For present purposes, the relevant ground was that it was not lawful for the Review Tribunal to permit any period of 'legal lacuna' to come into being at the point between the discharge of the authorisation and the return of the person to their own home.

Larkin J noted that the Trust's position was understandable, because it was naturally "anxious to protect those persons conscientiously discharging difficult duties from being exposed unnecessarily to liability" (paragraph 34). However, he considered that this was to misunderstand the task of the Review Tribunal, which was to determine whether the authorisation criteria are met, which were not "*addressed to the administrative desiderata or even the perceived necessities of the Trust. Those criteria do not imply, far less express, a general test of the public interest*" (paragraph 35) but rather – in summary – were concerned with the best interests of the detained person. If the Review Tribunal found that the that the deprivation of liberty was not a proportionate response to the risk of harm then "*the Tribunal has no lawful option* […] *but to revoke the authorisation to deprive P of his liberty. If the Trust considers that P still needs to be cared for, then the Trust can continue to care for P but cannot rely on the authorisation that has been revoked in order to protect P's carers from any liability that can arise if P is still deprived of his liberty*" (paragraph 38). Larkin J also noted that "*the Review Tribunal decision did not itself have the effect of altering the day to day care of Mrs Patterson; the decision simply revoked an authorisation that afforded specified protection against civil and criminal liability. It opened up the possibility of certain other forms of relief to Mrs Patterson but it was not itself equivalent, for example, to an order pursuant to a writ of habeas corpus requiring the release of an asylum seeker from a detention centre.*"

Whilst directed to the specific position in Northern Ireland (as to which, for those interested, see here for a presentation by Alex), the observations are of equal relevance both to those considering whether to grant DoLS authorisations in England & Wales, and to courts considering whether or not to discharge such authorisations on s.21A applications.

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Conferences

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

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

Adrian will be speaking at the following open events: the Royal Faculty of Procurators of Glasgow Private Client Conference (14 March, details here), the World Congress on Adult Support and Care in Buenos Aires (August 27-30, 2024, details here) and the European Law Institute Annual Conference in Dublin (10 October, details here).

Peter Edwards Law has announced its spring training schedule, here, including an introduction – MCA and Deprivation of Liberty, and introduction to using Court of Protection including s. 21A Appeals, and a Court of Protection / MCA Masterclass - Legal Update.

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 April. 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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