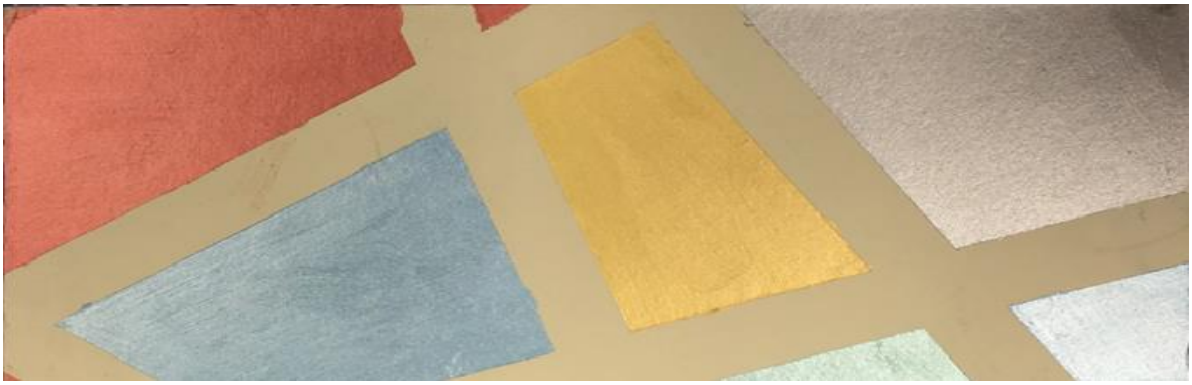
MENTAL CAPACITY REPORT:
HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

July 2019 | Issue 96



Welcome to the July 2019 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: when to appoint welfare deputies, termination and best interests, capacity in the context of sexual relations and birth arrangements, and the interaction between the MHA and the MCA in the community;

(2) In the Property and Affairs Report, fraud and vulnerability; news from the OPG, and deputyship and legal incapacitation;

(3) In the Practice and Procedure Report: Court of Protection fees changes; contingency planning, costs and s.21A applications; mediation in the Court of Protection;

(4) In the Wider Context Report: the Chair of the National Mental Capacity Act Forum reports, a new tool to assist those with mental health/capacity issues to know their rights, older people and the CPS/police; and books for the summer;

(5) In the Scotland Report: establishing undue influence and an update on the Scott review.

You can find all our past issues, our case summaries, and more on our dedicated sub-site 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.

Editors
Alex Ruck Keene
Victoria Butler-Cole QC
Neil Allen
Annabel Lee
Nicola Kohn
Katie Scott
Katherine Barnes
Simon Edwards (P&A)

Scottish Contributors
Adrian Ward
Jill Stavert

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

Personal welfare deputies – to appoint or not?

Re Lawson, Mottram and Hopton (appointment of personal welfare deputies) [2019] EWCOP 22 (Hayden J)

Deputies – welfare matters

Summary[1]

The Vice-President of the Court of Protection, Hayden J, has outlined a set of principles to govern the appointment of personal welfare deputies. In *Re Lawson, Mottram and Hopton (appointment of personal welfare deputies)* [2019] EWCOP 22, a preliminary issue was listed in three applications for permission to apply for the appointment of a personal welfare deputy, namely "what is the correct approach to determining whether a welfare deputy should be appointed"? In particular, the question was whether such appointments should only be made – as the Code of Practice suggests (at paragraph 8.38) in "*the most difficult cases*."

To answer this question, Hayden J looked in some detail at the case-law, the Code, the structure of the MCA and the appointment of deputies in practice, including a rehearsal of evidence provided by the Office of the Public Guardian as to the numbers of personal welfare deputy appointees (currently averaging about 375 per year, compared to an average of around 15,000 property and affairs deputies) and the role of the OPG in supervising them.

Hayden J considered that the case law showed the Court of Protection:

> *51* […] *is gradually and increasingly understanding its responsibility to draw back from a risk averse instinct to protect P and to keep sight of the fundamental responsibility to empower P and to promote his or her autonomy.*

Having concluded his review, he held at paragraph 53 that a number of "*clear principles*" emerge:

> *a) The starting point in evaluating any application for appointment of a PWD is by reference to the clear wording of the MCA 2005. Part 1 of the Act identifies a hierarchy of decision making in which the*

[1] Tor having been involved in the case, she has not contributed to this summary.

twin obligations both to protect P and promote his or her personal autonomy remain central throughout;

b) Whilst there is no special alchemy that confers adulthood on a child on his or her 18th birthday, it nevertheless marks a transition to an altered legal status, which carries both rights and responsibilities. It is predicated on respect for autonomy. The young person who may lack capacity in key areas of decision making remains every bit as entitled to this respect as his capacitous coeval. These are fundamental rights which infuse the MCA 2005 and are intrinsic to its philosophy. The extension of parental responsibility beyond the age of eighteen, under the aegis of a PWD,[2] may be driven by a natural and indeed healthy parental instinct but it requires vigilantly to be guarded against. The imposition of a legal framework which is overly protective risks inhibiting personal development and may fail properly to nurture individual potential. The data which I have analysed (paragraph 26 above) may, I suspect, reflect the stress and anxiety experienced in consequence of the transition from child to adult services. As a judge of the Family Division and as a judge of the Court of Protection I have seen from both perspectives the acute distress caused by inadequate transition planning. The remedy for this lies in promoting good professional practice. It is not achieved by avoidably eroding the autonomy of the young incapacitous adult;

c) The structure of the Act and, in particular, the factors which fall to be considered pursuant to Section 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 PWD;

d) The above is not in any way to be interpreted as a statutory bias or presumption against appointment. It is the likely consequence of the application of the relevant factors to the individual circumstances of the case. It requires to be emphasised, unambiguously, that this is not a presumption, nor should it even be regarded as the starting point. There is a parallel here with the analysis of Baroness Hale in ***Re W*** [2010] UKSC 12. *In that case and in a different jurisdiction of law, the Supreme Court was considering the perception that had emerged, in the Family Court, of a presumption against a child giving oral evidence. The reasoning there has analogous application here:*

> *22."However tempting it may be to leave the issue until it has received the expert scrutiny of a multi-disciplinary committee, we are satisfied that we cannot do so. The existing law erects a presumption against a child giving evidence which requires to be rebutted by anyone seeking to put questions to the child. That cannot be reconciled with the approach of the European Court of Human Rights, which always aims to strike a fair balance between competing Convention rights. Article 6 requires that the proceedings overall be fair and this normally entails an opportunity to challenge the evidence presented*

[2] Note, the judgment uses the acronym 'PWD,' which may produce inadvertent cognitive dissonance in some as in other contexts it refers to "persons with disabilities."

by the other side. But even in criminal proceedings account must be taken of the article 8 rights of the perceived victim: see SN v Sweden, App no 34209/96, 2 July 2002. Striking that balance in care proceedings may well mean that the child should not be called to give evidence in the great majority of cases, but that is a result and not a presumption or even a starting point."

e) To construct an artificial impediment, in practice, to the appointment of a PWD would be to fail to have proper regard to the 'unvarnished words' of the MCA 2005 (PBA v SBC [2011] EWHC 2580) (Fam). It would compromise a fair balancing of the Article 6 and Article 8 Convention Rights which are undoubtedly engaged;

f) The Code of Practice is not a statute, it is an interpretive aid to the statutory framework, no more and no less. It is guidance which, whilst it will require important consideration, will never be determinative. The power remains in the statutory provision;

g) The prevailing ethos of the MCA is to weigh and balance the many competing factors that will illuminate decision making. It is that same rationale that will be applied to the decision to appoint a PWD;

h) There is only one presumption in the MCA, namely that set out at Section 1 (2) i.e. 'a person must be assumed to have capacity unless it is established that he lacks capacity'. This recognition of the importance of human autonomy is the defining principle of the Act. It casts light in to every corner of this legislation and it illuminates the approach to appointment of PWDs;

i) P's wishes and feelings and those other factors contemplated by Section 4 (6) MCA will, where they can be reasonably ascertained, require to be considered. None is determinative and the weight to be applied will vary from case to case in determining where P's best interests lie (PW V Chelsea and Westminster Hospital NHS Foundation Trust and Others [2018] EWCA Civ 1067);

j) It is a distortion of the framework of Sections 4 and 5 MCA 2005 to regard the appointment of a PWD as in any way a less restrictive option than the collaborative and informal decision taking prescribed by Section 5;

k) The wording of the Code of Practice at 8.38 (see para 20 above) is reflective of likely outcome and should not be regarded as the starting point. This paragraph of the Code, in particular, requires to be revisited.

Hayden J neither granted nor refused permission to the three applicants before the court, so their applications for permission to apply (and, if that is granted, to be appointed as personal welfare deputies) will have to be considered in light of these principles.

Comment

The principles set out above are quite densely expressed. However, they can be summarised as:

1. The Code of Practice is wrong insofar as it suggests that the starting point is that personal welfare deputies should only be appointed in the most difficult cases;

2. Each case falls to be decided on its merits, and by reference to whether an appointment is in the best interests of P;

3. P's wishes and feelings will form an aspect of that decision (for instance if it is clear that P would wish a family member to be appointed to be their personal welfare deputy);

4. The proper operation of s.4 and s.5 means that, in practice, personal welfare deputies will not often be appointed, in particular because the appointment should not be seen, in and of itself, as less restrictive of P's rights and freedoms.

In reaching his conclusions, Hayden J very clearly took a side in a debate that has been simmering for some time (and is an extension of that which is troubling the Supreme Court in *Re D* at the moment), namely the extent to which the rights of parents to have a specific role in decisions relating to their children should be extended where those children will always have impaired decision-making capacity. This graphic by Cara Holland at Graphicchange (@graphichange) summarises that debate in visual form:

The dilemma encapsulated here extends beyond 18 where the end of legal parental responsibility does not lead to the end of their emotional and moral responsibility. Hayden J's judgment makes clear that majority does, in fact, mean majority, and a deviation from the 'ordinary' decision-making structure set up under s.5 MCA 2005 will have to be justified.

Some reading the judgment might feel that it does not face head on the practical realities of decision-making in relation to those with impaired capacity. Despite cases such as *Winspear* emphasising that a failure properly to consult those interested in P's welfare has legal consequences, it is clear that many family members feel excluded from decision-making. Sometimes, this is because others involved are seeking to develop P's autonomy and enable them to secure their own life choices; sometimes this is for rather less noble reasons.

Others reading the judgment may feel relieved that Hayden J 'held the line' in terms of the decision-making structure under s.5 MCA 2005, which deliberately seeks to limit interference with legal capacity to specific issues and specific decisions, rather than handing extended surrogate decision-making power to one person and thereby, for benign reasons, depriving P of legal capacity. Although the CRPD made an entry in the case in support of the proposition that the court should be more willing to appoint personal welfare deputies where that choice represented the wishes and feelings of P, it could also have been deployed in support of the argument that a broader presumption in favour of appointment of such deputies would represent a move away from compliance with Article 12 CRPD by rendering more widespread

the legal 'incapacitation' of individuals with impaired capacity.

In practical terms, one very clear implication of this judgment is that it will be necessary to explain in any application for appointment as a personal welfare deputy why the 'collaborative and informal' decision-making structure that the MCA has put in place has not been serving P's interests.

Termination and best interests

Re AB (Termination) [2019] EWCA Civ 1215 (Court of Appeal) (McCombe, King and Peter Jackson LLJ)

Best interests – childbirth – medical treatment

Summary[3]

The question arose for determination whether it was in the best interests of a young woman with moderate learning disabilities to undergo a termination. Matters proceeded at speed in the case, Lieven J giving her judgment on the Friday, and the application for permission (by AB's mother) being made on the Monday morning, the hearing of the appeal being that afternoon, and the decision being announced at the conclusion of the hearing. Several weeks later, the Court of Appeal set out its reasons for – unusually – reversing an evaluative judgment of a first instance judge as to best interests.

Background

AB was a 24-year-old woman with moderate learning disabilities. She exhibited challenging behaviour and (in the words of the Court of Appeal) functioned at a level of between 6 and 9 years old. At the turn of 2019, AB was staying with her family in Nigeria and, in circumstances which were unclear, became pregnant; a fact that was discovered by her adoptive mother (CD) upon AB's return to this country in April 2019.

Capacity assessments were undertaken early in May which concluded that AB lacked the capacity to decide whether to continue with the pregnancy. CD was wholly opposed to abortion both from a religious and cultural point of view; she was a devout Roman Catholic and in Nigeria, she said, terminating a pregnancy was 'simply unheard of'. On 16 May 2019, by which time AB was about 16 weeks pregnant, CD arrived at the hospital with AB, together with all of AB's possessions packed into three suitcases and two rucksacks. CD told the hospital that she was 'handing over' the care of AB. Since that time, AB had lived in a residential unit. In her statement, CD said that she did not do this for fear of being ostracised by her community if AB had a termination, but because she felt she could not support AB in having a termination.

The NHS Foundation Trust responsible for the antenatal care of AB concluded that it would be in her best interests for the pregnancy to be terminated on the basis. CD was implacably opposed to the proposal and, accordingly, the Trust made an application to the High Court. By the time that the matter came before Lieven J, AB was 22, going on 23 weeks pregnant, which meant that there was considerable urgency to the decision as the latest possible date under the Abortion Act 1967 (in a case such as AB's) for termination is 24 weeks' gestation. Before

[3] Tor having been involved in the case in the Court of Appeal, she has not contributed to this summary.

Lieven J, CD maintained, contrary to her initial position, that she would then wish to have AB back to live with her even if she had a termination. As King LJ noted:

> *The rights and wrong of all of this were not matters with which the judge needed to concern herself and, for my part, the relevance is only in that it highlights that AB's home circumstances are complicated and that it would be naive to presume that an easy solution to the conundrum presented to the court would be for AB to have her baby and move back home where she and her baby would live with, and be cared for, by CD.*

The task of the court

Helpfully, the Court of Appeal outlined what the task of the court was in a case such as this:

> *Given that the doctors were united in their view that the test in s1(1)(a) Abortion Act 1967 was met* [ie that continuing the pregnancy involved a greater risk to the mental health of AB than if the pregnancy were terminated]*,the role of the court* [is] *to consider, by way of an evaluation of all the material factors, whether it would be in the best interests of AB to provide the consent necessary in order for the proposed termination to take place. It follows that, whilst the court's task in identifying the best interests of AB may overlap with the task of the doctors in applying the Abortion Act, they are not one and the same: Re X (A Child) [2014] EWHC 1871 per Munby J (as he then was) at [6-7].*

On behalf of CD, it was submitted, in reliance on *Re X*, that:

> *terminating a pregnancy without the consent of the woman carrying the child represents such a profound invasion of her Article 8 rights that it should only ever be contemplated where section 1(1)(b) of the Act is satisfied, that is to say "the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman".*

Eleanor King LJ, on behalf of the Court of Appeal, did not go this far, but emphasised that:

> *However one looks at it, carrying out a termination absent a woman's consent is a most profound invasion of her Article 8 rights, albeit that the interference will be legitimate and proportionate if the procedure is in her best interests. Any court carrying out an assessment of best interests in such circumstances will approach the exercise conscious of the seriousness of the decision and will address the statutory factors found in the Mental Capacity Act 2005 (MCA) which have been designed to assist them in their task.*

Having rehearsed the approach to best interests by reference to *Aintree*, and, in particular, paragraph 24 at which Lady Hale emphasised that it is a test containing a strong element of substituted judgment, King LJ noted that:

> *It is well established that the court does not take into account the interests of the foetus but only those of the mother: Vo v France (2005) 10 EHRR 12 at [81-82]; Paton v British Pregnancy Advisory Service [1979] QB 276; Paton v United Kingdom (1980) 3 EHRR 408. That does not mean that the court should not be cognisant of the fact that the order sought will permit irreversible, invasive*

> *medical intervention, leading to the termination of an otherwise viable pregnancy. Accordingly, such an order should be made only upon clear evidence and, as Peter Jackson LJ articulated it in argument, a "fine balance of uncertainties is not enough".*

The decision of Lieven J

Lieven J held that:

> *62. Focusing on AB and her own facts, the risks of allowing her to give birth are in no particular order; increased psychotic illness; trauma from the C section; trauma and upset of the baby being removed and the risk of the baby being placed with CD and AB losing her home as well as the baby. The benefits are that of her having a child born alive and the possibility of some, albeit future contact. She may take joy from this, it is not possible to know.*
>
> *63. In my view the balance in terms of AB's best interests lies in her having the termination. I should make clear that I do not underestimate the harm from this course, but I think that it is clearly outweighed by the harm from continuing the pregnancy.*

The appeal decision

The first ground of appeal was that Lieven J had erred in finding that, if AB's pregnancy continued to term, her baby would be removed by way of protective order on the part of the local authority and/or placed too much weight on this factor in the best interests analysis.

On the facts, Eleanor King LJ considered that:

> *The judge was entitled to take into account the expert evidence available which stated categorically that AB would be unable to care for a baby. The judge, far from improperly anticipating future events, was simply expressing the sad reality of the situation, namely that AB is incapable of caring for herself, let alone a baby. Based on the totality of the evidence from both the lay and medical witnesses, it cannot be said, or even argued, that for the judge to have concluded that AB will be unable to care for her baby, was premature, inappropriate or discriminatory.*

However, Eleanor King LJ found that Lieven J had erred in:

> *extrapolating from that finding a real risk that the baby would be placed with CD and that, as a consequence, AB would lose her home as well as her baby, a finding that erroneously impacted on the best interests analysis.*

The second ground of appeal was that Lieven J had erred in failing to carry out a detailed and careful balancing exercise in respect of whether termination or planned caesarean section were in AB's best interests, having regard to the need for powerful evidence of risk to the mother's life or grave risk to the mother's long-term health of continued pregnancy.

Eleanor King LJ identified that:

> *The unenviable task facing the judge was, amongst all the other factors, to weigh up the psychiatric/psychological risks to AB of each of the two alternatives as presented to her by the doctors:*

> *i) Termination would be at a stage requiring invasive intervention to bring the pregnancy to an end at a time when AB has an increasing awareness (but very limited understanding) of her pregnancy. AB knows she has a "baby in her tummy" and that it will be born. There is an acceptance by all the parties that AB was, and is, at the very least, 'engaged' with the pregnancy and has indicated on occasions that she likes the idea of having the baby;*
>
> *Or alternatively,*
>
> *ii) The continuation of the pregnancy to term when the baby would be born by caesarean section and would be taken away from her, if not immediately, then very soon thereafter.*

Eleanor King LJ did not express a view as to whether this ground of appeal was, itself, made out, but noted, "[w]*hilst ultimately the three experts were in agreement, it can be seen that they were faced with a most challenging task in trying to determine which of the two outcomes would be the worst for AB and ultimately the view was one expressed to be 'on balance*'."

The third ground of appeal was that the judge erred in failing to have full regard to AB's wishes and feelings and/or her Article 8 right to motherhood.

Eleanor King LJ found that:

> *Whilst it is clear that the judge did not apply any "automatic discount" to AB's view* [to use the phrase from Peter Jackson J's judgment in *Wye Valley*]*, in my judgement she failed to take sufficient account of AB's wishes and feelings in the ultimate balancing exercise. The fact that they might in the end be outweighed by other factors does not alter the fact that this was a significant omission.*

Interestingly, Eleanor King LJ also then went on to consider separately AB's beliefs and values, noting that

> *57. No reference is made in the judgment to the beliefs and values that would be likely to influence AB had she capacity, nor were any submissions made in relation to "beliefs and values" to this court.*
>
> *58. It is undoubtedly the case that AB has been brought up in a community whose religious and cultural beliefs and values are strongly opposed to abortion. This cultural background and these religious beliefs could, in the right circumstances, have a profound impact upon the best interests assessment. AB, however, has never had capacity and there can therefore be no direct evidence as to her actual beliefs and values; who can say if she might not have lost her faith or rebelled against the tenets of her community by the time she reached her twenties. It may be that, had she capacity, she would have been heavily influenced by the beliefs governing her community, but there is no evidential basis for concluding that to be the case, and to import those views into the best interests analysis would be mere speculation.*
>
> *59. It follows that the fact that the judge did not refer specifically to s4(6)(b) does not represent a shortcoming in her best interests evaluation; in other cases it might be different.*

Turning to consultation, Eleanor King LJ considered that Lieven J had erred in failing to place in the balance as to what outcome was in AB's best interests either the views of her mother or her social worker, noting that:

> *CD and Ms T each know AB better than the assessing psychiatrists could possibly do notwithstanding the lengthy, caring and careful assessments they had carried out. The judge had the expert evidence of the psychiatrists on the one hand and the views of those who know AB best on the other, but she did not weigh them up, the one against the other.*

Conclusion

Eleanor King LJ's conclusions should be set out in full:

> *71. Part of the underlying ethos of the Mental Capacity Act 2005 is that those making decisions for people who may be lacking capacity must respect and maximise that person's individuality and autonomy to the greatest possible extent. In order to achieve this aim, a person's wishes and feelings not only require consideration, but can be determinative, even if they lack capacity. Similarly, it is in order to safeguard autonomy that s1(4) provides that "a person is not to be treated as unable to make a decision merely because he makes an unwise decision".*
>
> *72. It may be that, on any objective view, it would be regarded as being an unwise choice for AB to have her baby, a baby which she will never be able to look after herself and who will be taken away from her. However, inasmuch as she understands the situation, AB wants her baby. Those who know her best, namely CD and her social worker, believe it to be in AB's best interests to proceed with the pregnancy as does the Official Solicitor who represents her in these proceedings.*
>
> *73. The judge's conclusion as to what was in AB's best interests was substantially anchored in the medical evidence. In my judgement, that medical evidence, without more, did not in itself convincingly demonstrate the need for such profound intervention.*
>
> *74. The judge was entitled to take into account the fact that AB would be unable to care for her baby and to place weight on the traumatic effect on AB of having her baby taken from her, but in my judgement she went beyond what the evidence could support in finding that AB risked losing her baby and her home.*
>
> *75. In many of the passages set out above, and in particular in her conclusion at [62], the judge made no mention of AB's wishes and feelings or of the views of CD, the social worker or the Official Solicitor This was, in my opinion a significant omission.*
>
> *76. The requirement is for the court to consider both wishes and feelings. The judge placed emphasis on the fact that AB's wishes were not clear and were not clearly expressed. She was entitled to do that but the fact remains that AB's feelings were, as for any person, learning disabled or not, uniquely her own and are not open to the same critique based upon cognitive or expressive ability. AB's feelings were important and should have been factored into the balancing exercise alongside consideration of her wishes.*
>
> *77. These were all important features of the case and needed to be part of the*

decision-making process, all the more so given that the medical evidence was, substantially, based on an attempt (albeit by experts) to assess AB's likely emotional reaction to each of two traumatic events.

78. I am conscious that, to borrow from Lord Sumption in Barton v Wright Hassall LLP [2018] UKSC 12, [2018] 1 WLR 1119, this is an appeal:

> *"15.....against a discretionary order, based on an evaluative judgment of the relevant facts. In the ordinary course, this court would not disturb such an order unless the court making it had erred in principle or reached a conclusion that was plainly wrong."*

79. To this I add that I also have in mind that the judge made her decision having heard the oral evidence and having written a careful and thoughtful judgment produced under considerable pressure of time. However, in my judgement, she clearly gave inadequate weight to the non-medical factors in the case, while the views expressed by the doctors were necessarily significantly predicated upon imponderables. In the end, the evidence taken as a whole was simply not sufficient to justify the profound invasion of AB's rights represented by the non-consensual termination of this advanced pregnancy.

Procedural matters

Eleanor King LJ was very concerned about how matters had come to court:

The Trust issued its application on 21 May 2019 by which time AB was 18 weeks pregnant. Keehan J gave directions on 3 June 2019 and listed the matter for hearing on 20 June. In her judgment Lieven J deprecated that proceedings were not issued by the Trust for some 5 weeks after they were aware of the pregnancy. I endorse her view. In fairness to the Trust however, it should equally be noted that having issued the proceedings, a further 4 weeks elapsed before the matter was heard. I am conscious that Trusts are rightly reluctant to make such applications and properly aim to reach agreement with the family in such fraught situations. I am also conscious that the courts are overwhelmed with urgent work and also that any judge giving directions for trial, in a case of this type, will be alert to the need to ensure that the trial judge has, in particular, the medical evidence necessary to inform the decision-making process. In my judgement however, an application for a declaration which will permit a Trust to carry out termination on a woman lacking capacity should be regarded and litigated as a medical treatment issue of the utmost urgency.

14. Given the critical urgency of such a case, it may be that, where it appears to a Trust that there is a potentially intractable divergence of views with the family, consideration should be given to an application being made at an early stage following the making of the "best interests" decision. The application should then be listed as a matter of urgency, even if it is subsequently withdrawn. If the pregnancy is allowed to reach a very late stage and a termination is then determined to be in the best interests of the mother, she will be unnecessarily exposed to what is on any

view a highly invasive and, for a woman lacking capacity, bewildering procedure. (In saying this I accept, of course, that there will inevitably be occasions where the pregnancy does not come to the authorities' attention until it is well established.)

Comment

The decision of Lieven J made very considerable waves, and caused (sometimes ill-informed) criticisms. It is very unusual for a judgment on best interests to be overturned by an appellate court on the basis that it was wrong, but it is difficult to escape the feeling that this was justified on the extremely difficult and finely balanced facts of this case; it is also difficult to escape the feeling that the decision at first instance might have been different had there been more time properly to undertake the exercise mandated by s.4 MCA 2005. We also anticipate that paragraph 71 of the Court of Appeal's judgment will feature regularly in future judgments as encapsulating the correct approach to best interests decision-making.

Capacity and sexual relations – trying to make it personal

LB Tower Hamlets v NB & AU [2019] EWCOP 27 (Hayden J)

Mental capacity – sexual relations

Summary

Hayden J has made further observations about the test for capacity to consent to sexual relations. We use the term "observations" advisedly, because his judgment does not, in fact, reach a conclusion as to whether the woman in question, NB, has or lacks capacity to consent to sexual relations.

The case is one that has been before Hayden J for some time, and generated a judgment ([2019] EWCOP 17) in which he expressed, in particular, real concern about the manner of reporting of a previous interim hearing. In this most recent judgment, reserved from the previous hearing, Hayden J identified that the questions concerning the protection of the vulnerable in media coverage "*will require to be addressed by the ad-hoc Court of Protection Rules Committee*."

For present purposes, the key feature of the case was that the question of capacity to consent to sexual relations was being posed in relation to a couple who had been married since 1992, with a daughter born in 1998, and NB now being beyond child-bearing age. In his interim judgment, Hayden J had indicated that he was reserving his judgment "*in order that I can take the time to look carefully and in some detail at the case law and its applicability to the facts of this case. It would appear, that it requires to be said, in clear and unambiguous terms that I do so in order to explore fully NB's right to a sexual life with her husband and he with her, if that is at all possible*." A critical element in this was whether the test – held by the Court of Appeal to be issue- or act- specific – could in some way be tailored in the case before him to take into account the particular situation of NB and AU.

Subsequent to that hearing, the Court of Appeal delivered judgment in *B v A Local Authority* [2019] EWCA Civ 913, delivering a fairly heavy hint that it would not look askance at an approach which enabled a conclusion to be drawn that NB had capacity to consent to sexual relations. Hayden J was in receipt of further written submissions

from both the Official Solicitor and the local authority; the husband, AU, apparently unable (or unwilling) to play any further part. It is fair to say that Hayden J does not seem to have had much time for the submissions of any party before him, and his judgment therefore essentially represents his own exegesis of the position.

Hayden J reviewed the case-law, and made the following series of observations:

> *27. The omnipresent danger in the Court of Protection is that of emphasising the obligation to protect the incapacitous, whilst losing sight of the fundamental principle that the promotion of autonomous decision making is itself a facet of protection. In this sphere i.e., capacity to consent to sexual relations, this presents as a tension between the potential for exploitation of the vulnerable on the one hand and P's right to a sexual life on the other.*
>
> *28.These are difficult issues involving intensely personal interactions. The lexicon of the law, perhaps even that of ordinary discourse, presents a challenge when seeking to distil the essence of the concepts in focus. With hesitation and some diffidence, it seems to me to be important to recognise and acknowledge, that in this interpersonal context, relationships are driven as much by instinct and emotion as by rational choice. Indeed, it is the former rather than the latter which invariably prevail. This fundamental aspect of our humanity requires to be identified and appreciated as common to all, including those who suffer some impairment of mind. To fail to do so would be to lose sight of the primary objective of the MCA. It would require a disregard of at least two decades of jurisprudence emphasising P's autonomy. Moreover, it would seriously risk discriminating against vulnerable adults with learning disabilities and other cognitive challenges.*
>
> *29. It strikes me as artificial, at best, to extract both instinct and emotion from an evaluation of consent to sex, they are intrinsic to the act itself. In many ways, of course, instinct and emotion are the antithesis of reason. However, whilst they may cloud decision making, perhaps even to the point of eclipsing any calculation of risk, they are nonetheless central to sexual impulse. To establish an inflexible criterion to what may properly constitute 'consent' risks imposing a rationality which is entirely artificial.*
>
> *30. It also needs to be emphasised that the law does not identify the criterion which are being considered here. The MCA 2005, in some ways like the Children Act 1989, is a distillation of principles which require to be applied in the context of a careful balance, one in which proportionality of intervention will always be an indivisible feature. Much of the applicable criteria concerning assessment of capacity, across a broad range of decisions, finds its way into this process via the conduit of expert evidence. This is all profoundly helpful to the practitioners and the professionals but the danger is that conceptual silos are created which fail to appreciate the individual and the infinite variety of people's lives.*
>
> […]
>
> *41. It is important to identify that depriving an individual of a sexual life in circumstances where they may be able to consent to it with a particular partner, is*

not 'wrapping them up in cotton wool'. Rather, it is depriving them of a fundamental human right. Additionally, I repeat, AU's Article 8 rights are also engaged in this context. He too has a right to a sexual life where there is true consent and mutual desire.

42. One of the central difficulties faced by practitioners, both in the court setting and in the wider community, is that the relevant tests for capacity are framed by psychologists, psychiatrists etc and a practice has developed of applying these tests as if they had the force of statute. It is necessary to emphasise that when an application is made to a judge, it is the judge who evaluates the broad canvas of evidence to determine the question of capacity.

43. In simple terms, in these circumstances, it is judges not experts who decide these issues. Judges have the enormous advantage of hearing a wide range of evidence about P from a diverse field of witnesses, often including family members. As I have sought to illustrate in my analysis of the law […]*, the Courts have repeatedly emphasised that the tests are to be applied in a way which focus upon P's individual characteristics and circumstances. Whilst it is difficult to contemplate many heterosexual relationships where a failure to understand a risk of pregnancy or sexual disease (consequent upon sexual intercourse) will permit a conclusion that P has capacity, it should not be discounted automatically. This is to elevate the expert guidance beyond its legitimate remit.*

44. Moreover, expert evidence gains its force and strength when challenged and robustly put to the assay. Theories grow, develop and, as the Courts have seen in recent decades, are sometimes debunked. Attributing to expert evidence the status of legislative authority serves also to deprive it of its own intellectual energy and inevitably, in due course, some of its forensic utility.

Rejecting the Official Solicitor's submission that the court should identify a category of individuals for whom pregnancy and sexually transmitted disease will not require assessment, Hayden J considered that this would be to:

48. […] *overburden the test and to introduce unnecessary technicalities. It is also, with respect to Mr Bagchi, difficult to reconcile with his own acceptance of the 'tailored' approach which he characterises as 'pragmatic and flexible'. At risk of labouring the point further, I am emphasising that the tests require the incorporation of P's circumstances and characteristics. Whilst the test can rightly be characterised as 'issue specific', in the sense that the key criteria will inevitably be objective, there will, on occasions, be a subjective or person specific context to its application.*

Hayden J went on to develop, in different ways, the theme that:

51. The applicable criteria in evaluating capacity to consent require to be rooted within the clear framework of MCA 2005 ss 1 to 3. The individual tests are not binding and are to be regarded as guidance 'to be expanded or contracted' to the facts of the particular case. They are to be construed purposively, both promoting P's autonomy and protecting her vulnerability.

[…]

54. That there is no need to evaluate an understanding of pregnancy when assessing consent to sexual relations in same sex relationships or with women who are infertile or postmenopausal strikes me as redundant of any contrary argument. Nor, with respect to what has been advanced in this case, can it ever be right to assess capacity on a wholly artificial premise which can have no bearing at all on P's individual decision taking. It is inconsistent with the philosophy of the MCA 2005. Further, it is entirely irreconcilable with the Act's defining principle in Sec. 1 (2) … 'a person must be assumed to have capacity unless it is established that he lacks capacity.'

[…]

56. […]*, a monogamous marriage of some thirty years duration, where there is no history of sexually transmitted disease, is probably a secure base from which to predict that this is a very low risk for the future. It is in this context that Mr Bagchi's absolutist approach runs the risk of 'dressing an incapacitous person in forensic cotton wool', to use Hedley J's striking phrase in A NHS Trust v P [2013] EWAC 50 (COP). It is not the objective of the MCA to pamper or to nursemaid the incapacitous, rather it is to provide the fullest experience of life and with all its vicissitudes. This must be kept in focus when identifying the appropriate criteria for assessing capacity, it is not to be regarded as applicable only to a consideration of best interests.*

[…]

60. […] *What I am emphasising here is the application of 'the Act specific test' (to use the favoured argot), deployed in a way which promotes P's opportunity to achieve capacity. This, as I have laboured to highlight, is nothing less than a statutory imperative. It cannot be compromised.*

[…]

66. The Court of Protection deals with human beings who, for a whole variety of reasons, have lost or may have lost capacity. This may be temporary, permanent, fluctuating or limited to a constrained sphere of decision taking. A declaration of incapacity whether tightly circumscribed or expansive in its scope, should not impose sameness or uniformity. The personality and circumstances of the incapacitous are as rich, varied and complex as those of anybody else. All this requires to be taken in to account when evaluating capacity in every sphere of decision taking. As practitioners and indeed as judges we must be vigilant to ensure that the applicable tests do not become a tyranny of sameness, in circumstances where they are capable of being applied in a manner that may properly be tailored to the individual's situation. To do otherwise would, for the reasons I have set out, lose sight of the key principles of the MCA 2005.

On the facts of the case before him, Hayden J "profoundly disagreed" with the assertion made by the local authority that:

65. .[…] *NB's assumed capacity to consent to a sexual relationship with her husband has been rebutted. On the contrary, the preponderant evidence suggests that she is capacitous. This was foreshadowed in Mr Bagchi's earlier*

> *submissions, referred at para 44 above (though I recognise that they were not structured around the test as now identified). The Local Authority may wish to consider a reassessment of NB's capacity in the light of this judgment. This will, of course, depend on whether the marriage survives.*

Comment

Whilst it is always dangerous to seek to summarise an extensive judgment such as that delivered in this case, its clear message is that it is both legitimate and indeed mandatory to consider the question of whether a person has capacity to consent to sex on the basis of the full facts of their situation, and with a clear eye to the interference with rights that a conclusion that they lack capacity will give rise to.

One may or may not agree that the relevant tests for capacity have been framed by psychologists, psychiatrists etc, as opposed to judges (a clear example of judicial framing being that of Cobb J in *Re A*, concerning capacity to make decisions as to social media), but it is undoubtedly the case that in a case that has come to court, it is the judge, not the expert(s) who must ultimately decide whether the person has or lacks capacity to make the decision in question.

What, of course, the judgment does not address is how a practitioner outside the court arena is to decide whether the person has or lacks capacity to consent to sexual relations. It may be that Hayden J considers that the level of interference with the person's rights is such that only a judge should ever conclude that a person lacks capacity to consent to sexual relations. Such could certainly be construed as an example of the calibration of the procedural guarantees implied into Article 8 ECHR (see, e.g. *AN v Lithuania* [2016] ECHR 462). It is to be hoped that, if, indeed, Hayden J does consider this to be the case, he makes this clear (and the basis upon which he considers this to be so) in what is presumably going to be the final judgment in this case in which he definitely determines whether or not NB has or lacks capacity to consent to sexual relations.

Until and unless Hayden J identifies a legal requirement for all such cases to come to court, practitioners should continue to consider the test for capacity to consent to sexual relations in relation to those individuals before them. They should do so, we suggest, by reference:

1. To the informational guidance endorsed by the Court of Appeal in *B*;
2. The act-specific test as endorsed by the Court of Appeal in both that case and the earlier *IM v LM* one.

However, in applying the test, it is clear in light of this decision that practitioners should be mindful:

1. that information must be tailored to the specific facts of the individual case so, for instance, it will not be relevant to consider whether the person can understand, retain and use/weigh information about the potential for pregnancy if this is of no relevance to their factual position;
2. of the support principle in s.1(3) MCA 2005; and
3. of the consequences of a conclusion that a person lacks capacity to consent to sexual relations.

We note, finally, that it remains of significance (and a factor not discussed by Hayden J in his judgment) that, as the Court of Appeal confirmed in *B* (at paragraph 51) that the ability to understand the concept of and the necessity of one's own consent is fundamental to having capacity: in other words that "P knows that she/he has a choice and can refuse".

Birth arrangements, interventions and the art (not science) of capacity

NHS Trust v JP [2019] EWCOP 23 (Williams J)

Best interests – birth arrangements – medical treatment

Summary[4]

In *NHS Trust v P* [2019] EWCOP 23, Williams J was asked to endorse the covert carrying out (under general anaesthetic) of a Caesarean section on a young woman, JP. JP, who had learning disabilities (the extent and impact of which were the subject of detailed consideration), was seen by the community midwife in February 2019 and was pregnant. She was in a relationship but at that time was living at home with her mother and spending time at her boyfriend's family home. Her due date was 14 July 2019. Over the ensuing 4 months, the community midwifery team, clinicians from the relevant NHS Trust, a learning disabilities team, and local authority adult and children's social workers had been involved with JP and her pregnancy. By 11 May, she had moved out of her mother's home into a supported living placement. Over the ensuing months those around JP had been seeking to support her through the pregnancy and to reach a decision as to how the delivery was to be managed.

The team at the applicant Trust eventually concluded that the only safe way to manage the labour for JP was for her to have a caesarean section under general anaesthetic. That was contrary to JP's wishes; she had expressed a wish to have a natural birth, and hence the care plan would involve an element of deception. The plan also envisaged that the local authority would take steps to remove JP's baby from her after birth (whether temporarily or permanently was not clear from the judgment).

The Trust did not make the application for declarations as to JP's capacity and best interests until 31 May, by which time JP was roughly 33 weeks pregnant. Williams J was unclear why this was the case, and noted that:

> 7. *The listing of the final hearing on a date between the 36th and 37th weeks of her pregnancy introduced unnecessary pressure into the process. Unless it is unavoidable because of late awareness of a pregnancy, I see no reason why it should not be possible for these applications to be issued and heard before they become time critical.*

Capacity

On the Trust's application, Williams J expressed himself concerned as to the evidence of JP's decision-making capacity. The COP3, completed by JP's consultant obstetrician and gynaecologist, Dr Sullivan, was founded upon a diagnosis of "*Microcephaly (behavioural disorder)*."

[4] Katie having been involved in the case, she has not contributed to this summary.

Williams J declined to determine JP's capacity on the basis of the doctor's evidence, supported by hospital notes, but he declined to do so, holding, at paragraph 25 that:

> *I consider that where an applicant Trust asserts that a patient is suffering from a condition such as microcephaly leading to a significant learning difficulty that appropriate evidence demonstrating the condition (microcephaly) and its consequences (learning disability or significant learning difficulties) is placed before the court. Whilst I would not rule out the possibility of a consultant obstetrician and gynaecologist, particularly one with the expertise of Dr Sullivan, providing the only evidence of a learning disability, it seems to me far from satisfactory in matters of such profound importance to JP for the evidence of the impairment or disturbance in the functioning of the mind or brain to come from a clinician other than a consultant psychiatrist or psychologist, particularly where it is known that JP is known to a psychiatric team. Where such evidence is likely to be available because JP is and has been under the care of a learning disabilities team for some 2 ½ years the first port of call for such information ought to be from that specialist team, preferably the lead consultant.*

The proceedings were adjourned (for a short period) to enable confirmation as to the impairment or disturbance from JP's learning disability psychiatrist. Ultimately, on the basis of the combined evidence, Williams J declared himself:

> 28. [….] *satisfied on the basis of the medical evidence set out above that JP currently lacks capacity both to conduct these proceedings and to take a decision for herself on the issue of her medical treatment relating to her ante-natal care and the delivery. In particular she is unable to make a decision for herself because she does not understand the information relevant to the decision and is unable to use or weigh that information as part of the process of making the decision. The evidence from the health visitor and Dr Sullivan make it clear that many attempts have been made to convey information in a way tailored to JP's learning disability about the process of delivery and the risks attendant upon it and the options available but because of her learning disability JP has been unable to understand that information or to use or weigh it. This inability to make a decision for herself is caused by the impairment or disturbance of the functioning of her mind or brain arising from her diagnosed learning disability. The evidence of the efforts made by the health visitor, learning disability support and Dr Sullivan make clear there is no means by which she could currently be enabled to make a decision. The lack of capacity is likely to be permanent but will certainly endure until after the baby is born.*

Best interests

With specific reference to the element of deception, Williams J directed himself that:

> *21 It is a fact of the proposed care plan that it will involve an element of deception of JP. In NHS Trust-v-K and Ors [2012] EWCOP 2922; Re AB [2016] EWCOP 66; Re P [2018] EWCOP 10 and NHS Trust (1) and (2) -v-FG [2014] EWCOP 30 the court has confirmed that*

> *deception can be compliant with the individuals Article 8 rights provided the best interests exercise has been carried out. It seems to me that if it is in JP's best interests for deception or misrepresentation to take place then the court would be obliged to authorise that. The question of the level of deception would no doubt feed into the evaluation of whether the best interests of JP were met by the plan which involved that deception; the greater the deception the more it might potentially weigh against JP's best interest and vice versa but as a matter of principle seems to me that deception cannot be a bar to authorisation of a procedure. To hold otherwise would be to supplant the best interests of JP by some other principle, perhaps of public policy, that the court should not condone white lies.*

Williams J accepted the medical evidence that, objectively, a vaginal delivery was likely to be profoundly distressing for JP and extremely risky in terms of her health, and that the "*alternative of a planned caesarean under general anaesthetic is the least worst of all of the options that exist*." All the clinicians and JP's support worker agreed that the proposed plan was in her best interests, as did the Official Solicitor – who, via the solicitor instructed on JP's behalf – had been unable to engage with her.

Williams J noted that:

> *41. In so far as it has been possible to discuss matters with JP it is clear that her wish is to give birth naturally. It is clear that she wishes to retain autonomy over what happens and her body. Those are very important factors.*

> *42. Section 4(6) requires that in evaluating 'best interests' I consider past and present wishes, beliefs and values that would be likely to influence JP's decision if he or she had capacity and the other factors she would be likely to consider if she or she were able to do so. The evidence demonstrates that JP does not tolerate pain well and welcomes intervention which reduces pain. She appears to believe that gas and air will eliminate the pain of childbirth. Regrettably that is likely to be an erroneous belief. It is more likely that JP would experience considerable pain, discomfort and distress from the process of childbirth. This is in part a natural physical consequence but the emotional distress that she might experience will in my view be all the greater because she does not understand truly what will be happening to her. If she were able to understand the great physical and emotional toll that giving birth naturally can give rise to it seems likely that she would wish for an intervention that would minimise or eradicate that pain. Were she to have capacity I conclude that she would, along with many other expectant mothers, opt for an elective caesarean probably under general anaesthetic.*

Williams J noted that the following matters weighed against the approval of the proposed treatment plan:

> *43. i) It is against JP's expressed wishes. She is likely to experience distress, distrust, anger, frustration at both the deception that may be necessary and the carrying out of a surgical procedure against her will in respect of such a profoundly important matter. This is likely to be all the greater because it is*

> *proposed that the baby will be removed from her care.*
> *ii) It appears likely to be against the expressed wishes of some family members close to her, including the putative father of the baby.*
> *iii) There are risks associated with the administration of general anaesthetic in the hospital environment.*
> *iv) There are far higher risks associated with the administration of anaesthetics outside the hospital environment if that became necessary.*

However,

> *44. Taking a broad approach to the factors which bear upon JP's best interests I am satisfied that it is in her best interests overall to approve the proposed treatment plan. The risks attendant upon an attempted vaginal delivery are so high that they plainly outweigh the risks linked to the proposed treatment plan. The other disadvantages to JP of approving the proposed treatment plan are not such as to outweigh the overall medical advantages to her of approving it. The reality is that this is a case where the proposed treatment plan is the least worst option. There is no ideal solution.*

Postscript

Because of the way in which the application had been brought, Williams J had had to make his order first and then finalise his judgment subsequently. Before it was finalised, he received:

> 48. […] *the happy news that JP has indeed gone into labour, I believe on the 19 June, and had delivered her baby without the care plan I had authorised being implemented. Thus JP, against my evaluation of the probabilities, was able to give birth to her baby naturally. The capacity for individuals to confound judges' assessments is a reminder (to me at least) of the gap between probability and actuality.*

It is not obvious from the postscript whether JP's baby was, in fact, removed.

Comment

This case stands as a reminder both of the 'high-end' nature of the interventions that the Court of Protection can be invited to make in obstetric cases, and of the importance of ensuring that where judicial endorsement for such interventions are being sought that the need is recognised at an early stage. It also serves as a reminder of the need for in care in establishing the nature of the material impairment or disturbance in the functioning of the mind or brain and the causative nexus between that impairment/disturbance and the functional inability to make the decision in question. And, as the judge wryly noted, the outcome of the case shows that the assessment and determination of capacity is as much an art as it is a science (hence, by way of shameless plug by Alex, the importance of the work being done under the auspices of the Mental Health and Justice project to refine the practice of that art).

Finally, in terms of representation, this case could be added to the list of those discussed in this article where we might feel uneasy at the "best interests" construction of the function of litigation friends. Whilst there is no reason at all to think that all concerned with the Official Solicitor's office did not direct themselves very carefully before agreeing with the plan as being

in JP's best interests, the fact remains that she did not have anyone before the court actively advancing arguments supporting her clear wish to retain autonomy over what happens and her body.

Medical treatment, best interests, and the desire to live

Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust v TG & Anor [2019] EWCOP 21 (Cohen J)

Best interests – medical treatment

Summary

If proof were needed that *Bland* has politely been consigned to the history books, it can be found in the decision in *Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust v TG & Anor* [2019] EWCOP 21 which appeared on Bailli several months after being decided in February 2019.

The case concerned the question of whether it was in the best interests for intubation to continue for a woman, TG, an inpatient in the critical care unit of the Royal Bournemouth Hospital. TG had been at church 16 December 2018 when she collapsed, having suffered a massive subarachnoid haemorrhage, and then a secondary cardiac arrest.

Some 8 weeks later, TG still had her endotracheal tube in place. She was attached to a ventilator but received little support from it in the sense that it was not something that appeared to be an important part of keeping her alive and it was anticipated that she will be likely to be removed from it within the near future. The scans which have taken place and the EEG sequences show that TG had suffered severe cerebral dysfunction and that there is very extensive damage to the cerebral cortex. There were no wave patterns which suggest sentience. She was in a vegetative state at the moment. She had eye opening and blinking and had some movements to her right shoulder and neck area. It did not appear that her level of consciousness or the degree of responsiveness hadchanged significantly over the course of the eight weeks since her arrest.

The agreed medical evidence, including from the independent expert, was that the chances of meaningful improvement were very small and there was no chance of meaningful recovery. The independent expert considered that there was

> *8. a small chance of recovery to MCS minus which would be the best outcome. If that happened, she may be able to have awareness of pain but nothing more than minimal consciousness at a very low level.*
>
> *9. There is, he says, no chance of her recovering to a stage of MCS plus, a level which might permit very simple vocalisation and answers to basic questions and the ability to recognise someone who was close to her. That would, at best, enable her to follow with her eyes or respond to pain or touch but he says, in this case there is no chance of that degree of recovery being reached. He says her memory will almost certainly completely have disappeared and her previous personality will not emerge.*
>
> *10. His view, shared by the other professionals who have expressed their opinion, is that it is not in her best*

> *interests to continue with intubation and that nature should be allowed to take its course with the likely result of an early death.*

What was not being said on the face of the judgment, either by the Trust or the expert, that continued intubation would either (1) be clinically inappropriate; or (2) would be physiologically futile in the sense of not continuing to keep her airways clear.

The neurological expert expressed the view that, if contrary to his advice, intubation considered, it would referable in the near future for discussions to take place with the family with a view to a tracheostomy. If successfully done, his view was that this would :

> *11.* […] *enable, at least in theory, a range of other options for her care because at the moment she is confined and has been since admission to the critical care unit. If a tracheostomy succeeded then it may be that care in the community, either in a special nursing home or at home might become possible. If the tracheostomy became complicated and caused problems, that may mean that she would have to remain in hospital, albeit in a less acute unit.*

Although not stated expressly on the face of the judgment it is clear that the Trust – rightly – brought the application following because, as had been identified by the Supreme Court in *NHS Trust v Y* [2018] UKSC 46, at the end of the medical process there was a lack of agreement between the Trust and family.

The Trust took the view that there was no benefit in the continuation of treatment except the fact that TG would remain alive. Relying upon the decision of the House of Lords in *Bland* in which there was no prospect of any improvement in the patient's position,

> *18.* […] *by analogy the Trust sought to persuade me that medical treatment should not be persisted with when it is futile and secondly, that the patient in this case, as in Bland, would be completely indifferent to the medical treatment, whether it continued or not and whether she remained alive or not.*

However, Cohen J identified that:

> *18* […] *that case needs to be seen on its facts. It was, of course, a case decided before the arrival of section 4 of the Mental Capacity Act, to which the individuals wishes, feelings, beliefs and values are central feature. Certainly, in the Court of Appeal judgments in Bland, Butler-Sloss LJ as a starting point, put at the centre self-determination, and I return to that in a moment.*
>
> *19. The law has moved on since Bland and there are two other passage of the authorities of particular relevance. The first is paragraph 62 of Briggs (no. 2) [2017] 4WLR 37, where Mr Justice Charles said this:*
>
> > *"But in my view, when the magnetic factors engage the fundamental and intensely personal competing principles of the sanctity of life and of self-determination which an individual with capacity can lawfully resolve and determine by giving or refusing consent to available treatment regimes:*
> >
> > *(i) the decision maker and so the judge must be wary of*

> *giving weight to what he thinks is prudent or what he would want for himself or his family, or what he thinks most people would or should want, and*
>
> *(ii)* *(ii) if the decision that P would have made, and so their wishes on such an intensely personal issue can be ascertained with sufficient certainty it should generally prevail over the very strong presumption in favour of preserving life."*

20. These matters were also considered in the case of Lambert v France [2000] 30 EHRR 346 (application number 46043/14), a judgment delivered by the European Court of Human Rights in June 2015. At paragraph 142 the court said this:

> *"In a case such as the present one, reference should be made, in examining a possible violation of Article 2, to Article 8 of the Convention and to the right to respect for private life and the notion of personal autonomy which it encompasses. In Pretty the Court was not prepared to exclude that preventing the applicant by law from exercising her choice to avoid what she considered would be an undignified and distressing end to her life constituted an interference with her right to respect for private life as guaranteed under Article 8 of the Convention. In Haas it asserted that an individual's right to decide in which way and at which time his or her life should end was one of the aspects of the right to respect for private life."* (emphasis added)

Cohen J therefore delved into TG's wishes, although before doing so he noted that he did not consider that the issue of indignity was one that featured large in this case, arriving at that conclusion for a number of reasons:

> *22.* […]*, first of all it is quite clear from the statements made by the family and friends that personal dignity is not something that featured large in TG's life or thoughts. Secondly, I am satisfied that the issue of pain is not one that impacts in this case as it is not felt by the patient. If pain does emerge, as it might if she were to regain a minimal degree of consciousness, that should be amenable to treatment with medication*

Praising the quality of the statements of TG's husband and son, Cohen J noted that they had two principal strands:

> *24.* […]*. They have two principal strands: first, that if her presence was a comfort to others (as I find it to be) she would want to be there whatever the cost to her. Family was central to her and she would want to remain a part of the family no matter what form it would take for as long as possible. Secondly, she had the utmost respect for life because of its intrinsic value and that it was for no-one other than the Lord to take away. It is for Him alone to end and she would never accept anyone else facilitating death. I also take into account the statement of her friend M who had a discussion with her about Dignitas in the context of a programme on television and she recalls*

> *TG saying, "Why do people want to go?" before adding something like "They're not God and they don't know what will happen in the future." It is absolutely clear from everything that I have read that her Catholic faith and her belief in God were and are a crucial part of her life.*

Cohen J agreed that this represented "compelling evidence" that TG would not have consented to the withdrawal of intubation, and that her wishes and feelings and beliefs and values were plainly for the continuance of life. He noted that he had:

> *26.* […] *asked counsel if they were aware of any case in which the court has terminated life support against the wishes of the patient and they were unable to tell me that there ever was one; with the quality of expertise before me I am sure that there must therefore not have been such a reported case.*

Into the mix Cohen J also put the fact that he was being asked to make the decision two months after injury when the Royal College of Physicians' guidance indicated that in the case of a non-traumatic injury such as this, six months is required before a vegetative state is regarded as being permanent, such that he was being asked to make a decision at a point when it was possible that when it was possible that TG might make some recovery and be able to return to live at home even if she would be unaware of the fact.

The balance sheet identified by Cohen J (reconstructed here from continuous prose) was as follows:

Benefits of removal of tube	Benefits of maintenance of tube
First, it would be the end of the process which brings, or is likely to bring no significant benefit to TG.	On the other side there is the continuation of life
Secondly, it removes the possibility of indignity and/or pain.	there is the recognition of her wishes for herself and for her family
	thirdly, it enables her life to progress and be ended in accordance with the will of God
	fourthly, it permits the possibility, faint though it may be, of some improvement in her state and
	fifthly, although this may be repetitious, it provides the ability for her to play a part in her family as she and they would wish, even though she would be unaware of it.

Cohen J therefore came to the:

> *30.* […] *clear decision that it is in the patient's best interests that intubation should continue. I recognise that this places a huge burden on the treating*

> *team. It is against their advice and their wishes and of course also those of Dr Newman but I remind myself constantly, this is her life and her wishes as I have found them to be and nobody else's. It may be that if the position were to remain the same in six months' time or no successful tracheostomy had been carried out that different considerations might apply but I am not looking at the future, I am looking at things as they are now and for those reasons I reach my decision and refuse the application.*

Comment

It is clear that the courts in this context now take very seriously their task of starting with the person's known wishes and feelings and following the logical implication of those wishes and feelings to their end. That can mean stopping treatment even in the face of opposition from a 'pro-life' team; conversely, as in this case, and as in *HB* (about CPR) taking the court on P's behalf very close to (but not quite over) the line of dictating to clinicians to provide treatment that they do not consider to be beneficial. It is undoubtedly the case, as Cohen J has identified, that the law has therefore moved on substantially since *Bland*, both in the increased focus on the (near) determinative place of wishes and feelings, and in the narrowing of futility from the broader concept of not providing wider benefit to the question of whether the intervention in question would actually work – in this case, to keep TG's airways clear.

The MHA and the MCA in the community

Birmingham CC v SR; Lancashire CC v JTA [2019] EWCOP 28 (Lieven J)

DoLS authorisations – DoLS ineligibility – Mental Health Act 1983 – Interface with MCA

Summary

Two local authorities made streamlined *Re X* applications on COPDOL11 forms to authorise the deprivation of liberty of two individuals who were either about to be (SR), or had been (JTA), conditionally discharged from ss37/41 of the Mental Health Act 1983. SR had mild learning disabilities and autism and would require 1:1 supervision in the community to prevent him consuming alcohol and to prevent risk of re-offending. SR wished to live in the proposed supported living placement and was happy with the proposed care arrangements. JTA had a learning disability, communication difficulties and bipolar disorder. In 2016 the tribunal had conditionally discharged him on conditions that included one of residence and that he "*shall not be permitted to leave his accommodation unless accompanied and supervised at all times*".

There was no dispute that both individuals lacked capacity to consent to their care arrangements which gave rise to a deprivation of liberty. The fundamental issue was, in light of the Supreme Court's decision in *MM v Secretary of State for Justice* [2018] UKSC 60, it was lawful to authorise a deprivation of liberty under the Mental Capacity Act 2005. In *M*, the individual had the relevant capacity and it was held that the conditions of a conditional discharge cannot deprive liberty because the MHA does not permit it. But did the MCA permit it? This was left open by Lady Hale:

> *27. Whether the Court of Protection could authorise a future deprivation, once the FtT has granted a conditional discharge,*

> *and whether the F-tT could defer its decision for this purpose, are not issues which it would be appropriate for this court to decide at this stage in these proceedings.*

Government guidance was produced in light of the *MM* decision which distinguished between (a) those whose best interests require a care plan depriving liberty to help them perform daily living activities or self-care, and (b) those who deprivation of liberty is primarily to protect the public. It suggested using the MCA to authorise the former and MHA s.17(3) escorted leave for the latter.

Lieven J held that both SR and JTA would fall into case B of the eligibility categories because, at the time the COP order comes into effect, they would be subject to a hospital treatment regime but not detained under it. Thus, they were eligible to be deprived of liberty under the MCA so long as this was not contrary to a MHA requirement. Her Ladyship concluded that it was in the best interests of both individuals to be deprived of liberty in their respective placements. As to protecting the public:

> *41. In the case of SR, it might be argued that the purpose of the deprivation of liberty and some of the other elements of the care package is the protection of the public, rather than the care of SR. However, for the reasons given by Moor J in ZZ I think that is a false dichotomy. It is strongly in SR's best interests not to commit a further offence, or to place himself at risk of recall under the MHA, if the Secretary of State were to conclude that the risk of other offences was too great. In those circumstances the provisions of the care plan in terms of supervision and ultimately deprivation of liberty is, as Moor J put it, "to keep him out of mischief" and thereby assist in keeping him out of psychiatric hospital. This is strongly in his best interests, as well as being important for reasons of public protection.*
>
> *42. It is for this reason that I am not convinced that the division the Secretary of State makes in the Guidance between patients whose care plan is in the patients' best interests, and those where the deprivation of liberty is primarily for the purpose of managing risk to the public, is one that stands up to close scrutiny. However, on the facts of this case I have found that both patients would fall into the first category in any event.* (emphasis added)

Accordingly, Lieven J authorised the deprivations of liberty.

Comment

Parliament clearly planned for the scenario whereby a conditionally discharged patient lacking the relevant capacity could be deprived of liberty under the MCA 2005. So long as there is no compatibility (eg as to residence), such a two-pronged approach is in our view lawful. It is not entirely clear from the judgment but, in light of *M,* it would be unlawful for the MHA conditions in JTA's case to deprive liberty. Whether any watering down of the condition regarding constant community supervision was envisaged is unclear, the judgment merely observing, "*There is no inconsistency between the two orders, it is merely that under the MHA, as interpreted in M, there is no power to deprive the patient of his/her liberty. That does not prevent the MCA powers being used*" (para 46).

The approach of Lieven J also accords with that of Hayden J in an unreported CTO case determined on 5 July 2019. The Vice-President took the view that there was no jurisdictional bar to the Court of Protection authorising P's deprivation of liberty, so long as the CTO conditions did not give rise to confinement. Hayden J has given permission for the relevant recital to the order to be published, and it is reproduced below:

> *AND UPON the Court being satisfied that neither the decision in Secretary of State for Justice v MM [2018] UKSC 60, nor that in Welsh Ministers v PJ [2018] UKSC 66, prevents the Court of Protection making an order under s.16(2)(a) Mental Capacity Act 2005 authorising (by s.4A(3)) the deprivation of liberty in the community of an individual lacking the material decision-making capacity who is subject to a Community Treatment Order, so long as that Community Treatment Order does not contain conditions that on their face give rise to the confinement of the individual.*

The SR/JTA decision will enable incapacitated restricted patients to be lawfully discharged from MHA hospital detention and deprived of liberty under the MCA in the community which is a welcome development. We anticipate, however, that increasing attention will be paid to the claim that it is in SR's best interests not to commit further offences. After all, the MCA is not a policing statute. It is designed to protect P from harm. However, the consequences of *Cheshire West* are testing the boundaries of MCA ss5-6 as practitioners cry out for Article 5 procedures to authorise the expansive notion of deprivation of liberty.

Strictly speaking, para 41 is *obiter* because para 42 confirms that the best interests of both SR and JTA required a care plan depriving liberty to help them perform daily living activities or self-care. Other cases may not be so clear cut on the facts. But it is worth bearing in mind that, as the MHA Code states at para 14.10, "*it is not always possible to differentiate risk of harm to the patient from the risk of harm to others*". For no person is an island.

Editors and Contributors

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

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 Wellcome Research Fellow at King's College London, and created the website www.mentalcapacitylawandpolicy.org.uk. To view full CV click here.

Victoria Butler-Cole QC: vb@39essex.com

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

Neil Allen: neil.allen@39essex.com

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

Annabel Lee: annabel.lee@39essex.com

Annabel 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.

Nicola Kohn: nicola.kohn@39essex.com

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.

Editors and Contributors

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.

Katherine Barnes: Katherine.barnes@39essex.com

Katherine has a broad public law and human rights practice, with a particular interest in the fields of community care and health law, including mental capacity law. She appears regularly in the Court of Protection and has acted for the Official Solicitor, individuals, local authorities and NHS bodies. Her CV is available here: 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; 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

Conferences at which editors/contributors are speaking

Liberty Protection Safeguards: Implementation of the Mental Capacity (Amendment) Act 2019

Alex is chairing and speaking at a conference about the LPS on Monday 23 September in London, alongside speakers including Tim Spencer-Lane. The conference is also be held on 5 December in Manchester. For more information and to book, see here.

Clinically Assisted Nutrition and Hydration Supporting Decision Making: Ensuring Best Practice

Alex speaking at a conference about this, focusing on the application of the BMA/RCP guidance, in London on 14 October. For more information and to book, see here.

Advertising conferences and training events

If you would like your conference or training event to be included in this section in a subsequent issue, please contact one of the editors. Save for those conferences or training events that are run by non-profit bodies, we would invite a donation of £200 to be made to 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.

We are taking a break over summer, and our next edition will be out in September. 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.

Michael Kaplan
Senior Clerk
michael.kaplan@39essex.com

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

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

Chambers UK Bar
Court of Protection:
Health & Welfare
Leading Set

The Legal 500 UK
Court of Protection and
Community Care
Top Tier Set

clerks@39essex.com • DX: London/Chancery Lane 298 • 39essex.com

LONDON
81 Chancery Lane,
London WC2A 1DD
Tel: +44 (0)20 7832 1111
Fax: +44 (0)20 7353 3978

MANCHESTER
82 King Street,
Manchester M2 4WQ
Tel: +44 (0)16 1870 0333
Fax: +44 (0)20 7353 3978

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

KUALA LUMPUR
#02-9, Bangunan Sulaiman,
Jalan Sultan Hishamuddin
50000 Kuala Lumpur,
Malaysia: +(60)32 271 1085