Mental Capacity Law Newsletter June 2016: Issue 66

Court of Protection: Health, Welfare and Deprivation of Liberty

Introduction

Welcome to the June 2016 Newsletters. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Newsletter: Neil Allen comments on the Law Commission's interim statement, Charles J on deputies and Article 5, and an updated Guidance Note on judicial authorisation of deprivation of liberty;

(2) In the Property and Affairs Newsletter: Senior Judge Lush on the difference between property and affairs and welfare deputies and new OPG guidance;

(3) In the Practice and Procedure Newsletter: an appreciation of Senior Judge Lush by Penny Letts OBE ahead of his retirement in July;

(4) In the Capacity outside the COP Newsletter: a major report on the compliance with article 12 CRPD of the three jurisdictions of the United Kingdom and a guest article by Roy Mclelland OBE on the new Mental Capacity (Northern Ireland) Act 2016;

In large part because its editors have been all but entirely subsumed with work on the report on CRPD compliance, there is no Scotland newsletter this month.

Remember, you can now find all our past issues, our case summaries, and much more on our dedicated sub-site here. 'One-pagers' of the cases in these Newsletters of most relevant to social work professionals will also shortly appear on the SCIE website.

Editors
Alex Ruck Keene
Victoria Butler-Cole
Neil Allen
Annabel Lee
Anna Bicarregui
Simon Edwards (P&A)

Guest contributor
Beverley Taylor

Scottish contributors
Adrian Ward
Jill Stavert

Table of Contents

For all our mental capacity resources, click here.

The "Revised Approach" to Deprivation of Liberty[1]

On 25 May 2016, the Law Commission published a brief 10-page "Interim Statement" following a formal request from the Minister of State for Community and Social Care. It essentially provides a heads-up of the Commission's current way of thinking. A summary of the likely general direction of travel for reform; but not a final position. Nevertheless, after 83 nationwide events and 583 written responses from interested persons and organisations, the statement reveals what can only be described as a substantial change of approach.

Amongst the key messages arising from last year's consultation were:

- Avoid duplication with existing legislation, excessive legalism and unnecessary bureaucracy;
- Use existing care plans to provide authority for deprivation of liberty;
- Cater for article 8 rights in the scheme;
- The likely number of those in supportive care is small, given how low the threshold is for article 5;
- Use a tribunal, not the Court of Protection, due to its efficiency, accessibility, flexibility and simplicity;
- Have a bespoke system for hospitals;
- Have a new admission mechanism under the Mental Health Act 1983;
- Concerns raised over coroner's inquests;
- Lack of money;
- Any system based on *Cheshire West* is unsustainable.

The consultation reinforced the Commission's provisional view that DoLS needs to be replaced. The current safeguards were criticised for being overly technical; legalistic; failing to deliver improved outcomes for people; not designed for the now "deprived" populace; and expensive. But the Law Commission plans to depart significantly from its original "protective care" proposal. Many felt that it would be too costly and "*any new scheme needed to focus much more on securing cost efficiencies and value for money*". In response, the Commission stated:

> *1.36 There is some force in these arguments. Nevertheless, we do not accept that safeguards should be reduced to the bare minimum or that we should not consider any reforms that may generate additional costs. We remain committed to the introduction of a new scheme that delivers article 5 ECHR safeguards in a meaningful way for the relevant person and their family. Moreover, there are some reforms that remain fundamental to our new scheme and will need to be properly financed, such as rights to advocacy.*
>
> *1.37 Nevertheless, it is our view that the new scheme must demonstrably reduce the administrative burden and associated costs of complying with the DoLS by*

[1] Note: Alex is on secondment to the project and is not able to comment upon the statement. This note has been prepared by Neil Allen.

> *providing the maximum benefit for the minimum cost. With this in mind, we have therefore concluded that the new scheme should focus solely on ensuring that those deprived of their liberty have appropriate and proportionate safeguards, and should not seek to go as widely as the protective care scheme."* (emphasis added)

Before considering the highlights of the yet-to-be-named scheme of safeguards, it is important to analyse the proposed amendments to the 'core' of the Mental Capacity Act 2005. The reason being, some of the potential criticisms of the new scheme may in part be met by them.

1. Amendments at the Core

What is potentially encouraging is the Commission's desire to maintain "*as much as possible*" the article 8 protections contained in its former supportive care scheme but "*in such a way as to minimise the demand on services*". These protections primarily aim to ensure that there is proper consideration given, and necessary assessments undertaken, before a best interests decision is made as to the need to remove someone lacking capacity into institutional care. They aim to confer better preventive measures. The original version envisaged independent advocates, or an "appropriate person", being tasked with ensuring that the person had access to the relevant review or appeals processes (eg under the Care Act, Social Services and Well-Being (Wales) Act, or the Court of Protection). It required local authorities to keep the health and care arrangements under review, and to ensure the care plan included a record of capacity and best interests assessments, setting out restrictions and confirming the legal arrangements under which the accommodation was being provided. In short, it aimed to secure better implementation of the 2005 Act and better access to advocacy services.

The second important core amendment proposes to give "*greater priority to the person's wishes and feelings when a best interests decision is being made.*" This is hugely significant and furthers (although may fall short of ultimately achieving) one of the aims of the UN Convention on the Rights of Persons with Disabilities. It seems likely, therefore, that the MCA s.4 best interests checklist will contain either a hierarchy of factors or a rebuttable presumption. The latter may be the wiser bet. What might be on the horizon, for example, is something similar to Northern Ireland's Mental Capacity Act 2016 which requires that the decision maker "*must have special regard*" to the person's past and present wishes and feelings, beliefs, and values, so far as they are reasonably ascertainable. And the more others intend to depart from those, the more is needed by way of justification.

Another interesting, and potentially weighty, proposal is "*qualifying the immunity from legal action*" under MCA s.5 "*to provide additional procedural safeguards in respect of certain key decisions by public authorities*." This could be the key to the provision of better article 8 safeguards. The Commission does not give any indication as to what these key decisions might be. But, again, if Northern Ireland is anything to go by, they could be wide-ranging. The 2016 Act provides additional safeguards for serious interventions and certain treatments:

> *"Serious interventions" include interventions which (a) involve major surgery, (b) cause serious pain/distress/side-effects, (c) affect seriously the options available to the person in the future or have a serious*

> *impact on their day-to-day life, (d) in any other way have serious physical or non-physical consequences, (e) any deprivation of liberty, (f) imposition of a treatment attendance requirement, (g) a community residence requirement. Other than in an emergency, the Northern Irish Act requires a recent enough "formal capacity assessment" by a suitably qualified person and a corresponding statement of incapacity. It also requires a nominated person to be in place for P with whom to consult when determining best interests.*
>
> *"Certain treatments" cover electro-convulsive therapy and, broadly, what amounts to serious medical treatment under our 2005 Act. For these, a second opinion must be obtained.*

If the Law Commission was to adopt something similar, it would mean that others would not have a liability defence for acts done or decisions made on behalf of those lacking capacity unless and until those safeguards were fulfilled. It may result in the better implementation of the 2005 Act by reinforcing the stick of article 8 procedures that accompany the carrot of a defence to liability. With these core amendments in mind, let us now consider the main highlights of the Commission's proposal for the replacement of DoLS.

2. The Revised Approach

a. "Deprivation of liberty"

It appears that the new safeguards will continue to be triggered by a "deprivation" of liberty. There is no suggestion that this will be defined in the legislation. It seems likely, therefore, that entry into these revised safeguards will continue to be governed by case law and, ultimately, the Strasbourg Court. This should come as no surprise given that any hope of legal certainty in borderline cases is little more than a search for the philosopher's stone. Parliament would either have to provide a trigger that was pitched below the article 5 threshold (so as to avoid otherwise unlawful deprivations of liberty) or leave it to case law.

If the entitlement to additional safeguards is going to hinge on "deprivation of liberty", the judiciary are likely to continue to err on the side of caution, keeping the bar low. More case law seems likely. Although the scheme embraces article 8 concerns, it is most disappointing to hear that article 5 will remain the trigger. And it may mean no getting away from the negative connotations of the language of "deprivation of liberty".

b. Responsibility for securing the safeguards

The plan is for this to shift away from the care provider to the commissioning body that is arranging the care. This should help streamline the process and better embed the safeguards when making care arrangements. But it remains to be seen how this will apply to self-funders, or where there is more than one commissioning body, such as hybrid funding package between the NHS and a local authority.

Noticeable by its absence is a supervisory body. The role will be abolished. Instead, the authorisation to deprive liberty derives from the commissioning body itself. So local authorities and presumably NHS bodies will essentially authorise themselves to detain. Query, again, how this might work for self-funders and hybrids. On the face of it, authorising oneself to detain a vulnerable person could be a significant cause for concern. But whether that concern is justified will

depend upon the detail to follow. Who within the commissioning body will authorise? What checks and balances will there be? We will have to wait for the draft Bill at the end of the year to see exactly what the Commission has in mind.

c. Access all areas

Aside from the defined group below, the proposed authorisation scheme is very much a one-size-fits-all. It therefore applies anywhere including hospitals, care homes, supported living and shared lives schemes, domestic and private settings.

d. Evidence required

The evidence necessary for a DoL authorisation from the commissioning body will include (a) a capacity assessment; (b) objective medical evidence of the need for a deprivation of liberty on account of the person's mental health; (c) arranging provision of advocacy (or assistance from "an appropriate person"); (d) consultation with family members and others; (e) an existing care plan. This is not an exhaustive list. But notable by its absence is any reference to best interests. The DoL evidence focuses more specifically therefore upon whether the person's mental health warrants detention. We wait to see whether and how best interests is provided for in the draft Bill.

e. Article 5 safeguards

The Interim Statement provides examples of the safeguards; so there may be more. For now, the person (and others, such as family members and advocates) will have the right to seek reviews of the DoL, bring legal proceedings to challenge it, and comprehensive rights to advocacy. The Commission wants to ensure that the current processes under the Care Act and the Social Services and Well-Being (Wales) Act can be used to review the DoL. And, where appropriate, commissioning bodies should be able to rely on existing assessments to avoid unnecessary duplication. The availability of well-funded advocacy services and the scope of non-means tested legal aid will clearly be critical here.

Unlike the current DoLS scheme and the Mental Health Act 1983, no-one independent of the commissioning body will be deciding whether the person ought to be deprived of liberty. This may be one of the most controversial proposals in the Commission's revised approach. After all, the reason why the Supreme Court in *Cheshire West* dropped the threshold was to promote independent scrutiny:

> *Policy*
>
> *57. Because of the extreme vulnerability of people like P, MIG and MEG, I believe that we should err on the side of caution in deciding what constitutes a deprivation of liberty in their case. They need a periodic independent check on whether the arrangements made for them are in their best interests. Such checks need not be as elaborate as those currently provided for in the Court of Protection or in the deprivation of liberty safeguards (which could in due course be simplified and extended to placements outside hospitals and care homes). Nor should we regard the need for such checks as in any way stigmatising of them or of their carers. Rather, they are a recognition of their equal dignity and status as human beings like the rest of us.*

Ironically, it seems that the bar is so low, and the number of people deprived is so high, that providing an independent check is unaffordable. The Commission states:

> *1.42 In addition we are considering whether a defined group of people should receive additional independent oversight of the deprivation of their liberty, which would be undertaken by an Approved Mental Capacity Professional. Owing to the vast number of people now considered to be deprived of their liberty following Cheshire West, it would not be proportionate or **affordable** to provide such oversight to all those caught by article 5 of the ECHR. Whilst we are still working to develop the precise criteria that would operate to identify this group, we envisage that this group would consist of those who are subject to greater infringement of their rights, including, in particular, their rights to private and family life under article 8 of the ECHR.* (emphasis added)

Clearly the right to bring legal proceedings will at least entitle the person to have an independent judicial best interests check at periodic intervals, depending on the availability of legal aid. But that may be after the damage is done. The issue is whether independent scrutiny – the "cornerstone" of the current best interests assessment – is required before the detention occurs. The increased provision of advocacy services may to some extent mitigate the risks of misjudgments and professional lapses. But many people may be concerned about this aspect of the scheme. The "precise criteria" are going to be key here.

The extra safeguard for this group will be a referral to an Approved Mental Capacity Professional who, in light of the accompanying DoL evidence, would "*agree or not agree*" to the proposed DoL: "*Their role would not extend to ongoing reviews and the monitoring of cases*". The adequacy of this safeguards will depend upon the detail. Will AMCPs merely say "*yay or nay*"? Or will they have the power to impose conditions? If so, what type? Will they see the person before approving the DoL? These issues will have a bearing on the risk of rubber stamping.

f. Mental Health Act 1983

The Commission's original proposal was to introduce a lower-level power for compliant incapacitated patients, with the MHA reserved for those objecting. After consultation, this has been abandoned. Instead, the new scheme will not apply to those detained in hospital for the purpose of mental health assessment/treatment. So if compliant incapacitated patients "*are to be admitted to hospital (general or psychiatric) for purposes of assessment and treatment for mental disorder, their admission should be on the basis of the existing powers of the Mental Health Act*".

This will avoid the difficult interface we presently have between DoLS and the MHA. If the purpose of admission is physical healthcare, the NHS body will authorise the DoL under the Commission's scheme. Whereas if the purpose is mental healthcare, the MHA will be used. In legal terms, this has the benefit of simplicity and more effectively closes the *Bournewood* gap. In medical terms, however, it means having to categorise the person's treatment and determine the key purpose. But the distinction between "physical" and "mental" healthcare is likely to remain so long as we have an Act specifically catering for

mental health. Only a fused system would avoid it and that does not appear on the table.

The increased use of the MHA will inevitably lead to more people being entitled to section 117 aftercare. It would not be at all surprising therefore if this provision receives close attention during the parliamentary process. No mention is made in the Interim Statement of the interface between the MHA and the Commission's scheme when it comes to deprivations of liberty in the community. So it remains to be seen whether there will be tensions between the scheme and section 17 leave, guardianship, community treatment orders, and conditional discharges. If the commissioning body is self-authorising the DoL under the MCA, there is perhaps less room for confusion and disagreement.

Many people may worry about the resulting increased use of the MHA. Apparent stigma was a concern raised in the consultation. Although it would be at the outer reaches of, and perhaps beyond, the remit of the Commission's brief, there is a timely opportunity to amend perhaps the most stigmatising aspect of the MHA, namely the compulsory treatment powers. Unless the government decides to grasp that nettle during the parliamentary process, the opportunity seems likely to be missed this time round.

g. Coroners

The Commission proposes to remove the scheme from the definition of "State detention" in the Coroners and Justice Act 2009. Deaths will be reported to the new medical examiner system proposed by the Department of Health, which will make enquiries and referrals to a coroner if the death is attributable to, amongst other matters, a failure of care. This is likely to be welcomed by many.

h. Tribunal or COP?

Here the law reform jury is out. The Commission "*will be considering our position further over the coming months*".

i. The Name

The frontrunner from the consultation for the new scheme appears to be the "liberty safeguards", followed closely behind by "capacity safeguards". But it might be worth reflecting on whether a name is actually required. The proposed scheme will be part of the 2005 Act and should not be something separate to it. That Act contains safeguards already. So perhaps the best option is simply not to assign a name: they are merely extra safeguards for key decisions. Suggestions are sought by 23 June 2016 to Olivia.Bird@lawcommission.gsi.gov.uk. Please avoid "Boaty McBoatface"!

Neil Allen

Ever spreading tentacles? Article 5 and deputies

Staffordshire CC v SRK & ors [2016] EWCOP 27 (Charles J)

Article 5 ECHR – "deprivation of liberty" – deputies

Summary

SRK acquired a brain injury following a road traffic accident, necessitating 24-hour care. The compensation funded the purchase of an adapted bungalow and his care regime. The effects of his injuries meant that he had to be under continuous supervision and control, was not free to leave, and lacked capacity to consent

to the care arrangements. The care was arranged by a specialist brain injury case manager and provided by private carers. The accommodation and care costs were privately-funded and administered by a financial deputy, without any input from the local authority. An issue arose as to whether this confinement was attributable to the State, directly or indirectly, so as to engage Article 5.

Direct responsibility

Charles J held that the State does not become directly responsible simply because of steps taken by a local authority investigating an alleged deprivation of liberty, or by actions of the CQC: "*Such steps are part of the supervision and regulation of private providers of care and do not found a sufficient direct participation by the State as a decision maker, provider or otherwise in the creation and implementation of SRK's (private) deprivation of liberty within Article 5*" (para 131). The same is true of an application for a welfare order, a civil court awarding damages, the Court of Protection appointing a deputy, and the deputy itself: none of these make the State directly responsible (para 132-3).

Indirect responsibility

However, the civil court awarding damages, the COP when appointing a deputy, the deputy itself, and trustees or someone acting under a lasting power of attorney to whom a damages award is paid and who must make best interests decisions, they should all be aware that a regime of care and treatment can create a (private) deprivation of liberty. And "[t]*hat knowledge of the courts means that the State has that knowledge…"* (para 135). The State thereby can become indirectly responsible by failing to comply with its positive obligations under Article 5 to prevent arbitrary detention. The following guidance was therefore given to deputies:

> *58. As a result, in my view, a deputy should raise those issues with the relevant providers and the relevant local authority with statutory duties to safeguard adults. By so doing he would be taking proper steps to check whether D and/or the local authority could put in place arrangements that meant that P was not objectively deprived of his liberty or that would make the care arrangements less restrictive and/or remove any restraint. More generally he would be enabling public authorities and others with duties to safeguard adults to perform such duties and so the role described by Munby J in Re A and Re C, which is an important part of the regime of law, supervision and regulation in England and Wales.*

Equally, "*the court awarding the damages, the COP and trustees or an attorney to whom damages are paid should also ensure that such steps are taken*" (para 136). As a result, the local authority with the adult safeguarding role will know, or should know, of the situation and this "*triggers its obligations to investigate, to support and sometimes to make an application to court (or to consider doing those things*)" (para 137, emphasis added). A failure to make a welfare order in these cases would breach the State's positive obligations and mean that the State was responsible for the deprivation of liberty (para 146):

> *147. I have reached this conclusion with real reluctance because it seems to me that in this and many other such cases a further independent check by the COP will add nothing other than unnecessary expense and diversion of private and public resources which would be better focused elsewhere.*

148. But, in my view, the cautious approach taken in Cheshire West, and the points that:

i) the need for a welfare order and evidence supporting it will focus the minds of those involved on the ground, and thereby reduce the risk of misjudgements and professional lapses (see paragraph 121 of HL v United Kingdom cited above) by promoting both (a) decision making and reviews, and (b) investigation, supervision and regulation on a properly informed basis,

ii) deputies and local authorities will not act in the same way in all cases,

iii) not all Ps will have supporting family members or friends,

iv) a different regime dependent on the identity of those involved would be impracticable or arbitrary, and

v) when, as here, a deputy, providers and a local authority have properly examined the issues, and their conclusion is supported by the family, a streamlined and so paper procedure for the making of the initial welfare order and paper reviews is likely to be appropriate.

Comment

This is the first domestic case since *Re A and Re C* [2010] EWHC 978 (Fam) to thoroughly examine the issue of State responsibility in the Article 5 context. The outcome is not surprising, given the breadth of the positive obligations. In essence, courts awarding damages, the COP, trustees, deputies and others to whom damages are paid "should" consider the issue and raise it with the local authority. The State's knowledge arising from that referral then triggers indirect responsibility for the deprivation of liberty. This accords with the position under DoLS for self-funding detained residents, whereby the State becomes indirectly responsible when the care home requests a DoLS authorisation.

In this case, the deputy had notified the local authority which made a *Re X* application using COP DOL10. What is not altogether clear is what should happen if a local authority fails to seek judicial authorisation for the detention. Paragraph 59 might suggest that the person who notifies should themselves ensure that an application is made. And that is why the cost of doing so should be factored into the calculation of damages awards in the future (para 10(6)). For solicitor deputies, who owe P a duty of care as well as other professional obligations, following the streamlined procedure may be a surmountable challenge. But for family members or friends, it is not altogether clear why and how they should be expected to make the application. This will not be within the contemplation of a would-be LPA. And it is an onerous task for them, bearing in mind that typically there will have been little State involvement. Who will assess capacity? Who will draft the best interests determination? Who will provide the medical evidence? Confronting the challenges of the *Re X* process will therefore not be easy.

Updated Guidance Note: *Judicial Authorisation of Deprivation of Liberty*

In light of the myriad of developments since we last updated our Guidance Note, we have updated it to take account of developments up to and including *Re SRK*: it can be found here.

Deprivation of liberty for the under-16s

Re Daniel X [2016] EWFC B31 (Family Court (HHJ Roberts))

Article 5 ECHR – "deprivation of liberty" – children and young persons – inherent jurisdiction

Summary

Daniel X is the youngest (reported) person since *Cheshire West* to satisfy the nuanced acid test. He was 10 years old with severe autistic disorder and severe learning disability and accommodated in a specialist children's home, attending school. He was constantly supervised and physical restrictions were used to prevent him leaving. He had regular contact with his parents who agreed with the care order. For reasons explained elsewhere, because of the care order his parents could not consent to his confinement. Article 5 was therefore engaged. As a result, the care proceedings before the magistrates were transferred to a judge of the High Court to have the deprivation of liberty authorised for 12 months.

The inherent jurisdiction and children's services are still getting to grips with the impact of the Supreme Court's decision. But this decision is helpful when it comes to authorisation renewals and the evidence expected:

> *12. … the burden should be on the Local Authority to apply back to the court on an application for renewal of the order if appropriate and to prove their case again, albeit on paper, if unopposed and considered appropriate.*
>
> […]
>
> *34. It is agreed that 35 days before the expiry of this order Thurrock Borough Council, if it seeks to renew the order, will lodge an application to that effect and include medical evidence to confirm that Daniel still requires that type of accommodation; the evidence lodged will include evidence from the social worker about Daniel's up to date circumstances, possibly a school report, and a report from the* [independent reviewing officer] *that Y Home is still suitable for Daniel. The parents would then have the opportunity to respond within 14 days of being serve. If the parents agree to the order being renewed or do not reply, the court will consider the application on paper. The Court has the option of appointing a Guardian for Daniel under rule 16.4 of the FPR if thought necessary but I do not think it necessary for a Guardian to be appointed on issue of the application. The Court may make the declaration sought on paper or may list the application for a hearing.*

Comment

All parties agreed that Daniel was deprived of liberty. So there is little analysis in the judgment as to exactly how the care arrangements satisfied the acid test. But chapter 9 of the Law Society guidance considers the issue. In order to minimise the risk of duplication, and unnecessary costs, in cases where a child is or may be deprived of liberty, local authorities may want to have the care proceedings listed before a Judge with a High Court so that both the care order and the deprivation of liberty can be addressed in one go. There will then be (at least) an annual review of the deprivation of liberty on the papers where there is consensus.

The horns of the dilemma

Cambridge University Hospitals NHS Foundation Trust v BF [2016] EWCOP 26 (MacDonald J)

Best interests – medical treatment

Summary

This case concerned an application by Cambridge University Hospitals NHS Foundation Trust ('the NHS Trust') in relation to BF, a 36 year old woman with a diagnosis of paranoid schizophrenia. At the time of the hearing BF was detained in a mental health unit pursuant to section 3 of the Mental Health Act.

BF had been referred to the NHS Trust with a history of bloating and abdominal distention that had worsened over a period of months. After a CT scan, examination and blood tests the medical consensus was that BF was likely to have ovarian cancer which required surgery. The planned surgery would involve a total abdominal hysterectomy which would mean the loss of BF's fertility.

BF was originally assessed as having capacity to consent to the surgery but following a problem with the anaesthetist finding a vein, BF suffered a psychotic episode and BF refused surgery stating that her distended abdomen was not due to a tumour but 'bad air'. Following this episode there were various assessments of BF's capacity the last of which concluded that she lacked capacity and so the application was made to the court.

The Trust sought the following declarations:

> *That BF lacks the capacity to consent to or refuse medical treatment, in particular total abdominal hysterectomy with bilateral salpingo-oopherectomy and omentectomy and bowel resection and colostomy, general anaesthetic, sedation and further ancillary treatment*

And

> *It is lawful being in BF's best interests to undergo total abdominal hysterectomy with bilateral salpingo-oopherectomy and omentectomy and bowel resection and colostomy, general anaesthetic, sedation and further ancillary treatment.*

In his judgment, MacDonald J recapitulated his summary of the principles applicable to the assessment of capacity from the *C* case. He also gave a pithy summary of the key principles applicable to the determination of best interests, noting in so doing that, whilst the "balance sheet is a very useful tool, the court must still come to its decision as to best interests by reference to the principles he had set out which were grounded in s.4 of the MCA 2005" (para 29).

The medical evidence before the court strongly suggested that BF had stage IIIB ovarian cancer. Mr L (Consultant and Lead Gynaecological Oncologist) considered that the probability of ovarian cancer was at least 80% and in this case even higher than 80%. The Official Solicitor acting on behalf of BF did not challenge the medical diagnosis.

Mr Justice MacDonald concluded that BF lacked capacity to decide to consent to or refuse the identified medical treatment. He further concluded that it was in her BF's best interests to undergo the medical treatment that her doctors wanted to give to her. He placed particular emphasis upon the fact that she had previously consented to the proposed surgery when she had capacity to do so. Whilst MacDonald J gave "anxious consideration" to the fact that BF had said that she wanted to have a child and the proposed treatment would render her infertile, he also had in mind that she had consented to the treatment which she knew would render her

infertile prior to the episode when the anaesthetic could not be administered causing her to have a psychotic episode. Given the prognosis the judge also considered that if the hysterectomy did not take place she would die within a period much shorter than that required to carry a baby to term.

Comment

On its facts, the case represents the sensitive application of the principles of capacity and best interests set out in the MCA to an extremely difficult dilemma. Of note, however, are the following:

- The application was, again, for declarations rather than decisions. Sir James Munby P in *Re MN* made clear his view that where (as here) what is being sought is a decision (i.e. to consent to the procedures in question), what should be sought is an order under s.16(2)(a) MCA consenting on P's behalf. A declaration as to lawfulness under s.15(1)(c) provides added comfort to the treating clinicians (but should not be framed as a declaration as to lawfulness and best interests, as s.15(1)(c) does not provide for such to be made);

- The unusual reporting of a happy ending. Before judgment was handed down the NHS Trust informed the court that the surgery had been performed as planned and the results of the testing undertaken during the operation indicated a benign or borderline tumour with no evidence of macroscopic residual disease. Mr L was therefore able to preserve BF's uterus and the right fallopian tube and right ovary, thus preserving BF's ability to have children in the future should she so wish. The tragic choice described in the judgment between a likely fatal prognosis and certain infertility was thus averted.

`

Conferences at which editors/contributors are speaking

The Use of Physical Intervention and Restraint: Helpful or Harmful?

Tor will be speaking at this free afternoon seminar jointly arranged by 39 Essex Chambers and Leigh Day on 13 June. Other confirmed speakers include Bernard Allen, Expert Witness and Principal Tutor for 'Team-Teach,' two parents / carers and Dr Theresa Joyce, Consultant Clinical Psychologist and National Professional Advisor on Learning Disabilities on the CQC. For more details, and to book, see here.

Mental Health Lawyers Association 3rd Annual COP Conference

Charles J will be the keynote speaker, and Alex will be speaking at, the MHLA annual CoP conference on 24 June, in Manchester. For more details, and to book, see here.

ESCRC seminar series on safeguarding

Alex is a member of the core research team for an-ESRC funded seminar series entitled 'Safeguarding Adults and Legal Literacy,' investigating the impact of the Care Act. The third seminar in the series will be on 'Safeguarding and devolution – UK perspectives' (22 September). For more details, see here.

Deprivation of Liberty in the Community

Alex will be doing a day-long seminar on deprivation of liberty in the community in central London for Edge Training on 7 October. For more details, and to book, see here.

Taking Stock

Both Neil and Alex will be speaking at the 2016 Annual 'Taking Stock' Conference on 21 October in Manchester , which this year has the theme 'The five guiding principles of the Mental Health Act.' For more details, and to book, see here.

Advertising conferences and training events

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

Chambers Details

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

David Barnes
Chief Executive and Director of Clerking
david.barnes@39essex.com

Alastair Davidson
Senior Clerk
alastair.davidson@39essex.com

Sheraton Doyle
Practice Manager
sheraton.doyle@39essex.com

Peter Campbell
Practice Manager
peter.campbell@39essex.com

London 81 Chancery Lane, London, WC1A 1DD
Tel: +44 (0)20 7832 1111
Fax: +44 (0)20 7353 3978

Manchester 82 King Street, Manchester M2 4WQ
Tel: +44 (0)161 870 0333
Fax: +44 (0)20 7353 3978

Singapore Maxwell Chambers, 32 Maxwell Road, #02-16,
Singapore 069115
Tel: +(65) 6634 1336

For all our services: visit www.39essex.com

CoP Cases Online

Use this QR code to take you directly to the CoP Cases Online section of our website

THE QUEEN'S AWARDS FOR ENTERPRISE INTERNATIONAL TRADE 2013

Editors and Contributors

Alex Ruck Keene: alex.ruckkeene@39essex.com

Alex is recommended as a 'star junior' in Chambers & Partners 2016 for his Court of Protection work. He has been in cases involving the MCA 2005 at all levels up to and including the Supreme Court. He also writes extensively, has numerous academic affiliations and is the creator of the website www.mentalcapacitylawandpolicy.org.uk. He is on secondment for 2016 to the Law Commission working on the replacement for DOLS. To view full CV click here.

Victoria Butler-Cole: vb@39essex.com

Victoria regularly appears in the Court of Protection, instructed by the Official Solicitor, family members, and statutory bodies, in welfare, financial and medical cases. Together with Alex, she co-edits the Court of Protection Law Reports for Jordans. She is a contributing editor to Clayton and Tomlinson 'The Law of Human Rights', a contributor to 'Assessment of Mental Capacity' (Law Society/BMA 2009), and a contributor to Heywood and Massey Court of Protection Practice (Sweet and Maxwell). To view full CV click here.

Neil Allen: neil.allen@39essex.com

Neil has particular interests in human rights, mental health and incapacity law and mainly practises in the Court of Protection. Also a lecturer at Manchester University, he teaches students in these fields, trains health, social care and legal professionals, and regularly publishes in academic books and journals. Neil is the Deputy Director of the University's Legal Advice Centre and a Trustee for a mental health charity. To view full CV click here.

Annabel Lee: annabel.lee@39essex.com

Annabel appears frequently in the Court of Protection. Recently, she appeared in a High Court medical treatment case representing the family of a young man in a coma with a rare brain condition. She has also been instructed by local authorities, care homes and individuals in COP proceedings concerning a range of personal welfare and financial matters. Annabel also practices in the related field of human rights. To view full CV click here.

Anna Bicarregui: anna.bicarregui@39essex.com

Anna regularly appears in the Court of Protection in cases concerning welfare issues and property and financial affairs. She acts on behalf of local authorities, family members and the Official Solicitor. Anna also provides training in COP related matters. Anna also practices in the fields of education and employment where she has particular expertise in discrimination/human rights issues. To view full CV click here.

Simon Edwards: simon.edwards@39essex.com

Simon has wide experience of private client work raising capacity issues, including *Day v Harris & Ors* [2013] 3 WLR 1560, centred on the question whether Sir Malcolm Arnold had given manuscripts of his compositions to his children when in a desperate state or later when he was a patient of the Court of Protection. He has also acted in many cases where deputies or attorneys have misused P's assets. To view full CV click here.

Adrian Ward adw@tcyoung.co.uk

Adrian is a practising Scottish solicitor, a consultant at T C Young LLP, who has specialised in and developed adult incapacity law in Scotland over more than three decades. Described in a court judgment as: "*the acknowledged master of this subject, and the person who has done more than any other practitioner in Scotland to advance this area of law*," he is author of *Adult Incapacity*, *Adults with Incapacity Legislation* and several other books on the subject. To view full CV click here.

Jill Stavert: J.Stavert@napier.ac.uk

Professor Jill Stavert is Reader in Law within the School of Accounting, Financial Services and Law at Edinburgh Napier University and Director of its Centre for Mental Health and Incapacity Law Rights and Policy. Jill is also a member of the Law Society for Scotland's Mental Health and Disability Sub-Committee, Alzheimer Scotland's Human Rights and Public Policy Committee, the South East Scotland Research Ethics Committee 1, and the Scottish Human Rights Commission Research Advisory Group. She has undertaken work for the Mental Welfare Commission for Scotland (including its 2015 updated guidance on Deprivation of Liberty). To view full CV click here.