Essex CHAMBERS

MENTAL CAPACITY REPORT: THE WIDER CONTEXT

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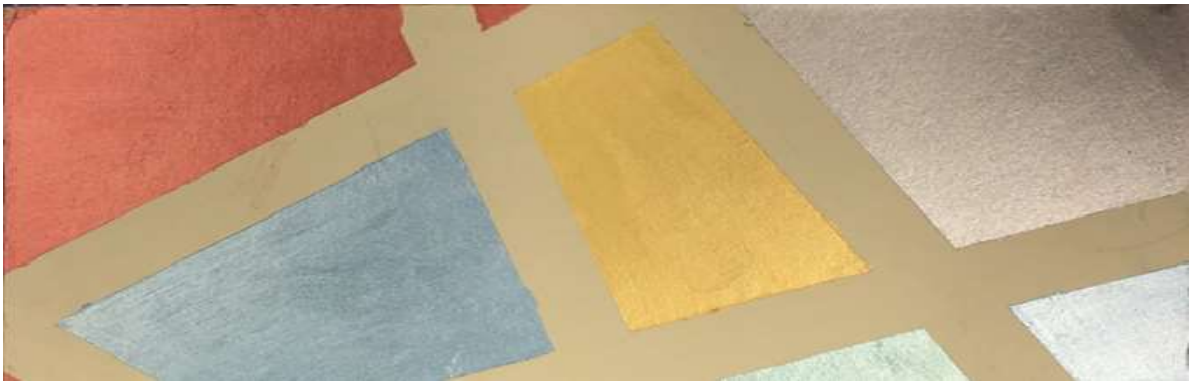

Welcome to the February 2021 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: vaccination; interim authority to treat pending a final order, and a further LPS impact assessment;

(2) In the Property and Affairs Report: guidance following *ACC* for professional deputies;

(3) In the Practice and Procedure Report: a checklist for international relocation, covert treatment and the courts, and recording of court proceedings;

(4) In the Wider Context Report: decision-making and 16/17 year olds, FAQs following the *Devon* judgment on personal assessment, spotting coercion and control and the BIHR's resources for service providers;

(5) In the Scotland Report: further developments relating to the Scott review, including an update from the Chair, and Scottish consideration of relocation.

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. We have taken a deliberate decision not to cover all the host of COVID-19 related matters that might have a tangential impact upon mental capacity in the Report. Chambers has created a dedicated COVID-19 page with resources, seminars, and more, here; Alex maintains a resources page for MCA and COVID-19 here, and Neil a page here. If you want more information on the Convention on the Rights of Persons with Disabilities, which we frequently refer to in this Report, we suggest you go to the Small Places website run by Lucy Series of Cardiff University.

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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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When is the refusal of treatment by a 16/17 year old binding?

Re X [2021] EWHC 65 (Fam) (Munby J)

Other proceedings – judicial review

Summary[1]

> *This case is about whether X, a young woman declared to be Gillick competent and "mature and wise beyond her years", should be afforded the exclusive right to decide her own medical care in the same way as her peers aged 18 years and older*

X, who was 15 at the time of judgment, is a Jehovah's Witness. She suffers from serious sickle cell syndrome. At times this results in a crisis, when the view of her treating clinicians is that blood transfusion is necessary.

Her case is also the latest consideration the courts have given to the question of when the refusal of medical treatment by a child under the age of 18 may be determinative.

The Trust had brought her case to court in May 2020, seeking authorisation for transfusion notwithstanding her objections, which was granted. In October 2020 a further crisis ensued, and the matter returned to court. The Trust was now seeking not only an order authorizing transfusion in this case, but a 'rolling order' which would authorise transfusions as and when needed until X is 18. At that hearing counsel for X raised the question of whether, as a Gillick competent child of nearly 16, her refusal of treatment should be determinative. The court authorized treatment in the circumstances of medical crisis, but set the matter down for full argument.

[1] Note, Tor and Alex having been involved in the case, they have not contributed to this note.

Gillick competence

It was common ground that X *was* Gillick competent, and so the judgment does not descend into detailed analysis of the concept. However, Sir James Munby did make two important observations:

- On the relationship between Gillick competence and s. 8, drawing on the analysis of Lord Donaldson in *In re R* [1992] Fam 11 and *In re W* [1993] Fam 64: in medical treatment cases the analysis is '(1) Until the child reaches the age of 16 the relevant inquiry is as to whether the child is Gillick competent. (2) Once the child reaches the age of 16: (i) the issue of Gillick competence falls away, and (ii) the child is assumed to have legal capacity in accordance with section 8, unless (iii) the child is shown to lack mental capacity as defined in sections 2(1) and 3(1) of the Mental Capacity Act 2005' (at [57]);

- On the relationship between Gillick competence and capacity under the MCA 2005: the tests have "*nothing obvious in common, not least because they are rooted in different areas of scientific knowledge and understanding*" (para 73) ; there is no obvious read-over between the two, save that it is difficult to see how a child who lacks capacity in the MCA sense would achieve Gillick competence (para 74). In this regard, Sir James disagreed with the suggestion in *Re S* and repeated in *Bell v Tavistock* that it is appropriate and helpful when considering Gillick competence to read across and borrow from the concepts and language in the MCA: 'its premise is that Gillick competence is in some way related or even analogous to capacity in the sense in which the expression is used in the 2005 Act. It is not; the two are, as I have said, both historically and conceptually quite distinct" (at [75]).

Nothing in the MCA 2005 threw the validity of the approach outlined in *Re R* and *Re W* into doubt. Nor did a line of authority from the Supreme Court of Canada. Considering the case of *AC v Manitoba (Director of Child and Family Services)* 2009 SCC 30, Sir James held that the case *"is not authority for the proposition that the decision of either a Gillick competent child or a child aged 16 or more is always, and without exceptions, determinative in relation to medical treatment. In the final analysis, as I read her judgment, the court always has the last word*." (at para 99). Neither this case nor other Canadian authorities to which the court was referred suggested any need for judicial re-evaluation of *Re R* and *Re W*.

Compatibility with ECHR

The judgment then goes on to consider whether that approach is compatible with the European Convention of Human Rights. In short terms, the answer given is 'yes':

- Article 2: even if it was correct that Article 2 was not engaged, this did not prevent 'the preservation of life' being a factor that the State can consider when evaluating whether other rights are engaged;

- Article 3: assuming that it were the case that imposing medical treatment on an adult who did not wish it would amount to a breach of Article 3, the case is different where treatment of a child – even a Gillick competent child – is being considered. This is because of the strong arguments in

favour of securing the child's future autonomy. The need to balance autonomy and the need to protect the child and support them to survive into adulthood is recognized in various provisions of the UN Convention on the Rights of the Child (at para 119]) and nothing in the Strasbourg jurisprudence requires a recognition that a child – even a Gillick competent child – is autonomous in the way an adult is (para 120).

- Article 5: on the facts of the case, Article 5 did not arise. No order had been made for X to be restrained or prevented from leaving hospital, and she did not in fact seek to do so. The difficult question as to how a Gillick competent child could be 'of unsound mind' did not therefore fall to be answered, but Sir James expressed the view that the solution is to be found in the 'carve out' recognized in *R (Ferreira) v Inner South London Senior Coroner* [2017] EWCA Civ 31.

- Articles 8 and 9: the analysis in relation to Article 3 applied to the argument that there was any breach of Articles 8 or 9. In fact, given that those rights are qualified rights, the argument that there was no breach where the intention is to preserve the lives of children until adulthood (which Sir James recognised as a legitimate aim at para 134) was all the stronger.

- Article 14: any differential treatment on the basis of age was justified, and no breach of Article 14 ensued. The reason for treating children differently was not a matter of administrative convenience, but the protection of children (see para 152).

The picture in the round

Sir James then considered the submission that For years, the debate about the interface between the MHA and the MCA (as to which, see further my shedinar here) and where it should be drawn in future has been bedevilled by the lack of actual data about how it works in practice, and how practitioners (of different backgrounds) understand it. The King's Fund, in a really important piece of research commissioned by the DHSC, has published a report: Understanding clinical decision-making at the interface of the Mental Health Act (1983) and the Mental Capacity Act (2005): drawing upon survey and qualitative interviews, the research captured data from more than 600 health professionals, including approved mental health professionals, section 12 doctors, approved clinicians, and best interests assessors among others. A blog by the report's author – a Tale of Two Acts – can be found here, and the underlying report here.times have changed and views as to the proper balance between medical paternalism and patient autonomy have altered. He agreed that "[o]*f course, a family court cannot be blind to the changes in society's views and values which are such a striking feature of modern life, and this is well recognised in the authorities*" (paragraph 159). Similarly, the common law is of course capable of moving with the times. However, the court could not simply reject the law as set out in *Re R* and *Re W*:

> *162. At the end of this lengthy analysis, my clear and firm conclusion is that the learning in In re R (A Minor) (Wardship: Consent to Treatment) [1992] Fam 11 and In re W (A Minor) (Medical Treatment: Courts Jurisdiction) [1993] Fam 64 emerges unscathed from Mr Brady's*

> *attack. The change for which he contends is a matter for Parliament, not the courts.*

X's application for declarations that she had the requisite decisional capacity to make exclusive decisions about her treatment, or would do once she attained the age of 16, was therefore refused.

The rolling order

The second question which arose for decision was whether to make the orders sought by the Trust.

Having found against X on the question of whether the court could make an order requiring her to be treated against her competent/capacitous will, Sir James was not persuaded that he should make the rolling order sought by the Trust. He was satisfied that it was possible to make such an order: "*I have no doubt that the court has jurisdiction to make the kind of contingent, anticipatory or prospective order*" which was sought (para 165]) but the real question was whether the court should.

Four submissions were made in support of the overall submission that an order should not be made, Sir James identifying that he agreed with the force of the submission, if not the detail of the points. Those four submissions were: (1) determining whether or not a medical treatment is required is highly fact specific, particularly in the context of whether blood transfusions are required; (2) granting a rolling order would run the risk of privileging medical paternalism over judicial protection; (3) there was a risk in a case such as X's of discrimination and religious stereotyping, based on the erroneous assumption that blood transfusions are always necessary whenever recommended by a clinician and that a patient who is a Jehovah's Witnesses is always wrong to refuse such a procedure; and (4) X had not yet had the opportunity to test the medical evidence rigorously, which would be a pre-requisite if there was to be a rolling order lasting two years.

Taken in the round, Sir James agreed that there should be no rolling order.

Comment

This case is a helpful restatement of principles, and a firm indication that if the law in relation to 16 and 17 year olds is to change that is a matter for parliament.

The clarification made by Sir James as to the nature of s. 8 ("*for the purposes of section 8 we are concerned only with legal capacity; the effect of the statute, in relation to its specific subject matter (medical treatment) is, as it were, to reduce the age of majority from 18 to 16 – that, and no more. Section 8 is not concerned with and does not operate so as to deem the child to have mental capacity*" is welcome. Similarly, the observation at paragraph 139 that "*many attempts have been made to demonstrate that purely common law rules, found only in a mass of case law, fall foul' of the ECHR requirement of being 'prescribed by law*" but "*I am not aware of any that have succeeded*" is a helpful reminder, and not only in this area of the law.

More controversial is the open question as to how Article 5 operates in cases of this nature. As Sir James recognized, the application of the *Ferreira* carve out is potentially problematic: a Gillick competent child objecting to treatment is not in the same situation as the patient in *Ferreira.* The child is not incapable of giving

consent: the issue is rather that they are not consenting. Although not requiring determination on the facts of this case, it is readily foreseeable that the issue may arise in the future: it is much less clear what the answer is.

Likewise, the 'pragmatic' approach adopted to the relationship between competence/capacity in children over the age of 16 – while making for a clear approach for practitioners to adopt – seems likely to attract further academic commentary, whether or not savouring "*of the Thomist schoolmen*" (at [71]).

Having determined that the court has the power to make a 'rolling' order but (rightly, given the facts of the case) deciding it was inappropriate to do so, the judgment also leaves open the question of when if ever such an order *will* be appropriate.

More than just anecdata about the MCA/MHA interface

For years, the debate about the interface between the MHA and the MCA (as to which, see further Alex's shedinar here) and where it should be drawn in future has been bedevilled by the lack of actual data about how it works in practice, and how practitioners (of different backgrounds) understand it. The King's Fund, in a really important piece of research commissioned by the DHSC, has published a report: Understanding clinical decision-making at the interface of the Mental Health Act (1983) and the Mental Capacity Act (2005): drawing upon survey and qualitative interviews, the research captured data from more than 600 health professionals, including approved mental health professionals, section 12 doctors, approved clinicians, and best interests assessors among others. A blog by the report's author – a Tale of Two Acts – can be found here, and the underlying report here.

Personal examination and the MHA – implications for practice under the MCA

NHSE and the DHSC had published guidance in November 2020 which had indicated that they considered that the provisions of the MHA allowed for video assessments to occur for purposes of making medical recommendations in relation to admission and for the AMHP making the application for admission. That guidance made clear that only the courts could provide a definitive interpretation of the law. It also set out the circumstances under which they considered that such assessments could take place.

In *Devon Partnership NHS Trust v SSHC* [2021] EWHC 101 (Admin), handed down on 22 January 2021, the Divisional Court has held that "the phrases "personally seen" in s. 11(5) and "personally examined" in s. 12(1) require the physical attendance of the person in question on the patient."

It does not appear that either the Trust or the DHSC intend to appeal. Even if the DHSC does appeal, then as the court did not 'stay' its judgment, organisations should not proceed on the basis that there is any doubt as to the position – it would only be if an appeal court overturned the judgment and gave a different interpretation of the law that the position would change.

We set out below some answers to FAQs that arise in consequence.

What should happen now?

No further remote assessments should be carried out, either by doctors making medical recommendations (s.12(1)) or the AMHP making the application for admission (s.11(5)).

The NHSE/DHSC guidance has now been amended to remove the relevant section – it can be found here.

Although s.20 (providing for renewal) uses the term "examine," rather "personally examine," it is not entirely easy to see any basis upon which to differentiate the position,[2] so it is suggested that renewals henceforth should be done on the basis of personal examination. It may, in some cases, be necessary if the responsible clinician is shielding (as many are in different Trusts) for the position of responsible clinician to be transferred to someone able to carry out this function.

The language of s.23 (discharge) does not include these terms, so it is suggested that there is nothing to prevent the responsible clinician (or the hospital managers) discharging a patient on the basis of remote consideration of the position, so long as they can properly be satisfied that the person no longer meets the criteria for detention.

What about people who have been detained on the basis of remote assessments?

The judgment does not address this, but the logical implication of this is that the applications cannot properly have been made, such that fresh applications will have to be made in order lawfully to continue the detention if it is considered to required.

The same also applies where the detention was brought upon on the basis of an 'in person' examination but then renewed remotely.

The judgment does not address the position in relation to whether claims for unlawful detention can be made in relation to patients who were detained on the basis of remote assessments, but it is important to note that even if a detention is unlawful because the correct procedure was not followed, this does not mean that the person will automatically be entitled to more than so-called nominal damages (i.e. £1). If it can be shown that, at all times, they met the substantive criteria for detention, then it is very likely that they will not be able to show that they suffered any loss, required to establish a claim for substantive damages (see *Bostridge v Oxleas NHS Foundation Trust* [2015] EWCA Civ 79).

What about CTOs?

Section 17A does not provide that there be personal examination (by either the RC or the AMHP), so there is nothing to stop the decision to put the person on a CTO being undertaken following remote consideration of the position if both the RC and the AMHP can be satisfied that the criteria are met.

One major area of potential difficulty is in relation to renewal; as set out above, it is not immediately obvious that it is possible to differentiate between "personal examination" (the language used for admission) and "examination" (the

[2] Although see here for an argument that it may be possible to make the argument that renewals can be treated differently.

language used for renewal), and this applies equally to those who are on CTOs. This suggests that remote renewals cannot be used for CTOs and that CTOs which have at any stage seen the underlying detention renewed remotely cannot continue in force. The resulting audit that is no doubt taking place in many Trusts to identify which of their patients may be on these CTOs (and whom, in consequence, might have to be subject to fresh admission applications) may serve as an – inadvertent – natural experiment in identifying which patients are on 'legacy' CTOs are which really do require the framework of these instruments. That challenge had been levelled by the Independent Review of the MHA 1983, but the White Paper presumably did not expect that this challenge was to be brought to a head quite so abruptly.

It should be noted that the consequences in terms of liability where anyone has been on a CTO which has been the basis of a remote renewal are – or should be – different to the position where they have been detained. A CTO cannot be used to create a circumstance of deprivation of liberty (see *PJ*), so the challenge would be to the interference with the Article 8 rights of the patient.

Does the judgment have any implications in relation to Second Opinion Appointed Doctors?

Not directly, because the requirements in relation to SOADs in Parts 4 and 4A do not include the same statutory requirements for personal examination that the court was considering in the *Devon* case. The CQC's procedure for remote working in relation to SOADs (20 March 2020) remains in force. The judgment, though, does serve as a reminder that the protections contained within the MHA are there for a reason, and deviations forced upon practitioners by the pandemic should always be justified.

Does the judgment have any implications for DoLS?

Not directly. The MCA does not have any statutory requirement for face to face assessment for any part of DoLS. That having been said, the judgment serves as a reminder of the importance of procedural protections relating to deprivation of liberty. In this context, the DHSC's Emergency MCA/DoLS guidance reminds practitioners that face to face to visits are an important part of the DoLS framework and "can occur if needed, for example to meet the person's specific communication needs, in urgent cases or if there are concerns about the person's human rights." However, the guidance also makes clear that "[d]ecisions around visiting are operational decisions and ultimately for the providers and managers of individual care homes and hospitals to make. DoLS professionals should work closely with hospitals and care homes to decide if visiting in person is appropriate, and how to do this safely. Visiting professionals should understand and respect their local visiting policies, including for individual hospitals and care homes."

What about longer term implications?

The court in the *Devon* case made clear that it was:

> *acutely aware of the difficulties to which the statutory provisions – as we have construed them – give rise for the Trust and for others exercising functions under the MHA. Nothing we have said should be taken as minimising those*

> *difficulties. Whether and how to address them will be for Parliament to decide.*

It is possible that Parliament might be asked to amend the MHA on a time-limited fashion (time-limited amendments were introduced in the Coronavirus Act 2020 in relation to other aspects of admission under the MHA, although they were never brought into force). However, it is unlikely that this would or could happen in the very short term.

It should be noted that when the DoLS regime is replaced in due course with the LPS, there will be no requirement within Schedule AA1 to the MCA 2005 for face to face assessment. We do not yet have the regulations relating to assessment, but unless they provide for face to face assessment (which, if they track DoLS, is unlikely) then the approach in relation to 'mental capacity' detention and 'mental health' detention will continue to be different.

Short note: domestic abuse and coercion and control

In *F v M* [2021] EWFC 4, Hayden J has returned to the problem of coercion and control that he had previously considered in the context of the Court of Protection in *Re LW* [2020] EWCOP 50. The case is a deeply troubling one, turning on its own facts, but of wider importance is the extent to which Hayden J identified that it was only against the checklist of possible factors pointing to coercive and controlling behaviour in the Home Office's statutory guidance published under the Serious Crime Act 2015 that it was possible to identify that apparently innocent conduct had a very different, and more sinister complexion. See paragraphs 61 to 63, and, further, the detailed extracts from the relevant police interviews at paragraphs 45-60, which illustrate "*both the insidious and manipulative nature of coercive and controlling behaviour and its impact on the victim*."

Elections and mental capacity

In *Strobye and Rosenlund v Denmark* [2021] ECHR 95, the European Court of Human Rights held, on its face perhaps rather surprisingly, that there was no breach of the right to vote enshrined in Article 3 of Protocol 1 ECHR involved in the provisions in Danish law disenfranchising the applicants because they had been deprived of their legal capacity.

The Government argued that the measure complained of had pursued the legitimate aim of ensuring that voters in general elections had the required level of mental skills. Perhaps surprisingly, the applicants agreed. The court, in turn, agreed (and noted that in its earlier decision on voting rights and disability, *Alajos Kiss*, it had taken the same view, at paragraph 38).

The applicants' situation, and the proportionality and jurisdiction of the limitation on their voting rights, had been examined by the Supreme Court in Denmark with a degree of care that the ECtHR considered militated in favour of a wide margin of appreciation.

The court further found that there was no common ground at the international or European level. Whilst it identified that Article 29 of the UNCRD required that States Parties guarantee to persons with disabilities political rights and the opportunity to enjoy them on an equal basis with others, it also noted that the Venice Commission in its Opinion no. 190/2002 on its Code of Good Practice in Electoral Matters had a more cautious approach, accepting that under certain

cumulative conditions, provision may be made for depriving individuals of their right to vote. It should perhaps be noted that the court did not address the UNCRPD Committee's decision on the complaint brought by the applicants in the *Kiss* case, in which the Committee had held that "*an exclusion of the right to vote on the basis of a perceived, or actual psychosocial or intellectual disability, including a restriction pursuant to an individualized assessment, constitutes discrimination on the basis of disability, within the meaning of article 2 of the Convention*."

The ECtHR was also clearly struck by the fact that, with each legal amendment, the issue of disenfranchisement was considered afresh:

> *119. The Court recalls, however, that with each legal amendment, including the one leading to the right to vote in European Parliament elections in 2016, the issue of disenfranchisement was carefully assessed by the legislature in its laudable effort throughout many years to limit the restrictions on the right to vote. The fact that the development obtained required thorough legal reflection and time, cannot, in the Court's view, be held against the Government to negate the justification and proportionality of the restriction at issue. The Court also takes account of the changing perspective in society, which makes it difficult to criticise that the legislation only changed gradually (see, mutatis mutandis, Petrovic v. Austria, 27 March 1998, § 4, Reports of Judgments and Decisions 1998-II).*
>
> *120. The Court is therefore satisfied that the above elements significantly differed from the situation in Alajos Kiss (cited above, § 41), where the Court observed that there was no evidence that the legislature had ever sought to weigh the competing interests or to assess the proportionality of the restriction in question.*

The court therefore dismissed the application. Although it did not address the *Kiss* complaint to the UNCRPD Committee, it is inconceivable that it was not aware of it (and the Committee's observations on Denmark's compliance with the UNCRPD were in line with the decision). The ECtHR therefore clearly remains still to be convinced by the position adopted on fundamental issues by the CRPD Committee.

The position in the United Kingdom, it should be noted, is nuanced. There is no explicit prohibition on voting based upon mental incapacity (or a status such as mental disorder), s.73 Electoral Administration Act 2006 explicitly having abolished "[a]*ny rule of the common law which provides that a person is subject to a legal incapacity to vote by reason of his mental state*," but as Lucy Series explains in this blog, inadvertent barriers are placed in the way of individuals with cognitive impairments through requirements relating to registration.

BIHR resources for professionals

The fantastic British Institute of Human Rights has continued to add to its suite of free resources for service providers who want to understand what human rights-based practice actually means. Their resources include

- Mental Health, Mental Capacity and Human Rights: A practitioner's guide
- Learning Disability and Human Rights: A practitioner's guide

- Mental Health Early Intervention and Human Rights: A practitioner's guide
- Hospital Discharge and Human Rights: A practitioner's guide
- Rehabilitation and Human Rights: A practitioner's guide
- Mental Health Care for Children and Young People and Human Rights: A practitioner's guide
- Mental Health Accommodation and Human Rights: A practitioner's guide
- Social Care Intervention and Human Rights: A practitioner's guide
- Dementia and Human Rights: A practitioner's guide
- Nursing and Human Rights: A Practitioners' Guide
- Midwifery and Human Rights: A Practitioners' Guide
- End of Life Care and Human Rights: A Practitioners' Guide

The EU, independent living and the CRPD

In 2019, the European Network on Independent Living – ENIL and the Validity Foundation submitted two separate complaints against the Managing Authorities in Romania and Estonia, for using European Structural and Investment Funds (ESI Funds) to build new institutions for persons with disabilities. The two complaints can be found on Validity's website, along with the response from the European Commission provided in December 2020, finding that Member States are not violating EU law if they use ESI Funds to invest in new institutions. The Commission's response (to the Romanian complaint, identical here to that in the Estonian complaint) addressing the UNCRPD Committee's General Comment 5 (on living independently and being included in the community), makes clear the Commission's position that "[c]*omments adopted by that body do carry policy weight and should be taken into account when it comes to the implementation of the UNCRPD. However, General Comment No 5 does not create legal obligations for the State parties under the UNCRPD.*"

The Commission made clear that it does not consider that the size of a facility is key for assessing if it is a long-stay residential facility preventing the personal choice and autonomy or a community based care housing that is providing for independent living. Rather, "*focus should rather be put on assessing the existence of an institutional character and the lack of independent living in a residential setting.*"

ENIL and Validity have made clear that intend to seek to take this matter further, on the basis that they consider that it seriously undermines the prospect of full implementation of the CRPD within the European Union.

Research corner: the MCA and the translation gap

In England and Wales, the concept of mental capacity is codified in the Mental Capacity Act 2005 (MCA). Central to this concept is the functional test – whether the person can understand, retain, use and weigh information relevant to the decision, and communicate the decision that they have made. But what does it actually mean to 'understand' information, or

to 'use or weigh' information? The MCA does not contain any amplification of these phrases. While they carry legal meaning, these terms may not mean the same to all those who seek to apply them in health or social care practice.

Equally importantly, not all of the phenomena that professionals encounter in practice will fall cleanly under terms within the MCA functional test. Consider, for example, a person who declines to accept that they have an illness, or a person who seems not to care that the consequences of that illness could be very serious for them. This problem is well-identified in relation to the clinical concept of insight (and specifically 'red-flagged' as a concern in the 2018 NICE guidance on decision-making and mental capacity – see paragraph 14.24) but applies equally to many other phenomena.

As part of the Wellcome-funded Mental Health and Justice project, we wanted to start to bridge this translation gap. To do so, we turned in the first instance to the rich resource of Court of Protection (and relevant Court of Appeal) judgments, containing as they do both extensive extracts of evidence given by professionals (often, but not exclusively, psychiatrists) and the interrogation of that evidence by judges. In a paper published on 5 February 2021 in PLOS ONE, we analysed all available judgments where the terms of the MCA were applied in a way which went beyond merely repeating the words of the statute. Using this analysis, we developed a set of what we have called 'capacity rationales,' explanations given by the judge or expert witness for why a person did or did not have capacity to make the relevant decision. This typology has nine categories; (1) to grasp information or concepts; (2) to imagine/ abstract; (3) to remember; (4) to appreciate; (5) to value/ care; (6) to think through the decision non-impulsively; (7) to reason; (8) to give coherent reasons; and (9) to express a stable preference.

In our paper, we explain in detail how we developed these rationales from the text of the judgments, how different rationales appeared to be linked to particular impairments of mind or brain, and how we might begin to use these rationales to develop a more transparent and accountable way of applying the legal test of mental capacity to the phenomena encountered in practice. This task will require some care, not least because one of our findings was that MCA terms such as 'use or weigh' are often used in different ways. But allowing identification of a set of capacity building blocks, with a clear foundation in Court of Protection judgments, means that, at a minimum, we can start the conversation about what an inability to use and weigh might mean at a more gritty level. It also means that we can start to interrogate whether any of the rationales that emerge from our study are 'edgier' than others, such that reliance upon them for capacity determinations either inside or outside the courtroom should draw more scrutiny. Last but by no means least, we suggest that outlining these rationales will enable us to offer more specific and targeted decision-making support, to better meet our obligation under s.1(3) MCA 2005.

For the full paper, see here, and for a discussion between lead author, Dr Nuala Kane, and Alex Ruck Keene, see here.

Written by Dr Nuala Kane and Alex

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Alex is recommended as a 'star junior' in Chambers & Partners 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, including as Visiting Professor at King's College London, and created the website www.mentalcapacitylawandpolicy.org.uk. To view full CV click here.

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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), and a contributor to Heywood and Massey Court of Protection Practice (Sweet and Maxwell). To view full CV click here.

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Neil has particular interests in ECHR/CRPD human rights, mental health and incapacity law and mainly practises in the Court of Protection and Upper Tribunal. Also a Senior Lecturer at Manchester University and Clinical Lead of its Legal Advice Centre, he teaches students in these fields, and trains health, social care and legal professionals. When time permits, Neil publishes in academic books and journals and created the website www.lpslaw.co.uk. To view full CV click here.

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Annabel has experience in a wide range of issues before the Court of Protection, including medical treatment, deprivation of liberty, residence, care contact, welfare, property and financial affairs, and has particular expertise in complex cross-border jurisdiction matters. She is a contributing editor to 'Court of Protection Practice' and an editor of the Court of Protection Law Reports. To view full CV click here.

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Nicola appears regularly in the Court of Protection in health and welfare matters. She is frequently instructed by the Official Solicitor as well as by local authorities, CCGs and care homes. She is a contributor to the 5th edition of the *Assessment of Mental Capacity: A Practical Guide for Doctors and Lawyers* (BMA/Law Society 2019). To view full CV click here.

Katie Scott: katie.scott@39essex.com

Katie advises and represents clients in all things health related, from personal injury and clinical negligence, to community care, mental health and healthcare regulation. The main focus of her practice however is in the Court of Protection where she has a particular interest in the health and welfare of incapacitated adults. She is also a qualified mediator, mediating legal and community disputes. To view full CV click here.

Rachel Sullivan: rachel.sullivan@39essex.com

Rachel has a broad public law and Court of Protection practice, with a particular interest in the fields of health and human rights law. She appears regularly in the Court of Protection and is instructed by the Official Solicitor, NHS bodies, local authorities and families. To view full CV click here.

Stephanie David: stephanie.david@39essex.com

Steph regularly appears in the Court of Protection in health and welfare matters. She has acted for individual family members, the Official Solicitor, Clinical Commissioning Groups and local authorities. She has a broad practice in public and private law, with a particular interest in health and human rights issues. She appeared in the Supreme Court in *PJ v Welsh Ministers* [2019] 2 WLR 82 as to whether the power to impose conditions on a CTO can include a deprivation of liberty. 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 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.

Jill Stavert: j.stavert@napier.ac.uk

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

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

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

Advertising conferences and training events

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

Our next edition will be out in March. 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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