MENTAL CAPACITY REPORT: HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

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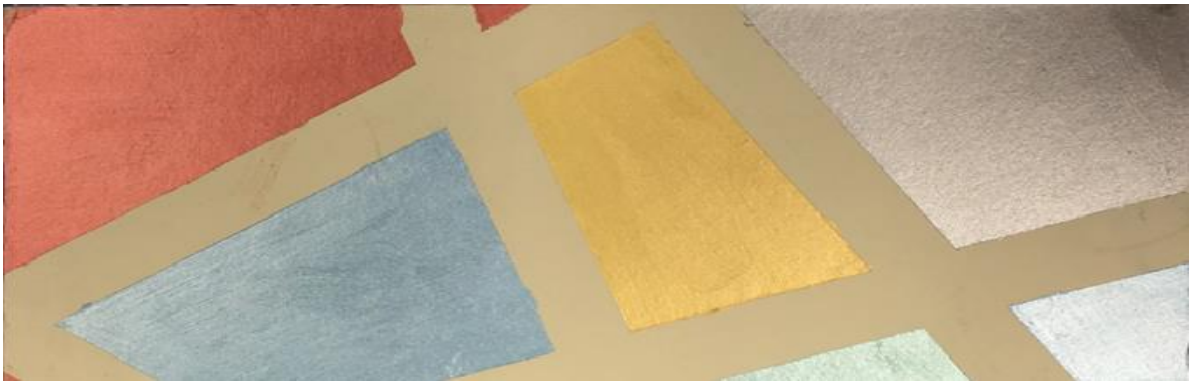

Welcome to the April 2022 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: Draft MCA and LPS Code published; capacity to terminate a pregnancy; the (limited) role of the Inherent Jurisdiction; and is an application needed in all vaccine disputes?

(2) In the Property and Affairs Report: the Court of Appeal weighs in on testamentary capacity, and the evidence used to prove it; and an invitation to the pilot for digital submission of property and affairs cases

(3) In the Practice and Procedure Report: reporting restrictions; the role of COP in MHA discharge planning; costs; and notable conferences on capacity;

(4) In the Wider Context Report: the impact of s.49 reports on mental health professionals; Article 2 and 3 damages claim; the M'Naghten test considered; and is having a deputy an Article 14 'status'?

(5) In the Scotland Report: Guardians' remuneration; open justice or anonymisation; and still time to contribute to the Scott Review or sign up to the World Congress on Adult Capacity in Edinburgh;

You can find our past issues, our case summaries, and more on our dedicated sub-site here, where you can also find updated versions of both our capacity and best interests guides.

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

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New MCA Code and LPS Consultation Published

On 17 March 2022 the DHSC published, on its own behalf, and that of MOJ and DfE, the long-awaited draft Code for consultation. The consultation runs until 7 July 2022. There is a detailed consultation document, together with two easy read summary booklets, one focusing on the wider MCA guidance, and one on the LPS guidance, both available on the consultation page here, and Alex has provided a video walkthrough here.

At the same time, there is also a consultation on 6 sets of draft regulations which will underpin the new system. When enacted, 4 of these sets of regulations would apply in England only. The remaining 2 sets of regulations would apply to both England and Wales. Separately, the Welsh Government has published 4 sets of regulations which would apply in Wales. The DHSC is also publishing a number of documents to help the sector prepare for implementation. These products are not subject to formal consultation, but feedback is invited as part of the consultation process. These are:

- The impact assessment – this constitutes the government's assessment of the financial impact of LPS, including the Code and regulations, as proposed for consultation
- LPS workforce and training strategy – this covers:
    - workforce planning
    - the learning, development and training on offer
    - what different organisations and sectors can do now to begin preparing for LPS
- LPS training framework – which makes recommendations about subject areas that LPS training should cover
- LPS National Minimum Data Set – which will be used to standardise the collection and submission of notification data that is sent to the monitoring bodies and NHS Digital
- Equalities impact assessment – which assesses the potential equality impact of the design of LPS overall, including the Mental Capacity (Amendment) Act 2019, the LPS regulations and the Code

Welsh Government is also conducting its own consultation on specific aspects in Wales (which includes an interesting additional set of criteria for people to be eligible to carry out the assessments and determinations for LPS purposes).

Many people will no doubt be writing many things in the coming weeks, but the purpose of this rapid reaction overview is to highlight what seem to be particularly important things to know about the draft Code to help in how you respond. For more on LPS, see Alex's resources page here.

The status of the Code

As before, it will be a statutory Code, i.e. laid before and approved by Parliament. Whilst it cannot create the law, the Code provides important amplification about how the MCA applies in practice. The MCA, in turn, sets out in (s.42) the categories of people who have to have regard to it when they are acting in relation to a person who lacks (or may lack) capacity, and – importantly – that any court (not just the Court of Protection) must take both the provisions of the Code and any failure to comply with it if relevant to a question before it.

A combined Code

First and foremost, this is a combined Code. Unlike the previous position where there was a separate Code for the 'main' MCA 2005, and an entirely separate Code for the Deprivation of Liberty Safeguards, this Code integrates the sections relating to the Liberty Protection Safeguards and the sections relating to the main MCA into one document. This obviously brings with it complexities – above all of navigation around what is now inevitably a lengthy document (although it should be remembered that the previous Codes, together, ran to 426 pages). However, it gives the important message that the Liberty Protection Safeguards are founded upon the MCA, and require a proper understanding of the concepts of capacity and best interests by those applying them. Some may ask how LPS can require a proper understanding of best interests if they do not make 'best interests' a part of the criteria for the grant of an authorisation: this is because best interests comes in at the earlier stage of the decision-making, i.e. choosing between the options available to the person. By the time thought is being given to whether one of the options will give rise to confinement, the laser-like focus should be upon whether it can be said to be truly necessary and proportionate to the risk of harm that the person would suffer otherwise.

The first 11 chapters of the Code will look broadly familiar in chapter headings terms to those familiar with the original 2007 Code. They provide an overview of the Act, before moving in stages through the principles, the concepts of capacity, best interests, the defence in s.5, the role of the Court of Protection, LPAs, IMCAs and advance decisions to refuse treatment. The LPS chapters then follow before chapters 21-26 then pick up the themes from the original Code of how the Act applies to children and young people, the relationship between the MHA and the MCA, the protection of people lacking capacity to make decisions for themselves, disagreement/dispute resolution, information access and research.

The core MCA chapters

DO NOT BE FOOLED by the similarity in chapter titles where these relate to the core MCA provisions: the content has been significantly revised in many places, to take account – broadly – of two matters:

- The fact that the original MCA Code was drafted prior to the Act coming into force so represented in many ways the 'best guess' as to what situations were most likely to arise in practice;
- That we now have a significant body of case-law both applying and, more importantly, interpreting the MCA, which has made clear that the original Code was wrong in a number of ways (as to this, see this guidance note).

Key changes to the core chapters include the following (over and above the weaving in of express LPS cross-references where relevant):

- The alignment of what the Code says (in paragraph 3) about what it means to lack capacity with what the Act says. The previous version talked about two-stage test, starting with what is often (but wrongly) called a 'diagnostic' test. The courts have, however, made clear this is incorrect because ss.2-3 require analysis of, first, whether the person is able to make their own decision (i.e. to understand, retain, use and weigh their relevant information and to communicate their decision).[1] It is only if the person cannot do so that you move on to considering whether they have an impairment or disturbance in the functioning of their mind or brain, and, if so – and importantly – whether their inability to make the decision is **because of** that impairment or disturbance. This last point is of particular importance given that, since the original MCA Code was drafted, the courts have made clear that the High Court's inherent jurisdiction has survived (in rather ill-defined form) to secure the interests of those who have capacity to make a decision but are under coercion.
- More 'granularity' in how to think about capacity assessments. Although the Code is not a substitute for professional guidance documents, which translate the specific requirements of the Act into approaches directly relevant to the particular discipline(s) in question, the Code does tackle head-on in more detail some of the problems that have been identified in practice, such as fluctuating capacity and so-called 'executive dysfunction;'
- Clearer guidance about the role of wishes and feelings, beliefs and values in the making of best interests decisions in light of the extensive body of case-law determined under the MCA. The guidance also reflects the considerable evolution of the approach to making decisions about life-sustaining treatment since the Act came into force;
- Clearer guidance about how s.5 MCA 2005 operates in a context where the MCA on the one hand expressly does not provide for surrogate decision-makers where no deputy or attorney (or Court of Protection judge) is involved, but on the other hand has to be applied, in most contexts, by a person or body. The Code also makes clear the categories of care and treatment which involve more serious interventions, and the more rigorous steps required before the person or body can properly say that they are able to rely upon the defence;
- The Code also reflects the development of the case-law to outline the circumstances when it is possible to proceed to give (or where relevant) withhold medical treatment without going to court. The Code also provides more detail about when and how the Court either must or should be involved in medical treatment cases, welfare cases and situations involving a person's property and affairs;
- In relation to deputies, the Code picks up, in particular, the decision in *Lawson & Mottram* relating to the appointment of health and welfare deputies, making clear that, whilst there is no presumption against appointing a deputy, the operation of s.5 MCA 2005 means that, in practice, fewer health and welfare deputies will be appointed than property and affairs deputies;
- The chapter on Advance Decisions to Refuse Treatment includes, most significantly, consideration of how

[1] Although note that the draft Code does not refer to the decision of the Supreme Court in *JB*, which put this beyond doubt. This will undoubtedly be rectified in the final version.

subsequent doubts about whether the person had capacity to make the ADRT are to be resolved, which is to be read together with the chapter on capacity, which makes that the presumption of capacity is not retrospective, such that if proper reasons are identified to suggest that the person did not have capacity, it will be for them, or someone on their behalf, to show why those doubts are ill-founded;

- The chapter on children and young people reflects the fact that there is now a body of case-law explaining the interaction between the MCA and the concept of *Gillick* competence post-16, and also makes clearer that decision-makers need to be aware that, where a 16-17 year old lacks capacity to make a relevant decision, they may in many cases have a choice as to whether to proceed under s.5 MCA 2005 or by way of obtaining consent from a person with parental responsibility. They need, however, both to be aware that they are making a choice, and that the choice will have consequences for how they proceed, and what happens if there is a disagreement. The chapter also addresses the increased – express – interaction between the MCA and other pieces of legislation relating to children arising both out of the fact that much of that legislation expressly now refers to the MCA 2005 (e.g. the Children and Families Act 2014) and because of the operation of LPS from age 16;
- The 'interface' chapter reflects the fact that underlying policy interface between the MCA and the MHA relating both to treatment and detention is unchanged as a result of the MCA(A) 2019, albeit reframed in perhaps more comprehensible language. It also makes clear that there will be many situations in the community in which s.17(3) MHA 1983 will provide sufficient authority to deprive the person of their liberty, such that it is not necessary to have parallel authorisations.

Many may feel that the scenarios in the Code could do with work – if that is your response, then the obligation upon you is to provide sufficiently gritty scenarios for the civil servants to work up into case studies.

The CRPD

One thing that readers might expect to see express reference to is the Convention on the Rights of Persons with Disabilities. The introduction makes clear that the MCA and the Code "are important parts of the UK's commitment to the United Nations Convention on the Rights of Persons with Disabilities regarding promoting and protecting the rights and freedoms of people who may lack capacity to make decisions." However, the Code does not then make express reference to the CRPD throughout. This is because the CRPD is not binding upon public authorities and courts in the same way as (for instance) the European Convention on Human Rights (which is expressly referred to in a number of places). However, the effect of Article 12 CRPD – the right to legal capacity – can be felt in the significantly greater emphasis throughout the Code on (1) supporting individuals to make their own decisions at the time; (2) supporting individuals to make their own decisions in advance of potential incapacity; and (3) ensuring proper consideration of the person's wishes, feelings, beliefs and values in best interests decision-making.

The LPS chapters

Chapter 12 is likely to be one of the chapters most closely scrutinised. It contains the Government's (non-statutory) definition of deprivation of liberty promised during the passage of the MCA(A) 2019. It contains a number of strong statements, including:

- The Government's interpretation of the 'acid test' set down by Lady Hale in *Cheshire West*;
- The Government's view of the essentially unlimited potential for a person to give

advance consent so as to prevent a confinement (including in a psychiatric hospital for purposes of assessment / treatment under the MHA 1983) being seen in law as a deprivation of liberty;
- A wide interpretation of the so-called *Ferreira* carve-out in relation to medical treatment for physical health problems.

The LPS chapters then move through an outline of the overall process, discussion of the responsible body, the appropriate person, the assessment conditions, consultation, the role of the Approved Mental Capacity Professional, the operation of the interim/emergency power in s.4B MCA 2005, and monitoring the reporting.

It is perhaps important to emphasise that the purpose of a Code is not to set out an operational protocol, but rather to outline how the Act is intended to work in practice. In particular, given the enormous range of situations within which LPS can apply, and the different types of organisations which will be Responsible Bodies, the Code could not seek to prescribe how, operationally, obligations should be discharged. Rather, it is to make clear expectations about the way in which tasks are to be done, for instance, the expectation that the process of authorisation will be complete within 21 days (para 13.26), and steps that can sensibly be expected to be seen to secure both appropriate levels of operational independence and appropriate levels of expertise amongst those undertaking different tasks.

The Code answers, at least in draft, the following key questions that are regularly asked about LPS:

- Who can carry out key tasks (in each case subject to further eligibility requirements set out in the relevant regulations), the draft Code identifies the following professionals as eligible to carry out the following functions:
    1. Capacity/necessity and proportionality assessment/determination: (1) medical practitioner; (2) nurse; (3) occupational therapist; (4) social worker; (5) psychologist; (6) speech and language therapist.
    2. Medical assessment: registered medical practitioner or registered psychologist.
    3. Approved Mental Capacity Professional: (1) nurse; (2) social worker; (3) psychologist; (4) speech and language therapist; (5) occupational therapist.

    One question that will no doubt feature heavily in the minds of some during consultation is whether, if these are cemented into law in the final version of the regulations, it will be possible to secure the policy goal of thinking about LPS at the same time as thinking about care planning – to avoid duplication, and to avoid the DOLS problem of decisions being made and then checked afterwards, when it is all too late. Many local authorities, for instance, do not use qualified social workers to undertake care and support planning work under the Care Act, so would not be able to use materials gathered during this directly for LPS purposes. One question that some may want to think about is whether it would be appropriate to distinguish between 'assessment' and 'determination' and require that at least one part of these two tasks is carried out by a qualified social worker.

- Who can be an Appropriate Person. The draft Code makes clear that, although the Act is silent about who can be an Appropriate Person, the DHSC expects that it to be an unpaid role. There will therefore be no role for the equivalent of paid RPRs under DOLS. Where there is no person who can be an unpaid Appropriate Person, a (paid) IMCA will be required throughout so long as it is in the person's best interests (it is difficult to imagine circumstances when it will not).

- How many people need to be involved. The draft Code makes clear that the DHSC expects that there should be at least two professionals involved in carrying out the three assessments and determinations required, with a degree of independence from each other. The draft Code provides a set of principles for Responsible Bodies to consider in setting up their arrangements to facilitate this independence.

- How long the process should take. There is no statutory time-frame for completion of the process of assessment, unlike under DOLS. However, the draft Code makes clear that the DHSC expects that the LPS process should be completed within 21 calendar days of receipt of referral. It is likely that CQC / Ofsted will use this as a marker against which to stress-test the performance of Responsible Bodies.

- Whether legal aid is available. The draft Code makes clear that non-means-tested legal aid will be available where the person is subject to an LPS authorisation, for the person themselves, for their Appropriate Person. Importantly, it also makes clear that non-means-tested legal aid will be available "in relation to s.4B of the Act," which means that it is possible for the person / their Appropriate Person to challenge the situation where an LPS authorisation has been applied for but not yet granted.

Refusing a deprivation of liberty order

An NHS Trust v ST (Refusal of Deprivation of Liberty Order) [2022] EWHC 719 (Fam): (MacDonald J)

Article 5 ECHR – Children and young persons

Summary

This is another shocking case concerning the acute shortage of suitable residential therapeutic placements to meet the needs of children and young people.

ST was an extremely vulnerable child with highly complex needs. She was 14, autistic, had a moderate learning disability and her distressed behaviour included physical violence and damage to property. She was living with her parents and two younger siblings whilst having 6:1 staff support at school pursuant to an education, health and care plan. Her behaviour escalated, resulting in her siblings having to lock themselves in their bedrooms for safety and the school placement was terminated. She made regular and determined efforts to run away from home, lacking road sense and any sense of stranger danger.

On 21 January 2022, following a previous attempt by the family to present ST to hospital, Dr S advised that ST should not be admitted to hospital unless there was a medical need as "*there is clear risk of harm to her and others if she is admitted and this is not an appropriate place of safety in a crisis*". [11] Her family was still unable to care for her at home, with her parents resorting to locking her in the dining room, and on 15 February 2022 her father presented her to hospital. She was admitted to a general paediatric ward solely as a place of safety, there being no physical or psychiatric need for medical treatment, following which the local authority employed a private company to provide two security guards and two carers to supervise her on a 4:1 basis. There followed a litany of incidents in which her welfare was fundamentally compromised, including:

(i) *On 17th March 2022, ST was held down by security guards and a support worker. Nurses witnessed the security guards on top of ST's legs and holding down her arms while she was laying upset in her bed, there was also a male support worker holding her head from above pressing her head into the mattress*

with fingers coming over her forehead. ST was screaming very loudly and sounded very scared. Nursing staff advised that restraint of the head was not appropriate.

(ii) On 18 March 2022, two security guards attempted to force ST back into her room, during which incident ST slapped and kicked both guards. ST was tranquilised with Lorazepam.

(iii) On 18 March 2022, ST was placed in a hold and was thrashing and kicking out. She was thereafter held as she was taken back to her room and placed on in a hold on the bed. ST was again tranquilised with Lorazepam.

(iv) On 19 March 2022, ST was subjected to what are described in the hospital records as "multiple assisted walks and minimal safe holds". She was again tranquilised with Lorazepam.

(v) On 20 March 2022, ST was subject to three restraints and was required to walk around the ward in a restraint hold by two security guards. ST was also placed in a hold on the ward floor on three occasions.

(vi) On 21 March 2022, ST was placed in restraint involving two security guards and two carers. Again, her head was restrained. She was also later held in a restraint on the floor of the ward twice.

(vii) On 22 March 2022, ST became distressed whilst restrained when walking and fell to the floor kicking and screaming. This was witnessed by other patients and parents on the ward becoming upset and scared. ST was subjected to a restraint hold by five people comprising four security guards and a mental health support worker.

(viii) On 22 March 2022 ST had to be further restrained twice by 11am and had received two doses of chemical restraint by 1pm.

(ix) On 23 March 2022 ST was the subject of restraint and escort back to her room after she hit a District Nurse.

(x) On 23 March 2022 ST was the subject of further restraint by two security guards and two carers after she had refused to co-operate and urinated on the floor. A further restraint hold was later required. ST was tranquilised with Promethazine.

(xi) On 24 March 2022 (i.e. today) ST was placed in a hold by two security guards and two carers and then held on the floor of the ward. ST was tranquilised with Promethazine.

(xii) *On one occasion ST managed to break into a treatment room in which a dying infant was receiving palliative care and had to be restrained in that room by three security guards.*[16]

The hospital made an application under the inherent jurisdiction to authorise what was an undisputed deprivation of ST's liberty, but the court declined to authorise the arrangements at this interim hearing. In his *ex tempore* judgment, MacDonald J held:

> *32. I have decided that I cannot, in all good conscious, conclude that it is in ST's best interests to authorise the deprivation of her liberty constituted by the regime that is being applied to her on the hospital ward. I cannot, in good conscience, conclude that it is in the best interest of a 14 year old child with a diagnosis of Autistic Spectrum Disorder and moderate learning disability to be subject to a regime that includes regular physical restraint by multiple adults, the identity of whom changes from day to day under a rolling commercial*

> *contract. I cannot, in all good conscience, conclude that it is in ST's best interests for the distress and fear consequent upon her current regime to be played out in view of members of the public, doctors, nurses and others. I cannot, in good conscience, conclude that it is in ST's best interests to be subject to a regime whose only benefit is to provide her with a place to be, beyond which none of her considerable and complex needs are being met to any extent and which is, moreover, positively harmful to her.*

Indeed, the situation was described as '*a brutal and abusive one for ST*,' so much so '*that not even the necessity of keeping ST safe in circumstances where no alternative placement is available can justify such authorisation, because it simply cannot be said on the evidence before the court that the placement she is in currently is keeping her safe*.' [34] To authorise the arrangements '*would be to grossly pervert the application of best interests principle*.'[36]

On a late application by the local authority, the court made an interim care order and set the scene for a human rights claim:

> *43. Manchester City Council has been aware at least since 24 February 2022 that ST is in a placement that is manifestly ill equipped to meet her needs and which is depriving her of her liberty for the purposes of Art 5 of the ECHR. Further, the NHS Trust acknowledges that ST has been deprived of her liberty in extremely challenging situations for over a month before the matter was brought before this court. On the face of the evidence before the court, neither Manchester City Council or the NHS Trust has taken any steps to seek to bring the matter before the court in a timely manner to seek authorisation for the consequent breach of ST's Art 5 rights.*
>
> *With respect to that omission, it is simply not an answer to say that there have been "multiple meetings". It is likewise not an answer to say that there is a shortage of suitable placements and that "searches have been ongoing". The bottom line is that ST has, on the evidence currently available to the court, been deprived of her liberty without authorisation in a manifestly unsuitable placement for over a month prior to 18 March 2022, due to the apparent inaction of Manchester City Council and the NHS Trust.*

Witness statements were called for from the local authority directors of Children's Services and Legal Services and a senior member of staff at the Trust. Over the subsequent weekend, the local authority identified a bespoke, short-term placement for ST and applied for a declaration authorising her deprivation of liberty in that placement. It continues to search for a residential educational placement.

Comment

This is another example of the courts' willingness in a children's context to give proper meaning to the concept of best interests by refusing to authorise interim arrangements which deprive liberty in manifestly unsuitable circumstances, despite the absence of other available options. As such, it demonstrates the human rights baseline below which public bodies cannot venture. Given the interim nature of this hearing, there are other interesting issues which might be subsequently considered. These include whether rapid tranquilisation itself amounts to a deprivation of liberty requiring authorisation (paragraph 37), and the remit of parental responsibility and Article 5 ECHR when a child requires 6:1 staff at school and is displaying escalating behavioural distress at home.

Capacity to terminate a pregnancy, and to litigate about it

S v Birmingham Women's And Children's NHS Trust [2022] EWCOP 10 (07 March 2022) (HHJ Hilder, sitting as a Tier 3 judge)

Mental capacity - medical treatment

Mental capacity – litigation

Summary

In *S v (1) Birmingham Women's and Children's NHS Trust (2) Birmingham and Solihull Mental Health Trust* [2022] EWCOP 10, SJ Hilder, sitting as a Deputy High Court Judge, determined that S has capacity to consent to a termination of her pregnancy. The proceedings were heard on an urgent basis, given the time limit for the lawful termination of the pregnancy pursuant to the Abortion Act 1967.

S was 38 years old and 23 weeks pregnant. She was, at the time of the hearing, detained under section 3 of the Mental Health Act 1983. In 2010, S was diagnosed with bipolar affective disorder in relation to which she had had four hospital admissions but she had responded well to Lithium treatment. SJ Hilder observed that S had achieved much in her life, having obtained a degree in modern languages from Cambridge University and having her own business in language tutoring. S had a strong wish to become a mother but felt that time was running out. After a relationship ending, she decided to conceive a child by IVF using a sperm donor.

SJ Hilder set out the relevant provisions of the Abortion Act 1967 ("AA 1967") and the Mental Capacity Act 2005. In relation to AA 1967, the court noted that, whilst consent (either by a capacitous pregnant woman or by the Court of Protection in the best interest of a non-capacitous pregnant woman) is fundamental to the lawfulness of abortion, it is not sufficient: it also depends upon two medical practitioners being satisfied that the conditions of the AA 1967 are met. The Court of Protection cannot require a clinician to perform a procedure who is unwilling to do so. SJ Hilder acknowledged that it was unknown whether the availability of termination as a practical option, but accepted that, given the statutory time limits, the court needed to consider the evidence and make a determination.

After setting out the relevant provisions of the MCA 2005, SJ Hilder noted the following from the case law:

1. *"There is a space between an unwise decision and one which an individual does not have the mental capacity to take and … it is important to respect that space, and to ensure that it is preserved, for it is within that space that an individual's autonomy operates*." *PC v. City of York* [2013] EWCA Civ 478, para 54

2. The ability to use and weight the relevant information is concerned with "*the capacity actually to engage in the decision-making process itself and to be able to see the various parts of the argument and to relate one to another*." *PCT v. P* [2011] 1 FLR 287, para 35

3. A person need only weight the salient features, it might be that they are unable to use or weigh some of information objectively relevant to the decision in question. "*It is not necessary to have every piece of the jigsaw to see the overall picture*" (*London Borough of Tower Hamlets v. PB* [2020] EWCOP 34, para 13).

4. *"Even when an individual fails to give appropriate weight to features of a decision that professionals might consider to be determinative, this will not in itself*

> *justify a conclusion that P lacks capacity. Smoking, for example, is demonstrably injurious to health and potentially a risk to life. Objectively, these facts would logically indicate that nobody should smoke. Nonetheless, many still do*" (*PB*, para 14).

She also carefully considered the case of *Re SB (A patient; capacity to consent to termination)* [2013] EWHC 1417 (COP), but noted the test for capacity to a decision to terminate pregnancy had not yet been comprehensively set out in the case law.

The trusts relied, in particular, on two capacity assessments: one from an Obstetric Consultant and the other from a Perinatal Consultant Psychiatrist. Both clinicians had indicated that the decision as to capacity lay with the other specialty. The psychiatrist noted that S had laid out the pros and cons in relation to termination – the most prominent con was the lack of a father figure, but she was also concerned about her finances and lifestyle. In terms pros, she wanted to be a mother. The psychiatrist concluded that S's mental illness was, on the balance of probabilities, having a significant impact on her ability to weigh the pros and cons of the decision. The obstetrician discussed the surgical and medical methods of termination. She was concerned about S's ability to use and weigh the information because this had changed since a deterioration in her mental health and that S was unsure about termination. SJ Hilder summarised their evidence at [57]:

> *The clinicians note that S's wish for a termination is a marked change of position to her wish to become pregnant in the first place; and that this change of position coincides with a deterioration in her mental health. They conclude that the wish for termination is a reflection of the negative cognitions of S's mental health condition and therefore S lacks capacity to make the decision.*

S and her sister also gave evidence. S took the affirmation and confirmed her statement, given she was assessed by her representatives as having capacity to conduct the proceedings. She explained that she felt guilty about the lack of a father figure and how the IVF was a mistake. She described that she was not psychologically ready to be a parent now and she was reassured by having her eggs frozen. She was also clear that she cannot say she was 100% sure that she wants a termination; and questioned whether it was ever possible to be 100% sure about this type of decision.

SJ Hilder observed that neither clinician could set out the information relevant to this decision. She determined that, specifically on the facts of this case, the relevant information for the purposes of assessing whether S has or lacks capacity to decide to undergo termination of her pregnancy was at [52]:

> *a. what the termination procedures involve for S ('what it is');*
> *b. the effect of the termination procedure / the finality of the event ('what it does');*
> *c. the risks to S's physical and mental health in undergoing the termination procedure ('what it risks');*
> *d. the possibility of safeguarding measures in the event of a live birth.*

The court considered that discussions with S were more wide ranging, but that they were *'exploration of reasons for deciding one way or the other, rather than information foundational to making the decision.'*[54]

SJ Hilder did not consider that the reasoning of the clinicians was sufficient. She observed, in particular, that S had maintained her position for at least a month and that she had articulated reasons for her current stance. She was satisfied that she *'has amply enough "pieces of the jigsaw to see the whole picture."'* [58] In relation to S

being only 70 or 75% sure about whether to terminate or not, SJ Hilder noted that that *'reflects S's understanding of the magnitude of the decision she contemplates*.' [59] She was not therefore satisfied that the presumption of capacity had been rebutted.

Comment

The case serves as an important reminder to health providers, commissioners and professionals of considering as early as possible whether an application to court is required; and if it is, then, it should be done so promptly. SJ Hilder referred to Vice-President's guidance of 17th January 2020, which applies where a decision relating to medical treatment arises ("Guidance"). Providers/commissioners should be responsible for bringing any application that is required (Guidance, para 9); and the guidance sets out when consideration should be given to bringing an application to court (Guidance, paras 8-12). In a post-script to the judgment, SJ Hilder observed that the proceedings should have been brought to court much more promptly and by one of the health bodies. This matter falls squarely within paragraph 10 of the Guidance – the decision whether or not to terminate a pregnancy must *'surely involve one of the most serious interferences with a person's rights under the ECHR'*.[64]

The consequences of the delay were that (i) the court had to consider matters under an intense time pressure and (ii) the hearing was remote.

SJ Hilder also made important observations in relation to the process of assessing P's capacity, which is different to a record of such assessment. She noted at [47]:

> *It is important that such distinction is borne in mind because conflating the two risks both forgetting that assessment is a process which needs to be continued until it is possible to draw a conclusion and also giving an impression that the outcome was pre-loaded.*

On the facts, she considered that the two clinicians should have undertaken the assessment together; and that it quite clearly should have preceded the best interest meeting - the psychiatrist's assessment followed that meeting.

Finally, it is worth noting that S's legal representatives had determined that she has capacity to conduct the proceedings; and therefore, she instructed them directly. Thus, S gave evidence (taking the affirmation and confirming her evidence). Whilst SJ Hilder observed that both solicitor and counsel were very experienced, their position was that if the court concluded that S lacks capacity to consent to termination of pregnancy then they would welcome the chance to reconsider the position.

The (limited) role of the Inherent Jurisdiction: Part 1

PH v Betsi Cadwaladr University Health Board [2022] EWCOP 16 (31 March 2022) (Hayden J)

COP jurisdiction and powers – Interface with inherent jurisdiction

Summary

In *PH v Betsi Cadwaladr University Health Board* [2022] EWCOP 16 (31 March 2022), Vice President Mr Justice Hayden refused to make an order under the Inherent Jurisdiction to the effect that PH should be provided with supplements if he requested them. [15]

The application concerned PH, a 41-year-old man with longstanding medical difficulties. PH required PEG feeding as the result of a 2016 episode in which he drank hydrogen peroxide sustaining significant gastric injuries; PH also required round-the-clock in-patient care

following a fit in 2019 in which he sustained a hypoxic brain injury.

PH had been involved in long-running proceedings in which his previous care had been roundly criticised by the court. The court observed that he had been diagnosed as having a personality disorder which *'served historically to eclipse both the recognition of PH's symptoms as well as features of his personality'* [2]. Following the engagement of a new clinical team, there was a "sea change" in his care and presentation and an apparently positive outlook towards the future. PH retained the love and support of a partner, N, and a longstanding wish to move out of hospital into a home in Wales which had been prepared for his care.

As the judgment records, however, PH's outlook became increasingly desolate. He considered his life had become 'a living hell' [9] and that he was a 'burden to others.' As a result, he had begun to refuse the PEG feed which was his sole source of nutrition. PH had, by the time judgment was handed down, refused to take nutrition for 41 days.

Following his brain injury, PH had difficulties in speaking. Nonetheless, he was able to communicate 'clearly and unambiguously.' [5] The parties agreed, and the court heard oral evidence to the effect that PH retained capacity to accept – or refuse – feeding. Despite refusing nutrition, however, PH continued to accept water and antibiotics as required. The view was taken that he had effectively constructed his own palliative care regime. [14]

The question before the court was whether it should make orders under the Inherent Jurisdiction that PH should receive supplements should he request them. The court rejected this application.:

> *15…In London Borough of Redbridge v SNA [2015] EWHC 2140 (Fam), I made the following observations which strike me as having resonance here:*
>
> *"[33] The concept of the 'inherent jurisdiction' is by its nature illusive to definition. Certainly, it is 'amorphous' (see paragraph 14 above) and, to the extent that the High Court has repeatedly been able to utilise it to make provision for children and vulnerable adults not otherwise protected by statute, can, I suppose be described as 'pervasive'. But it is not 'ubiquitous' in the sense that its reach is all-pervasive or unlimited. Precisely because its powers are not based either in statute or in the common law it requires to be used sparingly and in a way that is faithful to its evolution. It is for this reason that any application by a Local Authority to invoke the inherent jurisdiction may not be made as of right but must surmount the hurdle of an application for leave pursuant to s100 (4) and meet the criteria there.*
>
> *[36] The development of Judicial Review, as illustrated by ex parte T (supra), has also served to curtail the exercise of the powers of the inherent jurisdiction. No power be it statutory, common law or under the prerogative is, in principle, unreviewable. The High Court's inherent powers are limited both by the constitutional role of the court and by its institutional capacity. The principle of separation of powers confers the remit of economic and social policy on the legislature and on the executive, not on the Judiciary. It follows that the inherent jurisdiction cannot be regarded as a lawless void permitting judges to do whatever we consider to be right for children or the vulnerable, be that in a particular case or more generally (as contended for here) towards*

unspecified categories of children or vulnerable adults."

16. It is also important to highlight the applicable statutory framework:

15 Power to make declarations
(1) The court may make declarations as to—
a) whether a person has or lacks capacity to make a decision specified in the declaration;
b) whether a person has or lacks capacity to make decisions on such matters as are described in the declaration;
c) the lawfulness or otherwise of any act done, or yet to be done, in relation to that person.
(2) "Act" includes an omission and a course of conduct.

17. Whilst the court may not make interim declarations, it may make orders and directions:

48 Interim orders and directions
1. The court may, pending the determination of an application to it in relation to a person ("P"), make an order or give directions in respect of any matter if—
a) there is reason to believe that P lacks capacity in relation to the matter,
b) the matter is one to which its powers under this Act extend, and
c) it is in P's best interests to make the order, or give the directions, without delay.

18. The above must be placed in the context of the overarching principles of the Act:

The principles
1. The following principles apply for the purposes of this Act.
2. A person must be assumed to have capacity unless it is established that he lacks capacity.
3. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
4. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
5. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
6. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

19. Thus, in the absence of a lack of capacity within the scope of Section 15 MCA, or any reasons for believing that P might lack capacity, as prescribed within the ambit of Section 48, there is no other gateway to a best interests' decision. There are good reasons for this. The court has no business in telling capacitious individuals what is in their best interests nor any locus from which to compel others to bend to the will either of what capacitious individuals may want or what the court might consider they require. Such a regime would be fundamentally unhealthy in a mature democratic society and would have the collateral impact of undermining the principle of autonomy which is central to the philosophy of the MCA. 20. The limited scope of the inherent jurisdiction is circumscribed by particular, albeit

> *nonexhaustive, criteria which relate to vulnerable adults whose capacity for decision taking is being overborne in some way (see Re SA [2005] EWHC 2942 (Fam); Southend-On-Sea Borough Council v Meyers [2019] EWHC 399 (Fam) (20 February 2019). Nobody has suggested that that is the case here. Additionally, and practically speaking, it is difficult to formulate a declaration which is flexible enough to incorporate a turning point (which may not be immediately clear), where provision of supplements, upon request, is contraindicated medically. Taking of blood samples e.g., to assess serum levels, will not be appropriate if the deterioration of skin tissue makes that difficult and potentially painful for no clinical benefit."*

While making no criticism of the Health Board – particularly given the difficult history of the case – for having brought the application, the court was clear that it had been *'no jurisdictional basis for bringing the case to court*.' [13] All parties agreed that PH had capacity to make decisions regarding his feeding regime, and in the absence of any external force such as may have required an intervention under the Inherent Jurisdiction, the court made no orders but left the ultimate management of PH's care to his treating staff and himself. [22]

Comment

This judgment builds on the growing body of case law, all of which points towards a very firmly defined and limited role for the Inherent Jurisdiction: a power which has limited – if any – role to play in the management of the lives of capacitous individuals.

The (limited) role of the Inherent Jurisdiction: Part 2

London Borough of Islington v EF [2022] EWHC 803 (Fam) (18 March 2022) (Alex Verdan QC, sitting as a Deputy High Court Judge)

Inherent jurisdiction

Mental Capacity – Contact

Safeguarding

COP jurisdiction and powers – Interface with inherent jurisdiction

Summary

In 2017 EF was a looked after child who, at the age of 14, met GH in an online chat room who was 11 years older than her. She initially pretended to be an adult and they began an online relationship. After revealing the following year that she was in fact 15, he posted an engagement ring from Brazil and said he would come to England when she was 16 to marry her. She briefly ended the relationship the following year but then it resumed.

From 2018-20 she experienced acute psychosis which led to self-injury and suicidal ideation and three hospital inpatient admissions. In 2019, GH came to England to meet her, until he was arrested for possession of child pornography and returned to Brazil, but contact continued.

EF now lived in semi-independent accommodation, receiving medication and psychiatric support for schizo-affective disorder, and attended college where she was studying an Art diploma. Her mental state was stable, and she was doing well. When she was 17, the local authority made a without notice application and interim orders were granted to prevent her leaving the country and her passport was withheld. An expert consultant forensic psychiatrist was instructed to assess her capacity and vulnerability.

There was insufficient evidence to show that EF had been groomed but '*there is in my judgment a real possibility that he will exploit her by taking advantage of her*.' [83] This was due to '*EF's age*

when the relationship started, GH continuing the relationship despite her age, his addiction to porn, him downloading child pornography, her mental ill health and vulnerability and him being willing for her to move to Brazil despite the risks to her health.' [83] GH's downloading of child pornography was '*extremely concerning and indicates a sexual interest in children as it was linked to his porn addiction*.' [84] The judge found that GH had probably sought to isolate EF from her family and the dynamic of GH's relationship with EF was one of undue influence.

Capacity

The expert was instructed to assess EF's capacity to litigate, to decide where to live, to decide as to the care and support she receives, to manage her finances, to have contact with GH, to marry, to relocate abroad and to engage in sexual relations. The evidence was '*clear*' that '*for the purposes of the MCA*' EF was able to make these decisions. [61] Specifically in relation to contact, however, the expert's view was that her '*limited understanding of the nature of the relationship impacts on her ability to weigh up the necessary information about her contact with GH*' and this is '*a consequence of her trauma history and subsequent vulnerability*.' [65] The expert's view was that EF '*could not understand the nature of her relationship with GH, the risks to her from the relationship nor weigh up all the competing factors*.' [70]

The judge agreed that EF's understanding of the risks posed from GH was '*superficial/minimal*.' [79] EF too would be concerned were a young female friend of hers to have a similar plan, but she '*could not see the very same risks for herself*.' [80] Indeed, she '*does not appreciate the risks to her physical safety nor the risks to her mental health*.' [81] What were those risks?

> *91. My conclusion based on Dr D's evidence is that if EF travels to Brazil there is firstly a significant risk that she would suffer a deterioration in mental state, and secondly that if that happened there is a real risk that deterioration could become severe and thirdly that in that event she would probably be unable to access the care and support she needs, and so would be at risk of exploitation by others and would be at serious risk of suicide. Although I have expressed each of the above separate stages as a likelihood I cannot say whether the serious risk of suicide is in itself a likelihood as there are a number of stages that need to occur although I do accept it is a real possibility. Nor can I say that the risk of suicide is an immediate one as the timing of it depends on a wide range of factors.*

Despite this evidence, the court concluded that '*it is clear from Dr D's evidence and the parties agree that EF has capacity*' [92] to make the relevant decisions and so the MCA was not applicable.

Inherent jurisdiction

The judge concluded that despite GH's undue influence, '*I do not find that EF is deprived or disabled from being able to make decisions but rather that the relevant decisions she is making are unwise ones*.'[90] The orders sought would be against EF and dictatorial in nature and should not therefore be made. The judge continued:

> *98. If I am wrong about that and there is a jurisdiction to make such orders against victims it only exists in truly exceptional circumstances. I am not satisfied that those exist in this case. The scale of interference is significant and not in reality time limited to 6 months as it is by no means certain that in 6 months' time the court will be in a different position as there is every chance that despite the work that EF will carry out with the LA her views will*

> *not have changed. The justification for the inference is the risk to EF's health and wellbeing and in the worst case her life. I have already dealt with my assessment of that risk [in paragraph 91 above].*
>
> *99. Moreover, EF is an adult with capacity and wants to be in a relationship with GH. She has known him for 3 years and separated from him once. She has received advice from professionals not to go and is intelligent enough to understand that advice and act on it if she so wishes. She plans to visit Brazil at least once before moving there permanently. She has saved up a reasonable sum so that she will have a degree of independence once over there. She plans to take a second mobile phone with her as another level of security. She has researched the medical and health facilities in Brazil and is aware of its shortcomings. She has agreed not to travel to Brazil until her course is completed. She has agreed to continue to work with the LA before she leaves. These are sensible decisions which show a degree of independence and critical thinking.*

In the absence of exceptional circumstances, the travel ban could not be justified. EF had undertaken not to travel before the end of her college course in four months' time, before which she will attend social work sessions proposed by the local authority dealing with a range of subjects including healthy relationships, support, life in the UK and life in Brazil, the object of which is to '*at least give her greater understanding of the risks*'. [55] The judgment ended with a judicial plea which bears full citation:

> *108. I end this judgment with a plea to EF. I have accepted that the LA and Dr D are right to be very worried about her because I have found that there are real risks to EF's wellbeing from moving to Brazil and living with GH.*
>
> *109. I have concluded that the professionals in this case have EF's best interest at heart and want to protect her and keep her safe.*
>
> *110. The court's view is that EF would be making a very unwise decision to move to Brazil.*
>
> *111. I urge her to work with them between now and July when her course finishes.*
>
> *112. I urge EF to attend all the sessions that the LA arrange for her.*
>
> *113. I ask EF to listen carefully to the advice given and think more deeply about the issues in this case.*
>
> *114. EF told me she would be worried if a friend of hers was about to embark on a similar trip. She needs to think about her own case as if she were that friend.*

Comment

Given the evidence, the position of the parties and the court that EF was able to make all of the relevant decisions is certainly not without interest. Reminiscent of *PC and NC v City of York Council*, one cannot help but wonder in this complex case whether perhaps EF was unable to comprehend the risks posed by GH but that the causative nexus had not been proven for MCA purposes. Neither was the nexus between GH's undue influence and EF's decision-making ability established for inherent jurisdiction purposes, for his influence did not deprive or disable her from making the decisions.

The crux of the case appears to be that despite the court's assessment of risk at paragraph 91, a travel ban would not have been a necessary and proportionate interference with EF's Article 8

ECHR rights in the context of this 3-year relationship. Moreover, the order would have been directed at EF, presumably by way of an injunction, which poses a challenge of logic. The basis for seeking an injunction was that EF was not acting of her own free will. So how could she be held accountable for breaching the injunction? She either is or is not able to exercise her own will.

Best interests and transplants

Manchester University NHS Foundation Trust v WV [2022] EWCOP 9 (08 March 2022) (Arbuthnot J)

Best interests - Medical treatment

Judgment has been handed down in the case of William Verden, which readers may recognise from appeals in the national press by William's family to find a kidney donor. William, now 17, started showing signs of kidney failure in 2019. Treatment with steroids did not help, and he was diagnoses with Steroid Resistant Nephrotic Syndrome (SRNS). He currently receives haemodialysis four times a week, and without a transplant his life expectancy would be around 12 months.

The case initially came to court because the Trust was seeking a decision that it was not in William's best interests to receive a transplant, and instead to continue with haemodialysis.

However, the position of the clinicians giving oral evidence differed from the Trust's initial stance; ultimately, no clinician giving evidence took the view that that a transplant was contrary to William's best interests. At the close of the hearing, the Trust's position was formally neutral on William's best interests and submitted that it was a matter for the court. Arbuthnot J recorded in her judgment that she had no doubt the Trust's initial position was reached after careful multi-disciplinary discussions, but the evidence of the Trust's witnesses *'had become more nuanced as they were able to reflect on and consider the oral evidence.'* [30]

The court heard evidence from a large number of witnesses. Dealing first with the nephrologists, the judgment records that the consultant paediatric nephrologist put forward by the Trust (Dr A) and the independent expert (Professor Saleem) had different experiences in relation to the likelihood of recurrence but both agreed that plasma exchange would be the normal way to treat this. The independent expert was clear that but for the complications presented by William's ADHD, autism and learning difficulties, a transplant would be offered.

The intensivists the court heard from (Dr B for the Trust, Dr Danbury as independent expert) dealt with the risks to William of post-operative treatment in paediatric intensive care if the transplant went ahead. Dr Danbury had considered that the risks were such that it might outweigh the benefits, on the basis that the Trust was initially suggesting 6 weeks sedation and ventilation would be required. Having heard the nephrologists give evidence, and in light of the fact that two weeks was by then the period proposed, he considered that this would be in William's best interests.

The court also heard from a consultant child and adolescent psychiatrist for the Trust (Dr C) and an independent child psychologist (Dr Carnaby) on the challenges which a transplant and the post-operative care required might pose for William. The court also heard from William's mother, and carried out a judicial visit to William himself.

Although the transplant carried with it significant complexities (in particular in relation to how William could be supported to tolerate the post-operative period and the sedation and ventilation required) this was ultimately a case in which the question before the court was stark. If the court decided a kidney transplant was not in William's best interests, he would die, and within only a

year or so. William and his family wanted the transplant. Notwithstanding the undoubted complexities and the risks of the transplant, it had the commensurate benefit of giving William a chance of long-term survival. The judge accordingly decided that a transplant was in William's best interests and approved sedation and ventilation for 14 days in the event of disease recurrence.[2]

Analysis

The Trust's own evidence at the hearing supported the conclusion that it was in William's best interests to receive a kidney transplant, even taking into account the short-term hardship he would experience. It is not clear why the Trust did not seek to rely on the evidence on which it had based its initial application, opposing transplantation; alternatively, it is not clear why, having apparently abandoned the evidence on which it initially relied, the Trust did not reconsider its position prior to the final hearing. On the face of the judgment, it is not clear why mediation was not more seriously pursued in this case to either seek to resolve the care planning issues that appeared to become the focus of the hearing, or to at least significantly narrow the issues in dispute before the court.

Fluctuating capacity in practice

CA v A Local Authority & Anor [2021] EW Misc 26 (CC) (08 November 2021) (HHJ Davies)

Mental capacity – Assessing capacity

Summary

In *CA v A Local Authority & Anor* [2021] EW Misc 26 (CC), HHJ Davies had to consider whether CA had capacity to make decisions in relation to her residence in the context of medical evidence concluding the CA had fluctuating capacity. The assessor had, however, determined that at the time of his assessment that she had capacity to make the relevant decision.

CA is 46 years old. She has been diagnosed with schizophrenia and a mild learning disability. She is deaf, registered blind, and has cerebral palsy on her left-hand side. She had been living in a British deaf home since September 2019 and had been asking to leave it.

The local authority's position was the issue should be adjourned for a further assessment by the clinician, given that the assessment had taken place in January and the hearing was in November. CA (supported by her litigation friend) invited the court to find that lacks capacity because of her current mental state – her mother supported that view.

HHJ Davies considered the decision of Sir Mark Hedley in *Cheshire West v PWK* [2019] [2019] EWCOP 57 and observed that Hedley recommended a *"longitudinal approach",* noting at [10] of the *CA* judgment:

> *By that I mean I am not looking at a snapshot decision, but I am looking at an overall view, if I can put it like that. In that case he said: "It is important to recognise in this case that there is likely to be a particular focus on understanding relevant information, retaining it and using or weighing it. There will be many occasions when PWK is hampered by anxiety when those grounds are clearly made out. However, that will not always be the case. It may fluctuate. The question is how the law deals with that".*

HHJ Davies noted that a distinction is made between, on the one hand, *"the general concept of managing affairs [as] an ongoing act"* and a specific act of making a will, on the other.[12] The

[2] Tor having appeared in this case, she has not contributed to the summary or analysis above.

former is a continuous state of affairs, the demands of which may be unpredictable and sometimes urgent.

On the evidence, HHJ Davies accepted that CA exhibited signs of being very unhappy and possibly depressed (but she did not have any medical evidence in respect of diagnosis). CA's mental health had suffered during lockdown; and the decision in respect of her residence was extremely stressful and very emotive. HHJ Davies referred to an example of CA being offered a specific placement but she was unable to give her view on it. HHJ Davies determined that CA lacks capacity to decide where to live; and that an '*ongoing act deciding about where she should live, her care and support*'. [15]

Covid vaccine round-up

North Yorkshire Clinical Commissioning Group v E (Covid Vaccination) [2022] EWCOP 15 (Poole J)

NHS Liverpool CCG v X and Y [2022] EWCOP 17

GA, Re (vaccination) [2021] EWCOP 66 (Sir Jonathan Cohen)

Best interests – medical treatment

There have been three further judgments published, both approving the vaccine as being in P's best interests: *Re GA (vaccination)* [2021] EWCOP 66; *NHS Liverpool CCG v X and Y* [2022] EWCOP 17; and *North Yorkshire Clinical Commissioning Group v E (Covid Vaccination)* [2022] EWCOP 15. In the latter case, Poole J observed that:

> 38.…*Earlier in the pandemic it could more reasonably be said that Covid-19 vaccines were "new" and that, if not "untested", the evidence for effectiveness and complications was not the same as it would have been for more established vaccination programmes. Now, millions of doses have been given and the evidence base is much larger albeit the vaccines have not been in use for long enough for longer term studies to be performed.*

Poole J went on to give general guidance at [53], including that:

> *i) The best interests assessment is not confined to evidence of the health benefits and risks of vaccination but involves a wide review encompassing all the relevant circumstances including those set out at s.4(6) and (7) of the MCA 2005;*
>
> *ii) In relation to the benefits and risks to the health of P from vaccination, it is not the function of the Court of Protection to "arbitrate medical controversy or to provide a forum for ventilating speculative theories." The Court of Protection will "evaluate P's situation in the light of the authorised, peer-reviewed research and public health guidelines." It will not carry out an independent review of the merits of those guidelines.*
>
> *iii) There may be exceptional cases where P's condition, history or other characteristics mean that vaccination would be medically contra-indicated in their case but in the great majority of cases it will be in the medical or health interests of P to be vaccinated in accordance with public health guidelines.*
>
> *iv) Hence, disagreements amongst family members about P being vaccinated which are at their root disagreements about the rights and wrongs of a national vaccination programme are not suitable for determination by the court. It will be in P's best interests to avoid delay and for differences to be resolved without recourse to court proceedings.*

Comment

Poole J's indication that where objections to the vaccine are rooted in a dispute about the national vaccine programme, not P's particular circumstance, they should be resolved without court proceedings, is welcome. Practitioners should feel confident making decisions in reliance on s.5 MCA (and, where light touch restraint is required to administer the vaccine, s.6 MCA) without feeling there is an obligation to issue court proceedings in respect of either first doses, or subsequent ones.

Restraint and Positive Behaviour Support Plans for people with Learning Disabilities

Tor and Dr Theresa Joyce have prepared *Restraint and care plans in the Court of Protection: Positive Behaviour Support plans for people with learning disabilities*.

The document is aimed at lawyers in the Court of Protection to help them interrogate Positive Behaviour Support (PBS) plans that are presented to the court for approval for people with learning disabilities. A few notable recommendations include:

- Monthly reviews of PBS plans may be needed if any physical restraint is being used. If there are reviews only every 6 to 12 months, then they are unlikely to be delivering appropriately detailed monitoring and adjustment of the plan.
- If there is no change in the rate of occurrence of behaviours and consequent restraint/seclusion, then consideration should be given to whether the staff team are trained and supported in delivering individually-based support to the person.
- If there are not improvements, it the environment may not be appropriate for the person's needs, in which case it may be necessary to find a placement for the person where these environmental issues can be considered as part of the commissioning process.

The authors consider that the use of restrictive physical interventions for people with learning disabilities and/or autism should be eliminated and, in many circumstances, can be eliminated even within the constraints within which the Court of Protection is invited to operate.

Covid-19 Vaccination in those with mental health difficulties

The recent article *COVID-19 Vaccination in those with mental health difficulties: A guide to assist decision-making in England, Scotland, and Wales* considers the legal frameworks in both England and Wales and Scotland for making decisions about vaccinations for those who lack capacity to take the decision for themselves. The article is written for medical practitioners and focuses on psychiatric inpatients (whether voluntary patients or detained patients). It considers the question of vaccinating people under the Mental Health Act, concluding that it *'is difficult to interpret vaccination as treatment for the symptoms of mental disorder'*, though airs some arguments to the contrary. It also considers the application of relevant advance decisions, and the position when proxy decision-makers disagree. It is a concise and helpful article for those charged with the welfare of psychiatric inpatients who lack capacity to take decisions regarding COVID-19 vaccination.

A review of deprivation of liberty applications relating to children

Alice Roe, Mary Ryan and Andrew Powell of the Nuffield Family Justice Observatory have recently published Deprivation of Liberty: A Review of Published Judgments. The authors considered the 31 reported judgments on this issue between 2014 and 2021, looking to judgments either authorising a deprivation of liberty under s.25 Children Act 1989 in secure accommodation, or under the inherent jurisdiction. The authors note that this is a small fraction of the total number of applications of

this type, and that in 2020/21, 392 applications were made in England and Wales for secure accommodation orders, and 579 applications were made in the inherent jurisdiction.

Notable themes identified include:

- Shortages of appropriate placements: there is a severe shortage of available placements in secure children's homes. The authors recognised a cohort of children whose needs cannot be met by secure children's homes, who are also not considered detainable under the Mental Health Act 1983 (noting children who display *'very severe self-harming or aggressive behaviours'*). The authors found themes that these children *'require specialist, intensive therapeutic provision, often in single occupancy restrictive placements. There is a severe lack of availability of this type of placement.'* These children had often been known to social services for years, and there appeared to be limited evidence of early intervention and support for the children's families.
- Shortages of secure mental health inpatient beds for children
- Judicial concerns about the increasing use of the inherent jurisdiction to deprive children of their liberty, often in 'emergency placements' which end up lasting for significant periods of time, which lack appropriate therapeutic or educational provision. In some recent cases (as above), courts have refused to authorise deprivations of liberty in these settings.
- Placements repeatedly breaking down and children being subjected to multiple moves.
- Children being moved far from their homes, including out of the jurisdiction into Scottish placements.
- The placement of children in unregistered or unregulated settings.
- Use of the High Court for injunctions against adults to protect children (with the authors noting these cases all took place between 2014 and 2016).

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Adrian is a recognised national and international expert in adult incapacity law. He has been continuously involved in law reform processes. His books include the current standard Scottish texts on the subject. His awards include an MBE for services to the mentally handicapped in Scotland; honorary membership of the Law Society of Scotland; national awards for legal journalism, legal charitable work and legal scholarship; and the lifetime achievement award at the 2014 Scottish Legal Awards.

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Jill Stavert is Professor of Law, Director of the Centre for Mental Health and Capacity Law and Director of Research, The Business School, Edinburgh Napier University. Jill is also a member of the Law Society for Scotland's Mental Health and Disability Sub-Committee. 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.

Conferences

7th World Congress on Adult Capacity, Edinburgh International Conference Centre [EICC], 7-9 June 2022 The world is coming to Edinburgh – for this live, in-person, event. A must for everyone throughout the British Isles with an interest in mental capacity/incapacity and related topics, from a wide range of angles; with live contributions from leading experts from 29 countries across five continents, including many UK leaders in the field. For details as they develop, go to www.wcac2022.org. Of particular interest is likely to be the section on "Programme": including scrolling down from "Programme" to click on "Plenary Sessions" to see all of those who so far have committed to speak at those sessions. To avoid disappointment, register now at "Registration". An early bird price is available until 11th April 2022.

The Judging Values and Participation in Mental Capacity Law Conference
The *Judging Values in Participation and Mental Capacity Law* Project conference will be held at the British Academy (10-11 Carlton House Terrace, London SW1Y 5AH), on Monday 20th June 2022 between 9.00am-5.30pm. It will feature panel speakers including Former President of the Supreme Court Baroness Brenda Hale of Richmond, Former High Court Judge Sir Mark Hedley, Former Senior Judge of the Court of Protection Denzil Lush, Former District Judge of the Court of Protection Margaret Glentworth, Victoria Butler-Cole QC (39 Essex Chambers), and Alex Ruck Keene (39 Essex Chambers, King's College London). The conference fee is £25 (including lunch and a reception). If you would like to attend please register on our events page here by 1 June 2022. If you have any queries please contact the Project Lead, Dr Camillia Kong.

Forthcoming Training Courses
Neil Allen will be running the following series of training courses:

22 April 2022	DoLS refresher for mental health assessors (half-day)
28 April 2022	The Mental Health and Capacity Act Interface (full-day)
6 May 2022	Necessity and Proportionality training (half-day)
13 May 2022	BIA/DoLS legal update (full-day)
16 May 2022	AMHP legal update (full-day)
17 June 2022	DoLS refresher for mental health assessors (half-day)
14 July 2022	BIA/DoLS legal update (full-day)
16 September 2022	BIA/DoLS legal update (full-day)

To book for an organisation or individual, further details are available here or you can email Neil.

Conferences (continued)

Pregnancy, Childbirth and the Mental Capacity Act: 4 May 2022

Ian Brownhill will be offering a course through Edge Training to assist delegates to navigate the challenging landscape of mental capacity law in the field of obstetrics. Delegates will cover the basics of the Mental Capacity Act and how the law should be applied in relation to specific decisions such as caesarean sections and birth plans. Related areas will also be covered such as contraception and termination of pregnancies. There will be particular consideration of those detained under the Mental Health Act and guidance on when to apply to the Court of Protection. To register, click here.

Essex Autonomy Project Summer School 2022

Early Registration for the 2022 Autonomy Summer School (*Social Care and Human Rights*), to be held between 27 and 29 July 2022, closes on 20 April. To register, visit the Summer School page on the Autonomy Project website and follow the registration link.

Programme Update:

The programme for the Summer School is now beginning to come together. As well as three distinguished keynote speakers (Michael BACH, Peter BERESFORD and Victoria JOFFE), Wayne Martin and his team will be be joined by a number of friends of the Autonomy Project who are directly involved in developing and delivering policy to advance human rights in care settings. These include (affiliations for identification purposes only):

> Arun CHOPRA, Medical Director, Mental Welfare Commission for Scotland

> Karen CHUMBLEY, Clinical Lead for End-of-Life Care, Suffolk and North-East Essex NHS Integrated Care System

> Caoimhe GLEESON, Programme Manager, National Office for Human Rights and Equality Policy, Health Service Executive, Republic of Ireland

> Patricia RICKARD-CLARKE, Chair of Safeguarding Ireland, Deputy Chair of Sage Advocacy

Planned Summer School Sessions Include:

> Speech and Language Therapy as a Human Rights Mechanism

> Complex Communication: Barriers, Facilitators and Ethical Considerations in Autism, Stroke and TBI

> Respect for Human Rights in End-of-Life Care Planning

> Enabling the Dignity of Risk in Everyday Practice

> Care, Consent and the Limits of Co-Production in Involuntary Settings

The 2022 Summer School will be held once again in person only, on the grounds of the Wivenhoe House Hotel and Conference Centre. The programme is designed to allow ample time for discussion and debate, and for the kind of interdisciplinary collaboration that has been the hallmark of past Autonomy Summer Schools. Questions should be addressed to: autonomy@essex.ac.uk.

Our next edition will be out in May. 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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