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MENTAL CAPACITY REPORT:
HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

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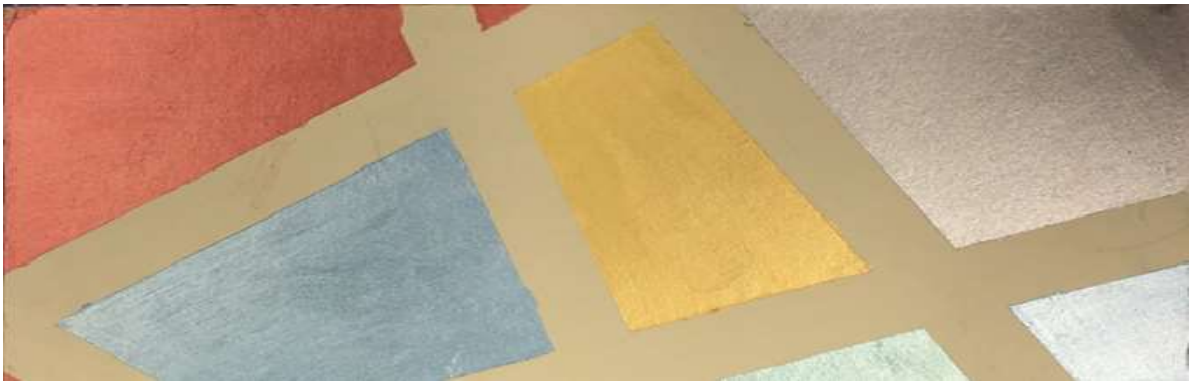

Welcome to the January 2021 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: vaccination; life-sustaining treatment decisions and the limits of the court processes; capacity and unusual sexual practices and what does Article 8 ECHR add to best interests?;

(2) In the Property and Affairs Report: removing attorneys and Child Trust Funds in the context of those with impaired decision-making capacity;

(3) In the Practice and Procedure Report: party status and restricting the provision of information; a rare judgment on transparency, and the police and the Court of Protection;

(4) In the Wider Context Report: DNACPR decision-making under scrutiny, safeguarding and the MCA – SARs under scrutiny; and important decisions relating to different aspects of childhood;

(5) In the Scotland Report: the interim review of the Scott Mental Health Law Review under scrutiny and recent developments from Scottish Government.

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.

Contents

DHSC Emergency MCA/DoLS guidance and vaccination

Although the latest iteration of the guidance does not address the January 2021 English lockdown (which Alex has covered here), it does cover vaccination. We have also published a guidance note (into its second update), available here. We note also, very briefly, the decision of MacDonald J in *M v H (Private Law Vaccination)* [2020] EWFC 93 concerning a dispute between parents as to the administration of each of the vaccines on the NHS vaccination schedule, in which he noted (at paragraph 4):

> *very difficult to foresee a situation in which a vaccination against COVID-19 approved for use in children would not be endorsed by the court as being in a child's best interests, absent peer-reviewed research evidence indicating significant concern for the efficacy and/or safety of one or more of the COVID-19 vaccines or a well evidenced contraindication specific to that subject child. However, given a degree of uncertainty that remains as to the precise position of children with respect to one or more of the COVID-19 vaccines consequent upon the dispute in this case having arisen at a point very early in the COVID-19 vaccination programme, I am satisfied it would be premature to determine the dispute that has arisen in this case regarding that vaccine.*

Treatment withdrawal – exploring the limits of the courts

Z v University Hospitals Plymouth NHS Trust & Ors [2020] EWCOP 69; *B v University Hospitals Plymouth NHS Trust & Anor* [2020] EWCA Civ 1772; *University Hospitals Plymouth NHS Trust v RS & Anor* [2020] EWCOP 70; *Z v University Hospitals Plymouth NHS Trust (No 2)* [2021] EWCA Civ 22

Best interests – medical treatment

On 6 November 2020, a middle-aged man referred to as RS suffered a heart attack and was

without oxygen for at least 45 minutes. He was taken to hospital and, sadly but unsurprisingly, was found to have sustained severe hypoxic brain damage. The prognosis was bleak – at best progress to being in a minimally conscious state at the lower end of the spectrum. The treating doctors determined that it was in his best interests for treatment to be withdrawn, and his wife agreed. RS came from a Polish Catholic family and members of his wider family still lived in Poland. He had not had much contact with his wider family, even those members who lived in England, but they were of the view that treatment should not be withdrawn. Cohen J heard the case, including an opinion from an independent expert instructed by the Official Solicitor, and decided that it was not in RS's best interests for treatment to be continued. He rejected the view that as RS was Catholic he would inevitably have wanted treatment to continue, and accepted the evidence of RS's wife, finding that he would not have wanted to be kept alive in a state which provided him with no capacity to obtain any pleasure and which was so upsetting to his wife and children. RS's wife understandably found giving evidence and being cross-examined very traumatic, and so her evidence was truncated. She later sent a letter to the judge with further information which she did not want to be shared with the wider family.

RS's wider family sought permission to appeal on the basis that the court failed to make sufficient enquiry into what RS's views would have been. In particular, the views of the Catholic Church should have been explored, and more time should have been spent on resolving the tension between RS's religious views and the view that he would not want further treatment. Further, the family submitted that the Judge breached natural justice and Art. 6 ECHR by prohibiting cross-examination of RS's wife on the grounds that she was distressed and/or by permitting her to communicate additional evidence by a confidential letter to the Judge which was not disclosed to the parties.

Permission to appeal was refused ([2020] EWCA Civ 1772). The Court of Appeal held that wider family had been represented by leading counsel at the hearing and no issue had been taken about various matters raised on appeal. There was nothing that could usefully have been achieved by postponing a decision. While it would have been better if the judge had made it clear that any further communication would probably need to be shown to ally parties, and had afterwards expressly confirmed that he would place no weight on any matter not disclosed, it was already known that RS had made choices in his personal life that were not in complete harmony with his religious obligations, so the letter could not plausibly be said to have played a part in the decision.

Treatment had been withdrawn following the first instance decision and restarted when the Court of Appeal application was lodged. Following the Court of Appeal's decision it was withdrawn, but again restarted when the family and the Polish Government submitted an application for interim relief to the European Court of Human Rights. While that application was pending, the family brought the matter back before Cohen J and sought permission to rely on expert evidence which they said showed that RS's diagnosis was better than had been thought and that he was already in a minimally conscious state.

Cohen rejected their application in forceful terms

[2020] EWCOP 70. The evidence had been obtained in an '*underhand way'* that was '*arguably unlawful and in breach of the rights of both RS and the Trust'.* The expert, who was a priest and neurologist, had prepared a report despite not having read the medical records, not having seen the reports of other doctors prepared for the proceedings, not having spoken to any member of the treating team, and not having read any of the court judgments. He had not kept notes of any of his conversations about the case, and was not a '*satisfactory witness'* .

Following the second hearing before Cohen J, the ECtHR rejected the applications before it as inadmissible. Treatment was withdrawn for a third time. A further, substantive, application was made by the birth family to the ECtHR, being ruled inadmissible a week late; on the same date a second application for interim relief was made by the birth family. A stay of the order of Cohen J therefore expired, and CANH was withdrawn. Three days later an out of hours application was made to the Court of Appeal for a further appeal on the basis that there had been a change in medical opinion. A stay was granted overnight and two judges of the Court of Appeal heard the case, dismissing the application for permission to appeal.

King LJ and Peter Jackson LJ had little hesitation in dismissing the appeal. They both noted the concern of the effect of the proceedings upon RS's care and treatment – four weeks after it had been found that continuation of CANH was not in RS's best interests, it had had to be reinstated three times. As King LJ noted, the order made by Cohen J on 15 December had provided that:

> *All care and palliative treatment given shall be provided in such a way as to ensure that, as far as practicable, the First Respondent retains the greatest dignity and suffers the least discomfort until such time as his life comes to an end.*

However, she continued:

> *It is difficult to imagine a greater assault upon the dignity of this man, who was until a matter of weeks ago a fit and healthy family man, to have had CANH withdrawn and reinstated on three separate occasions. Each reinstatement has required invasive treatment and the most recent one took place at a time when he was perceived by the medical team to be close to death, a situation that was seen by the birth family to justify an application for a stay in the middle of the night without notice to the Trust or the Official Solicitor.*

The court was also very concerned at the distress caused to RS's wife and children by the sequence of events.

King LJ made clear that the court will, if appropriate, review an earlier best interests determination: As Francis J put it *in Great Ormond Street Hospital v Yates (No 2)*, [2017] 4 WLR 131 at para.11, such a reconsideration will be undertaken *"on the grounds of compelling new evidence*" but not on "*partially informed or ill-informed opinion*." King LJ considered that the nature of the evidence that the birth family had sought to rely upon was to be characterised as being partially- or ill-informed.

One particular point of wider importance is the Court of Appeal's rejection of the argument that it was incompatible with Article 2 ECHR to withdraw food and fluids from a person capable,

or possibly capable, of feeling pain and of suffering. Peter Jackson LJ held that:

> *The welfare principle applies to all decisions, whatever the diagnosis. Mr Bogle founded his submission that it is incompatible with Article 2 ECHR to withdraw food and fluids from a person capable of feeling pain and of suffering with reference to statements from Airedale NHS Trust v Bland [1993] AC 789, which of course concerned a person in a vegetative state. However, there is no lack of well-established domestic authority to the effect that CANH can be lawfully withdrawn from persons who are not in a vegetative state* [which he then cited]

Peter Jackson LJ also held that Cohen J had been "*plainly entitled*" to reach the conclusion that it was not in RS's interests to be transferred to Poland, not least in circumstances where (contrary to the submission advanced by the birth family) his wife and children were against the move. As Peter Jackson LJ noted, their approach suggested that they had lost track of the fact for 17 years RS's real life had not been with them but with his own family in the UK.

With reluctance, the Court of Appeal granted a very short stay whilst the birth family made a further application to the ECtHR. The ECtHR dismissed that application as inadmissible, and the stay on the original order of Cohen J has therefore expired. We also understand that an application has been made by a Polish legal foundation to the Committee on the Rights of Persons with Disabilities for it to make a request for the UK to take interim measures to prevent the withdrawal of treatment pending consideration of its complaint under the Optional Protocol. A similar application was made in the case of the French national, Vincent Lambert; the CRPD made such a request, which received a very dusty reaction from the French courts. We anticipate that a similar reaction may well be given to any such request here (if, indeed, any is made).

Comment

While disputes about withdrawal of treatment between family members are fortunately rare, they are particularly distressing. Since RS's heart attack, his immediate family have had to come to terms with his brain injury, bring themselves to agree that treatment should be withdrawn, prepare for his death after treatment was withdrawn, more than once, and be taken through repeated court processes. All this in circumstances where the court has followed the caselaw and the requirements of the MCA 2005 and – critically – established that RS himself would not have wanted treatment to be continued. It is also difficult, we suggest, to escape the feeling that in this case RS's case has been taken up by those who wish to advance a cause as opposed to thinking about (from a domestic perspective) his best interests, or (from a CRPD perspective) the best interpretation of his will and preferences.

The case serves as a sad reminder of the importance of writing down your wishes in advance or appointing a lasting power of attorney. It also serves to remind why there are rules about the admission of expert evidence and obtaining the court's permission for it in advance.

Unusual sexual practices and capacity

AA (Court of Protection: Capacity to Consent to

Sexual Practices) [2020] EWCOP 66 (Keehan J)

Mental capacity – sexual relations

Summary[1]

This case concerned AA, a 19 year old man, who had been diagnosed as having autism and Asperger's Syndrome. He had interests relating to certain sexual practices including autoerotic asphyxiation ('AEA'). He had posted material about himself on the dark web, advertising his wish to be a submissive partner and his desire to be kidnapped and raped. Having been the subject of a care order prior to his majority, he was now the subject of an application before the Court of Protection for (in effect) an adult care order. He was subject to (or in receipt of) 24/7 support at his supported living placement, giving rise to a deprivation of his liberty.

Keehan J had to consider (1) AA's capacity to conduct proceedings and make decisions regarding AEA, internet and social media, consent to sexual relations and contact with others; (2) AA's best interests in those domains where he lacked capacity to decide; and (3) whether he should authorise AA's deprivation of liberty.

An expert psychologist, Dr Burchess, considered that AA had capacity in all material domains, and that AEA should be addressed as a specific decision in a domain different to engagement in sexual relations. An expert psychiatrist, Dr Ince, was instructed to report on AA's capacity to make decisions regarding AEA and to make decisions about the use of the internet and social media in the context of his contact with others whom he meets online.

The two experts agreed that the information relevant to making decisions regarding AED included: (1) the concept of AEA; (2) the manner in which AA engaged in AEA; (3) the range of risks and harm associated with the practice of AEA and their likelihood; and (iv) knowledge and use of safety strategies and their effectiveness (recognising that AEA is an inherently dangerous practice and potentially life threatening). Dr Burgess also included knowledge and experience of other strategies for obtaining sexual gratification. Dr Ince agreed but considered this was more complicated for AA because of issues relating to his diagnosis of ASD which were currently unassessed.

Dr Ince considered that AA lacked capacity to make decisions regarding AEA because (1) he had no knowledge of the risk of partial hypoxia and acquired brain injury;(2) he was unable to cross-transfer skills and knowledge because of his autism; (3) although he had a basic understanding of the risks in relation to plastic bags, he cannot transfer this knowledge to other similar mechanisms; and (4) AA could not retain information related to specific breathing techniques and similar information provided to him with the educative work undertaken with him.

In relation to the use of internet and social media, Dr Ince considered that, whilst AA was able to understand and retain the relevant information, he was unable to weigh this information and could not transfer the information from one specific scenario to another. Of particular

[1] Note, Neil having been involved in the case, he has not contributed to this summary.

relevance, Dr Ince identified that "[AA] *demonstrates knowledge for scenarios upon which he has been taught, but cannot transfer these to current or future scenarios – [AA], as a consequence of his ASD is, through necessity, an experiential learner, however in this area, such actions may cause him and others significant harm*."

In the course of his oral evidence, Dr Ince noted that AA had not undergone a sensory profile assessment. As Keehan J noted at paragraph 24

> *He considered this was a crucial assessment which would enable a much clearer understanding of the impact of ASD on AA's life and his capacity to make decisions: it was key to his whole life. A particular focus in Dr Ince's evidence was whether AA's engagement in AEA was a feature of his ASD or a personal preference to achieve sexual gratification. In the absence of a sensory profile, Dr Ince tended to the view that it was a manifestation of his ASD and, in any event, his inability to weigh the relevant information regarding AEA and his inability to cross-transfer skills and knowledge resulted from his ASD.*

In light of Dr Ince's conclusions followed that AA would lack capacity to have contact with others online, at least, in respect of his sexual interests.

Dr Burchess did not change his opinion in light of Dr Ince's evidence, but agreed that a sensory profile assessment was important.

In light of the evidence of Dr Burchess, there was agreement between the local authority and the Official Solicitor, and Keehan J agreed, that AA now had capacity to conduct the proceedings, and to make decisions about his residence, care and to have sexual relations. The issues in dispute were therefore whether AA had capacity to make decisions about his engagement in AEA and in relation to his contact with people he meets online.

Keehan J accepted that the issues in question "*engage*[d] *the most private and personal of AA's Article 8 rights and that the State should be very slow and cautious to interfere with the same"* (paragraph 45), and that:

> *46. Capacitous individuals engage in AEA notwithstanding that it is an inherently dangerous practice which carries a very real risk of acquired brain damage or unintentional death. Many capacitous individuals engage in contact with strangers on the internet or on social media which puts, or may put them, at risk of physical, sexual, emotional or psychological harm. They are entitled to make an unwise decision.*

Keehan J also accepted that he "*must not adopt an approach based on a moral judgment about AEA or on contacting strangers on the internet or social media. Nor must I adopt a protective stance towards a person when determining whether they have capacity to make a decision to engage in AEA notwithstanding that they are very likely to make an unwise or risky decision*" (paragraph 47).

Keehan J accepted that the relevant information for AA to make a decision in respect of AEA was as set out above. He noted that he had considered whether the impact on others (e.g. close family members) in the case of acquired brain injury or death as a result of engaging in AEA is a relevant factor. However, "*I have concluded it is not. I accept it would set the bar too*

high in comparison to capacitous adults who engage in the practice of AEA" (paragraph 49).

At paragraph 50, Keehan J accepted Dr Ince's evidence and conclusions that, on the current evidence, there was reason to believe that AA's engagement was a manifestation of his ASD and that he was unable to weigh information about the practice or cross-transfer information because of his ASD. He noted, and was particularly concerned by, Dr Ince's opinion that (1) AA potentially has a high threshold to sensory stimulus and thus may require a higher level of stimulus to achieve the same outcome; and (2) AA's 'addiction' and intrinsic compulsion to engage in AEA, and other restrictive and circumscribed interests, are likely to render it difficult to change his behaviour. This meant, Keehan J identified, that "in my judgment AA is at high risk of being unable to regulate his engagement with AEA and therefore at greater risk of serious harm or death" (paragraph 51).

Keehan J also preferred and accepted the evidence of Dr Ince that AA does not have capacity in relation to contact with those people he meets online because of his ASD and because of his inability to weigh information and to cross-transfer information (paragraph 52). He noted that the issue of whether AA had capacity to consent to support when engaged in AEA was a difficult one upon which neither expert felt able to offer an opinion; he therefore proposed to 'park' it and return to it at a later stage if clear and cogent evidence is available to enable me him determine this issue.

On its face oddly, but no doubt representing the fact that Keehan J was intending to return to the issue, the declaration relating to AA's capacity to make decisions about AEA and contact with others he may meet online was made on an interim (s.48) basis, rather than a final (s.15) basis. However, he declined to make any best interests decision in relation to his engagement in it (both parties, for different reasons, having submitted that none fell to be made) "*because it would be contrary to s.27(1)(b)* [which prevents the court consenting to sexual relations] *or, at least, the philosophy of this provision for the court to make a decision in respect of AEA on AA's behalf*" (paragraph 55).

Keehan J agreed that a care plan in relation to contact should be drafted for the court's approval which developed a best interests framework which (1) enabled the professionals and the court to be better informed about the impact of AA's ASD on his life and his functioning; (2) enabled the professionals and the court to better understand how AA could be supported to gain capacity to make decisions about these two issues; and (3) permitted AA sufficient autonomy of decision making and respected his right to a private life whilst balancing the need to protect him from harm.

Unsurprisingly in light of the evidence received, Keehan J held that it was "crucial" that a sensory assessment of AA was undertaken as soon as possible, and that, with the benefit of that plan, the local authority provided him with an education programme to enable him to understand alternative means of obtaining sexual gratification other than by engaging in AEA and enable him to contact others online safely and securely or, at least, to be able to weigh and understand the risks at which he places himself by this activity. He also considered it was essential therapy was made available to AA to AA to deal with his past

experiences and to explore how his ASD had an impact on his day-to-day life. Perhaps optimistically, Keehan J considered that he had "*no doubt that AA will readily engage with this therapeutic process*" (paragraph 61).

Keehan J concluded at paragraph 61 by holding that:

> *AA is subject to very invasive restrictions. At the moment they are necessary to protect him and to ensure his life is not unnecessarily endangered. I would hope that the local authority and the care provider will give anxious consideration to the degree, if at all, to which some of the restrictions may be reduced, pending the outcome of the assessments, education and therapy referred to above. Such reductions if safely achievable will recognise AA's right to a private life and will increase his autonomy.*

It appears from this concluding observation that Keehan J may have authorised the deprivation of liberty, although quite how he could have done in light of the finding that AA had capacity to make decisions about his residence and care arrangements is not immediately obvious. It is to be hoped that any further judgment might shed light upon this.

Comment

This case clearly troubled both the experts and the court, and rightly. It is a paradigm example of how complex an exercise respecting rights, will and preferences (to use the language of Article 12 CRPD is). Some may feel it plain wrong that the state was even intruding into such a private area for AA. Others may feel that the state is under a positive obligation to do so – not just by reference to Article 2 ECHR but also by reference to Article 10 CRPD (as to the rather underdeveloped commentary on this positive obligation, see here).

Whatever one feels about the decision reached in this case, it is perhaps significant to note the expressly provisional basis upon which Keehan J did so and the clearly identified steps that he set out to enable him to reconsider the balance in due course. Such might be thought to recognise the balance between humility and confidence identified as so important by Sir Mark Hedley in his observations about the judicial process.

More broadly, the situation where a person is an "experiential learner" is one that poses real and important challenges to the operation of the MCA 2005, and, in particular, for situations where the very experience in question (as here) is potentially dangerous.

Finally, it may be thought that Keehan J was wise not to pin his colours to the legal mast as regards the question of the operation of s.27(2)(b) MCA 2005. Not just because it was clear that everyone accepted that AEA is conceptually different for capacity purposes to sexual relations, it is far from obvious that s.27(2)(b) MCA 2005 actually covers situations where there is no other sexual partner involved. Whether its philosophy prevents best interests decisions being made in this regard may be a question to which Keehan J will have to return in the event that the work he has envisaged does not lead to a result whereby either (1) AEA gains capacity in this domain; or (2) ceases to express a wish to engage in it.

What does Article 8 add to best interests?

Re CVF [2020] EWCOP 65 (Lieven J)

Deputies – welfare matters

Summary

In this case, Lieven J was concerned with the capacity and best interests of a 29 year old woman, CVF, with diagnoses of diabetes, learning disability, emotionally unstable personality disorder, low self-esteem and feelings of abandonment. Her mother had made a personal personal welfare application in January 2018. The application stated that "*CVF is a vulnerable women whose capacity to consent to sex, to make decisions in respect of contact with unknown men and to make decisions in respect of her care is in dispute*" and that it "*would benefit CVF for there to be clarity in relation to her capacity and whether any best interest decisions need to be made. At present … there is a high level of police intervention and numerous safeguarding referrals due to there being no agreed position on CVF's capacity*". The local authority had, by order of the court, substituted as applicant, and the proceedings transferred to a Tier 3 (i.e. High Court) judge.

As so often, the proceedings had had a long backstory, and they had also taken a considerable number of twists and turns before their final resolution. Before Lieven J at the final hearing, questions of capacity in the relevant domains having been resolved, there were three issues, addressed in turn below.

Level of care

JF, representing herself, submitted that her daughter required 24/7 care. Lieven J observed that CVF did not wish such care, considering it to be intrusive and stopping her being independent. As Lieven J observed at paragraph 20, "[s]he wants more autonomy, and, in my view, she has a right to more autonomy." Lieven J, however, "fully appreciated," her mother's concerns:

> *20.* […] *I suspect that CVF's history of cyclical behaviour has something to do with relationships, often with boyfriends. In my assessment, JF is both a protective factor for CVF, the ultimate safety net, but also has not managed to allow CVF to gain greater independence and autonomy. This is a tension in many parent-child relationships, but it is magnified enormously in CVF's case because of her diagnosis, behaviour and the family history. It is very important to make clear that when I say 8 hours of care a day is appropriate, that does not fix that level forever and is completely subject to review and CVF's behaviour. The care plan unusually builds in a 3 month review process, due to CVF's fluctuations and also and an automatic review if CVF's relationship with J* [a former carer] *should fail, as that is clearly a risk factor. Those review provisions support a reduction of care and provide for a safety net now and in the future.*

Lieven J's reasons for holding that the reduction in care was in CVF's best interests were crisp:

> *In summary, firstly, the reduction in care accords with CVF's wishes and feelings under section 4(6) MCA 2005. Secondly, it is the least restrictive option under section 1(6) MCA 2005. Thirdly it is proportionate under Article 8 ECHR. Fourthly, it accords with CVF's best interests as in my view it is positively detrimental for CVF to have 24/7 care at the moment as all it serves to do is to make her feel undermined, triggers disruptive behaviours and reduces her*

> *motivation to become more independent and to improve functional abilities. Fifthly, to reduce the care in this way reflects the reality what CVF is currently receiving.*

She also referred to the well-known passage from the decision of Munby J in *Local Authority X v MM & Anor* [2007] EWHC 2003 (Fam) and the importance of understanding that those who lack capacity, must, to a proportionate degree, be allowed to take risks and to test out their own capabilities. It is not the function of the Court of Protection to remove all possible risk and protect the individual at the expense of a proportionate balance. As Munby J identified, "[w]*hat good is it making someone safer if it merely makes them miserable?*"

Whether the local authority should be substituted for JF as CVF's deputy for property and affairs

Lieven J had little hesitation in acceding to this position:

> *26. CVF's wishes are very clear. She does not wish for her mother to continue as her deputy. She feels that her mother is using this as a way to control her via the money. In my view, this is a very clear-cut situation because JF's role is leading to conflict between CVF and JF and is undermining the prospects of them having a better relationship. I can see no disadvantage to the Local Authority becoming property and affairs deputy and so clearing the way so that JF and CVF can try in the near future to regain a relationship. Such a change is plainly in CVF's best interests and accords with her wishes and feelings. I have no hesitation in making the order sought by the Local Authority.*

Whether JF should be appointed as CVF's personal welfare deputy

JF's application was made on the basis that she considered "*that the Local Authority and NHS Trust have failed to keep CVF safe, that they have underestimated the risks she is facing and are too amenable to accepting what she says despite the history of behavioural risks. JF feels that the Local Authority and the Trust have allowed CVF to be exploited over the last few months*" (paragraph 27).

Lieven J directed herself by reference to the decision of Hayden J in *Re Lawson, Mottram and Hopton (Appointment of Personal Welfare Deputies)* [2019] EWCOP 22, and in particular his observation that the structure of the MCA 2005 and, in particular, the factors which fall to be considered pursuant to the best interests test in s.4 may well mean that the most likely conclusion in the majority of cases will be that it is not in the best interests of P for the court to appoint a personal welfare deputy.

Lieven J agreed with the local authority that, on the facts of the case, it was not in CVF's best interests for her mother to be appointed as her personal welfare deputy:

> *31. Firstly, the application is not limited in scope and would give very wide-ranging power to JF over CVF's life. That could be remedied in an order being limited, but (secondly) CVF is strongly opposed to her mother having a deputyship order over her so such an order would be contrary to CVF's wishes and feelings. As I hope is clear from the earlier part of this judgment, although lacking capacity, CVF is very articulate and able to express her views. I therefore place a great deal of weight on her wishes and feelings and I*

would consider this to be the critical factor. That leads to the third point. Given her strong opposition to her mother having this power, it would be highly contrary to CVF's best interests for this application to be allowed. CVF has made exceptional progress over the last 9 months, largely because she has been able to exercise more independence and autonomy, in part because of lockdown, and the pandemic has forced a situation where she has had less contact with her family.

32. I do appreciate the risks, but the reality is that there has been a positive experience for CVF over the last 9 months. If I were to appoint JF as a personal welfare deputy, that would be deeply upsetting and contrary to CVF's emotional well-being. It also appears to be the case that over the last 9 months many of the things that have gone so well for CVF and enhanced her independence (travelling to Spain, work, engaging in relationships) are precisely the things her mother would think she should not allow as they are too risky. Therefore, the third reason is that such an order would be contrary to CVF's best interests. Fourthly, to grant the application would be an unnecessary and disproportionate interference in her Article 8 ECHR rights and there is no justification for such an interference on the facts of this case. CVF must be allowed to retain and develop autonomy and take risks within the safety net from the Local Authority. I therefore refuse JF's application.

Comment

Lieven J's judgments in this domain are often marked by a particular and close attention to the requirements of the ECHR alongside those of the MCA (see, for instance, *Re KR* [2019] EWHC 2498 (Fam)). This is no exception. This case shows why it is both necessary (as the Court of Appeal has previously held) and helpful to stress-test matters not just by the best interests criteria set down in s.4 MCA but the ECHR requirement to consider the necessity and proportionality of the relevant interference with the right to autonomy enshrined as an aspect of the right to respect to private life protected by Article 8(1) ECHR). Looking at matters through this prism, and in particular having close regard to the autonomy right of CVF, made clear the correct outcome of both the decisions in relation to the level of care she required and in relation to both deputyship applications.

Family care and lockdown regulations

NG v Hertfordshire County Council & Ors [2021] EWCOP 2 (Lieven J)

Best interests – contact

Summary

The (surprisingly) small body of reported cases relating to COVID-19 (representing the tip of a rather larger iceberg) has been added to in this important decision by Lieven J, concerning a 30 year old man, NG, with moderate to severe autism, mild learning disability and severe communication difficulties.

For many years, NG had had a care package arranged by his mother and step-father, funded by direct payments made by Hertfordshire County Council. At all material times, NG had lived in his own flat with carers coming there; he required 24 hour supervision and care. A dispute which started in 2017 relating to contact between NG and his step-father was resolved by

the Court of Protection in June 2018; following his judgment, a third person, HG, was appointed as deputy for health, welfare, property and affairs. On 23 March 2020, in light of the lockdown, HG suspended all contact with NG except for his carers (in circumstances where those carers had said that if family visits were to continue they would have to withdraw care as this would expose their care staff and their client to unnecessary risk). Between then and September 2020, his parents had no contact with him, and his care was provided entirely by paid carers.

A challenge to the decision was heard in June 2020, HHJ Vavrecka upholding the deputy's decision. In his judgment HHJ Vavrecka held that whilst when NG was with his step-father he was being provided with care, "*this was an arrangement for contact and has to be seen in the context of there being a care package which provided 24/7 care for NG. The Deputy quite properly in my view come to the conclusion that the parents did not need to 'provide care and assistance' given the care package (with adjustments) would ensure all of NG's care needs were met*." Further, HHJ Vavrecka held that "[i]*n looking at paragraph 6 of the Regulations, and whether NDG needs to 'provide care' within the terms of regulation 6, the factual position and the legal framework are both relevant. The decision of HG and the restrictions placed on contact by deputy and Home Instead were in my judgment appropriate and proper, and reflect a reasonable reading of the regulations and the contact order of HHJ Waller. The view that direct contact between NG and NDG is prevented by the "lockdown" rules in my judgment properly interprets the wording of the regulation as well as its spirit. I do not accept the submission that the Deputy has misinterpreted the regulations."*

The Official Solicitor appealed to Lieven J. As she identified, the principal issue turned upon the interpretation of the lockdown regulations. However, she had little hesitation in concluding that HHJ Vavrecka had been wrong to find that NG's parents were not providing care to him when they were spending time with him, the factual position being that his parents had bene providing him with a significant part of his care throughout his life, and in particular since he became an adult. She noted that there was *"so far as I am aware, no magic in the words 'shared care,' it is merely a reflection the reality of the care that is being provided*" (paragraph 43).

Turning to the exercise in statutory interpretation, Lieven J was concerned with the first lockdown restrictions (the Health Protection (Coronavirus, Restrictions) (England) Regulations 2020, but her conclusions are equally applicable to those applicable at the time her judgment was delivered (The Health Protection (Coronavirus, Restrictions) (All Tiers) (England) Regulations 2020, as amended by The Health Protection (Coronavirus, Restrictions) (No. 3) and (All Tiers) (England) (Amendment) Regulations 2021: as to which, see here). The critical wording was in relation to the definition of "reasonable excuse" for leaving home as including having "*the need* […] *to provide care or assistance, including relevant personal care within the meaning of paragraph 7(3B) of Schedule 4 to the Safeguarding of Vulnerable Groups Act 2006, to a vulnerable person, or to provide emergency assistance*" (contained, in the first Regulations, in Regulation 6; in the current Regulations in relation to Tier 4 areas – i.e. as at January 2021 – everywhere in England, in materially similar

form in paragraph 5(c) of Schedule 3A to the All Tiers Regulations).[2]

Lieven J noted that the word "need" in the Regulations varied according to the different reasonable excuse limbs, although in each case there had to be a need as opposed to simply a subjective desire. As she noted:

> *47. There can be no possible doubt that in enacting the first restrictions Regulations the Government was placing a very great emphasis on the importance of people staying at home and not mixing unnecessarily and without very good reason. However, it is equally clear that the Government intended to ensure that those who needed to leave their home to provide care or assistance to a vulnerable person should be allowed to do so. In this context it is important to have in mind that there are an enormous number of family carers providing care to persons outside their household. It is essential that care can continue to be provided throughout the course of the pandemic. The fact that it would be theoretically possible, or indeed practically possible, for that unpaid family care to be replaced by paid care does not mean that the family care is not meeting a need.*

Lieven J then put herself in the shoes of NG himself to ask what his needs were:

> *48. If one considers the need for the care from NG's perspective then, in my view, it is clear that he needs parental care as well as paid care. His physical needs can be met by 24/7 paid care, but his emotional needs and best interests are met by having a mix of family and paid care. It is wrong in my view to focus simply on the fact that his physical needs can be met by paid care. As NDG and the OS submitted, NG's best interests must be relevant to meeting his needs and those best interests include being cared for, at times, by his parents.*

By definition, she found, the fact that person is delivering care pursuant to a court order to a family member must amount to a reasonable excuse to leave the home (paragraph 49). Conscious, perhaps, that the number of situations in which this might be relevant was only the tip of a much greater iceberg, Lieven J looked at the broader issues in play in interpreting the regulation:

> *50.* […] *it is also important to have regard to article 8 ECHR and the protection of family life, subject to the justifications in article 8(2). A ban on family members being able to provide care to loved ones, in any circumstances where paid care is available, would be a very serious interference with the right to family life. That does not mean that such an interference would be incapable of justification, but it does in my view mean that a court should be very careful before reaching an interpretation which would give such precedence to paid over family care. There is nothing in the first restrictions Regulations, Guidance, or any Government document which would suggest the Government intended to prioritise paid over family care in this way or to interfere with article 8 rights in such a broad manner.*

The effect of the approach that had been taken

[2] The differences being that the definition expressly includes to provide assistance to a person with a disability, and does not make reference to emergency assistance.

below and that was being urged upon her, however, would create the effect of giving a priority to paid care:

> *51.* […] *NG's physical needs can undoubtedly be met by his paid carers, but his wider emotional and psychological need is to see and be cared for by his parents. Further, care from a loving family is not a one way street in which the focus is only on the person being cared for. Both NDG and AG plainly feel that they "need", in the sense that it is important both to them and to NG, to provide NG with care. The very nature of this bond is undermined by the somewhat mechanistic approach of considering that there is no need for the parents to provide care because someone else can be paid to do so.*

Finally, Lieven J found that her interpretation was supported by the principle against doubtful penalisation. In circumstances where breaching the requirement not to leave home without a reasonable excuse would give rise to a criminal offence, Lieven J held that "[i]*f the care had to be essential, or there was a priority given to paid over unpaid care, then the first restrictions Regulations needed to make that clear. The wording of regulation 6(2)(d) is broad and unspecific in respect to the nature of the care. It would therefore be wrong to create a criminal offence for someone providing care in the circumstances of AG and NDG*" (paragraph 52).

Comment

What is perhaps a little odd about this judgment at first reading is that it focuses so much on the lawfulness (or otherwise) of the actions of NG's parents, when NG's deputy had stopped contact on the basis of their analysis of NG's best interests (see paragraph 10). However, on the basis of the summary of the judgment of HHJ Vavrecka given by Lieven J it appears that the deputy also then took the view that such contact would give rise to criminal offences on the part of his parents. On one view, it is not obvious that the deputy could properly have taken that factor into account save and unless it could have been said not to be in NG's best interests for his parents to be subject to (potential) prosecution in leaving their home to come and have contact with him. The deputy might, perhaps, have been thinking that the option of his parents coming to see him was simply not an available option – but that does not seem to have been the reasoning that they employed, although there is a hint in paragraph 10 of the judgment that they had in mind something rather different, namely that, if the parents came to see NG, the care provider would withdraw care.

Be all that as it may, the fact that HHJ Vavrecka then founded himself (in part) upon the fact that direct contact was prevented by the lockdown rules mean that Lieven J had to ask herself the question of whether this conclusion was in fact correct.

Lieven J's interpretation of the relevant provisions in the lockdown regulations is clearly correct, although it is equally important to emphasise her observations at paragraph 47 as to the underlying purpose of the regulations (a purpose equally, if not more, relevant in January 2021 than it was in relation to those in play in March 2020).

Although Lieven J only touches upon this in passing, her interpretation is also then relevant to the other side of the coin in both the first lockdown regulations and the January 2021

iteration – i.e. the ban upon indoor gatherings subject to exceptions. If NG's parents have a reasonable excuse to be away from the place where they live to care for him, they could equally not be subject to a direction under (now) Regulation 9(3) of the All Tiers Regulations requiring them to stop gathering indoors with him to provide care to him.

On one view, all Lieven J's judgment does is to clear the decks to answer a question which was not asked on the face of the judgment – namely whether, even if it were lawful for his parents to visit, such visits would actually be in NG's best interests. Notwithstanding the obvious benefits identified by Lieven J to such visits in terms of providing NG with the emotional components of care, the care provider had previously indicated that it would withdraw care if they did so because of the risk to their staff (and to NG himself). That Lieven J did not have to grapple with the difficult consequences of this (including as to the potential obligations of the local authority) rather suggests that the care provider must have changed its stance.

Finally and more broadly, the observations made by Lieven J at paragraphs 48 and 51 about the different components of care are ones that are of much wider resonance and a welcome reminder of the importance of looking at the whole picture.

Fluctuating capacity and deprivation of liberty

A County Council v KK & Ors [2020] EWCOP 68 (Lieven J)

Article 5 – deprivation of liberty

Summary

In this case, Lieven J considered whether a "community DoL" order that had been in place in respect of an 18 year old woman ("JK") since January 2020 should be continued.

JK had been diagnosed with diabetes in 2008; and over the years had had many problems managing her diabetes and her mental health, which resulted in frequent stays in hospital. Those stays culminated in an admission to Intensive Care in January 2020, as a result of having four seizures as a result of not controlling her diabetes. HHJ Scarratt then issued an order depriving JK her of liberty at the regional hospital because she did not meet the threshold for being detained under the Mental Health Act 1983.

In April, JK had been assessed as lacking capacity to make decisions concerning her care and treatment. Over time, JK became more accepting of the restrictions in place at the hospital and she was eventually discharged to an independent placement on 5 October 2020, following a transition period. On 28 October 2020, JK was again admitted to hospital for an overnight stay as a result of high ketone levels, but otherwise she had been doing well and had managed to obtain a place on a university course.

A further assessment regarding her capacity concluded that:

1. JK had capacity to make decisions about the care and treatment of her diabetes, except when she was under considerable distress and had overwhelming emotions;
2. During those times JK was unable to weigh information about the management of her diabetes condition and during those periods she lacked capacity to manage her diabetes;

3. Developing skills to cope with her extreme emotion would help JK to develop her capacity.

In determining whether to continue the deprivation of liberty order, Lieven J had to consider three issues:

1. Whether JK lacked capacity in any material respects;
2. Whether the order now sought amounted to a deprivation of liberty within the meaning of Article 5; and,
3. Whether the order was in JK's best interests.

Given the most recent assessment, Lieven considered the authority of *DN v Wakefield MDC* [2019] EWHC 2306 (Fam), in respect of fluctuating capacity or potential future loss of capacity. She determined that when JK was upset or in a heightened state she lost the ability to weigh up relevant information and therefore *"she may prospectively lose capacity"* (para 26).

Applying the test in *Storck v Germany* (2005) 43 EHRR 6, Lieven J was far from convinced that the restrictions sought by the local authority constituted a deprivation of liberty: JK had capacity to decide where she lived, and the local authority sought only the court's authorisation to (i) transport JK to a place of safety in the event of a medical emergency (and could use reasonable force) and (ii) take steps to prevent her from leaving the hospital for the purpose of medical treatment (and could use reasonable force). Lieven J determined, however, that given the order was anticipatory in nature, rather than having the concrete facts before her, it was appropriate for her to assume that there would be a deprivation.

As to JK's best interests, Lieven J took into account JK's strongly held wishes and feelings that she did not want the deprivation of liberty to continue for two reasons: (1) she wanted her autonomy and (2) the order prevented her from pursuing her desired career with the police. She acknowledged the significant risks posed to JK, but cited Munby J in *Local Authority X v MM & Anor* [2007] EWHC 2003 (Fam) at [120] regarding the importance of understanding that those who lack capacity, must, to a proportionate degree, be allowed to take risks and to test out their own capabilities:

> *A great judge once said, "all life is an experiment," adding that "every year if not every day we have to wager our salvation upon some prophecy based upon imperfect knowledge" (see Holmes J in Abrams v United States (1919) 250 US 616 at pages 624, 630). The fact is that all life involves risk, and the young, the elderly and the vulnerable, are exposed to additional risks and to risks they are less well equipped than others to cope with. But just as wise parents resist the temptation to keep their children metaphorically wrapped up in cotton wool, so too we must avoid the temptation always to put the physical health and safety of the elderly and the vulnerable before everything else. Often it will be appropriate to do so, but not always. Physical health and safety can sometimes be bought at too high a price in happiness and emotional welfare. The emphasis must be on sensible risk appraisal, not striving to avoid all risk, whatever the price, but instead seeking a proper balance and being willing to tolerate manageable or acceptable risks as the price appropriately to be paid in order to achieve some other good – in particular to achieve the vital good of the*

> *elderly or vulnerable person's happiness. What good is it making someone safer if it merely makes them miserable?*

She determined that JK had reached a stage where she needed to be trusted to make her own decision; and that a deprivation of liberty order would cause her great stress. Lieven J therefore declined to continue the deprivation of liberty order.

Comment

The concept of fluctuating capacity can cause difficulties for many practitioners – Lieven J's reframing that concept as a "*potential future loss of capacity*" is a helpful way of thinking about it, particularly when considered alongside the often permissive (rather than definitive nature) of orders made in respect of an individual with fluctuating capacity.

Furthermore, Lieven J's observation of the distinction between the approach of the Court of Protection and that of Strasbourg to deprivation of liberty is important. The court is often faced with future restrictions on P's liberty and in the abstract a decision needs to be taken as to whether those restrictions might amount to a deprivation of liberty. That differs significantly to the position facing the Strasbourg court, which, in most cases, considers whether concrete facts do constitute a deprivation of liberty.

The judgment, though, does need to be read alongside that of Hayden J in *GSTT v R* [2020] EWCOP 4 where he held that the Court of Protection cannot make anticipatory decisions under s.16 MCA 2005 where the subject of the proceedings currently has capacity. Whilst the court can make declarations of lawfulness on a 'contingency' basis under s.15(1)(c), Hayden J was clear in *GSTT* that to the extent that the effect of the relief being granted by the court gives rise to a deprivation of liberty, any such deprivation of liberty can only be authorised under the inherent jurisdiction of the High Court. As Lieven J brought the order to an end, these rather knotty jurisdictional questions did not – thankfully – have to confront her.

Mid-year (partial) DoLS Statistics for England

Because of the unprecedented situation in this 2020-2021 data reporting year, NHS Digital have released adult social care activity data for the 1 April 2020 to 30 September 2020 period, to which 81% of local authorities contributed. During that period, compared to the year before 3.3% fewer DoLS applications were received by local authorities (102,595) and 16.5% fewer applications were completed (79,030). In addition, the data shows that the number of people receiving long-term social care support is reducing and there has been a 4% increase in the number of safeguarding concerns.

When to go to court to challenge a DoLS authorisation

With thanks to Irwin Mitchell, a more graphically refined version of the flowchart Tor did some years ago to summarise the effect of the judgment of Baker J in *RD* is now available here. As a reminder, this judgment sets out a decision-tree to identify when (1) the person themselves has capacity to bring the challenge; and (2) if they do not have capacity, when such a challenge should be brought, either as of right or on a best interests basis.

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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 February. 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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