Essex CHAMBERS

MENTAL CAPACITY REPORT:
HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

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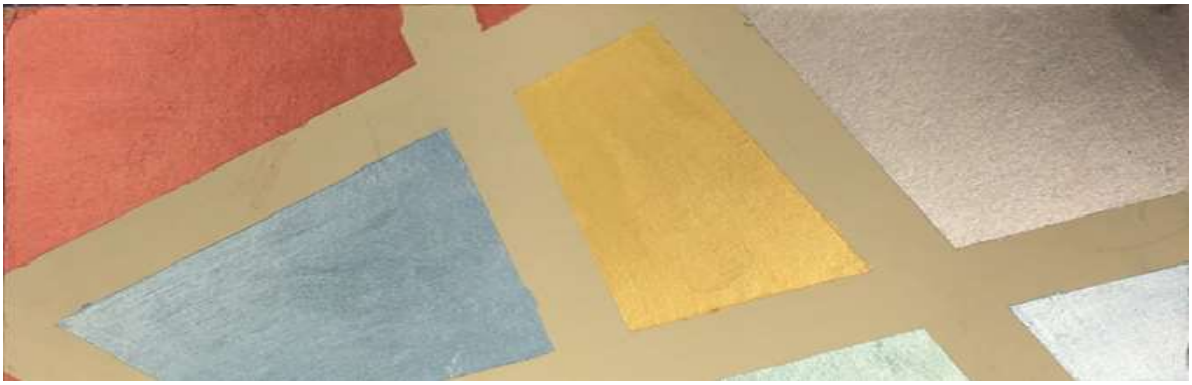

Welcome to the March 2021 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: two cases each on vaccination, how long to keep going with life-sustaining treatment and obstetric arrangements, and important decisions on both family life and sexual relations;

(2) In the Property and Affairs Report: Mostyn J takes on marriage, ademption and foreign law, and updates from the OPG;

(3) In the Practice and Procedure Report: reasonable adjustments for deaf litigants and a new edition of the Equal Treatment Bench book;

(4) In the Wider Context Report: DNACPR guidance from NHS England, NICE safeguarding guidance, reports on law reform proposals of relevance around the world and (an innovation) a film review to accompany book reviews and research corner;

(5) In the Scotland Report: Scottish Parliamentary elections, Child Trust funds and analogies to be drawn from cases involving children.

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

Care home visiting guidance – England

The DHSC has published both guidance for care homes and for visitors, that took effect on 8 March 2021 (as well as a one page summary). It is perhaps worth emphasising that there is no change in the law – visiting people in care homes is not, and has not been, unlawful (save in the exceptional situation where a care home has been closed to visitors at the direction of a Director of Public Health). Alex's summary of the guidance, together with the updated guidance for visiting out of care homes can be found here.

How long can you wait to allow the family to gather around the bedside?

Sandwell And West Birmingham Hospitals NHS Trust v TW & Anor [2021] EWCOP 13 (Hayden J)

Best interests – medical treatment

Summary

In this case Hayden J considered a version of a dilemma that presents itself frequently in clinical settings, although rarely so starkly: should treatment continue solely to allow family the time to be with the patient before they die? The case concerned a man, TW, who had suffered a catastrophic brain injury after a stroke at the age of 50. The view of those caring for him in the intensive care unit was that the interventions that they were carrying out – suctioning his airways and providing every aspect of his personal care – were sustaining the life of his body, but were doing no more than that. Absent ventilatory support, he would be likely to die

within minutes, but at most would not survive for long enough to be discharged from hospital, even to a hospice. It is not immediately obvious why his position was brought before the court, but it appears that it must have been a result of the fact his family (in different ways and for different reasons) did not agree that continuation of life-sustaining treatment was no longer in his best interests.

As Hayden J identified, following the medical evidence, the family's views appeared to diverge, but he did not see this as a conflict. TW's wife and his brother "*cling to a hope for recovery which cannot be founded in the evidence.* [His three adult] *daughters acknowledged the force of the medical reasoning and recognise it as irresistible*." However, TW's daughters, giving evidence together and remotely from Canada:

> *ask*[e]*d only for the chance to say goodbye to a much-loved father. It is the most natural and instinctive request. It is what most families would want. It is what any doctor would want to be able to facilitate, and it is what any judge would want to be able to achieve. I was struck by the way N put it: it was not merely what they wanted, she told me, it is what they knew their father would have wanted. It was, as she described it, a facet of his rights, and his dignity, at the end of his life, that she wanted to be able to deliver. Even in these unbearable circumstances the daughters focused not on their own needs but on what they believe to be their father's needs. I have no doubt that TW would have been immensely proud of his daughters' courage and, if I may add, rightly so.* (paragraph 28)

Hayden J found that this request was "*so powerfully and compellingly advanced*" that he returned to the Trust's Counsel to explore whether this position, which had changed from the case advanced, could be put separately to the doctors. TW's doctors gave further evidence, and Hayden J himself visited TW remotely in the hospital, observing that "[t]*his is an ICU ward in the middle of a pandemic, and it was impossible not to be struck by the exhaustion of all those involved. Their attention to TW, their commitment to their patient, their sensitivity to his welfare and privacy, revealed to me that even in these most distressing of circumstances, they had provided not only for his medical care, but had been vigilant to preserve his dignity as a human being*" (paragraph 30).

When Hayden J heard from Dr A, TW's consultant neurologist:

> *31.* […] *Dr A became emotional. It was the emotion, in my view, of a senior, dedicated, Consultant who had been working at an extraordinary rate for many months, in the most difficult of circumstances, and who as a human being was genuinely moved at being unable to facilitate a level of contact at the end of life that would have been his instinct as a doctor as well as a human being. His sympathy to the family was manifest. It was equally clear in the evidence of the other doctors, though expressed in different ways. Dr A impressed upon me the extent to which those working in ICU encounter death on a daily basis and in isolated circumstances. He told me that he had seen more deaths in the last twelve months than in the rest of his career put together. I gave a great deal of thought to N's carefully phrased request and to the equally powerful evidence of M and S. I*

> *wondered if it might be possible to achieve that which they desired.*
>
> *32. I cannot imagine a more difficult situation for a doctor than being in the witness box and having to confront this intensely modest and heartfelt request whilst being required to evaluate it against the broader medical context for his patient. The tension between basic human kindness, and professional, ethical responsibility, was exquisitely balanced. Dr B unwaveringly focussed upon his patient, whilst recognising the immensity of the tragedy unfolding. Key for him is the fact that TW has reached a stage where his situation, medically, is properly to be described as "precarious". Despite the best efforts of the team, and the commitment that I have outlined, there have been circumstances, in recent weeks, where even the professionalism and care of this team has not been wholly able to preserve TW's dignity.*

Hayden J noted that increasing medical interventions were being required to maintain TW's life. Although TW was not thought to have felt pain, Hayden J was clear that:

> *33. […] for it to occur in circumstances where treatment can achieve nothing, I consider that Dr B is right to recognise this as a compromise to his patient's dignity. The precariousness of TW's situation means that it is likely that he will sustain cardiac arrest and other infection which will require invasive treatment. In gentle and sensitive terms both Dr A and Dr B intimated that to require them to provide treatment in these circumstances, which they assess as contrary to TW's interests, comes perilously close to, if not crossing, an ethical boundary.*

TW's daughters lived in Canada, along with his second wife. Because of the pandemic travel restrictions, it was thought impossible to be able to arrange a visit in under three weeks. TW's situation was such that he would likely require invasive intervention in this period. In particular, further cardiac arrest was foreseeable. Hayden J was clear that:

> *34.* […] *Cardiopulmonary Resuscitation (CPR) to a patient in TW's circumstances has now become inappropriate, in the sense that it serves only to compromise his dignity whilst achieving nothing by way of treatment. I am ultimately satisfied that any plan artificially to sustain TW's situation to enable his daughters or wife to come over from Canada would be inimical to his best interests at the end of his life. Although I have been deeply moved by the evidence of these three impressive young women, I am ultimately unable to yield to their request, whilst fulfilling my obligations to their father. The medical evidence indicates that he would not know of their presence beside him.*

In the circumstances, Hayden J was clear that the continuation of ventilatory support and likely invasive treatment could no longer be reconciled with TW's best interests, and endorsed a palliative plan providing for the withdrawal of ventilator support.

Comment

As noted by Hayden J, in 'ordinary' circumstances, doctors would do all that they could to sustain life so as to allow family to gather to say goodbye. In reality, this is – understandably – as much in the interests of the family as it can properly be said to be in the best

interests of the person themselves (save and to the extent it could be identified that the person would wish to be kept alive so that their family could be with them). As with so many other areas, the pandemic is stress-testing ordinary practice almost to its limits, and it was hardly surprising that Dr A found it so challenging to have to confront head on the fact that in this case securing TW's continued life could be seen to be achieving nothing save compromising his dignity. Although, perhaps understandably, Hayden J did not push matters, he would have been very well aware that seeking to require the team to keep treating in such circumstances would have been to cross the line to require the doctors to treat in circumstances which they considered to be clinically inappropriate, a line which the Supreme Court has confirmed should not be crossed (see *Aintree* at paragraph 18). Even if, in very many cases, the line between best interests and clinical appropriateness now seems to be very thin, this case is a reminder that, ultimately there is a line, and clinicians both can – and where appropriate – should make clear when they are being asked to cross it.

When would continuing life-sustaining treatment be unethical?

Re NZ [2021] EWCOP 16 (Hayden J)

Best interests – medical treatment

Summary

In *NZ* Hayden J had to address, in even more acute form, the dilemma that he had addressed in *Sandwell And West Birmingham Hospitals NHS Trust v TW & Anor* [2021] EWCOP 13: the point at which continuing medical treatment can no longer be said to be appropriate. The facts of *NZ* illustrate the cruelty of the COVID-19 pandemic: a Muslim woman in her 30s took all the steps that she could to avoid catching it. She contracted it, however, and was admitted it to hospital. At that point, she was 32 weeks pregnant. Her condition deteriorated rapidly; after her son was delivered by Caesarean section, she was transferred to an intensive care unit, where she was started on extracorporeal membrane oxygenation ('ECMO'), described by the director of ECMO at the Trust as effectively the last resort treatment. ECMO, the court was told, was, until recent times, only really being considered as a viable option for patients who are otherwise regarded as fit, prior to their admission. It is only generally used for patients whose clinical condition places them at a 40% (or lower) chance of survival, despite having received all other intensive care treatments. During the course of the pandemic, the use of ECMO has increased approximately by a third. On average, 25% of patients do not recover. However, those patients who are placed on ECMO in consequence of conditions which are sequelae of symptoms arising from Covid-19 infection, have lower success rates than previously seen with other conditions. The director of ECMO at the Trust gave evidence that fewer than 50% of ECMO patients had been recovering in this second wave of the pandemic.

During the course of NZ's treatment, regular scans showed that NZ's pancreas had ceased to function, part of her left lung had died, and the remaining lung tissue had become 'densely consolidated or collapsed'. In addition to the death of those parts of the left lung and the remaining lung damage, there were signs of pneumothorax and evidence of pooling of blood, caused by the invasiveness of the ECMO

procedure. The treating team had started plans for a final visit for the family, but it then became clear that the family did not agree that continued treatment was not in her best interests.

The Trust therefore made an urgent application to court to endorse the plan to stop ECMO and move NZ to a palliative pathway.

The position of the Trust, explained by Dr H, the director of ECMO, was that, whilst there were patients who had stayed longer on the ECMO machine than NZ had yet done, they were all patients in whom a trajectory of improvement is identified relatively quickly, and that:

> *19.* […] *having regard to the views of the clinical team and to the second opinion from Professor A, he had come to the conclusion that he had passed a stage where he was seeking to preserve his patient's life, but had reached a point where he was, in reality, 'prolonging her death'. Though he expressed himself in sensitive terms, he signalled, to my mind, unambiguously, that he had reached a threshold beyond which further treatment would be professionally unethical.*

NZ's husband and sister took a different view, as Hayden J explained:

> *20. This is not grounded in any real difference as to the medical situation; it is, for them, a conflict between a religious belief, genuinely and devoutly held, and medical science. It is a conflict which cannot be reconciled. To condone any act that would be seen to bring life to an end would, the family believe, be inconsistent with their faith. They recognise the medical evidence and engage with it. In particular, they accept that continuation of treatment may cause NZ to suffer but consider that such suffering is the will of God and attracts God's love. MA told me that such suffering is to be welcomed and that NZ would welcome it. It is through suffering that we know God, he explained. This principle echoes not only throughout Islam, but throughout the whole of the Judeo-Christian tradition. It poses real ethical dilemmas for those who understand their faith in these uncompromising and uncompromisable terms. I do not doubt that these are the genuinely held beliefs of NZ's husband. Her sister also articulated them with equal force, though I note she required to be prodded to do so by her brother-in-law. I think it is likely that NZ, had she confronted this dilemma, would, in principle, have expressed the same religious view as her family. I am quite sure that she would have wanted to do all that she could to be with her children.*

Addressing these two positions, Hayden J emphasised that evaluation of best interests

> *21.* […] *is not confined to medical opinion alone, nor religious beliefs in isolation, nor even an assessment of wishes and feelings. Identifying best interests requires the broad canvas of NZ's life, circumstances and needs to be considered in their totality. Alongside this it must also be recognised that a court will never seek to compel or encourage a medical professional to act in a way that he or she considers unethical. The central imperative in medicine is to do good. Here the medical evidence establishes that continued ECMO treatment would achieve no benefit and cause continuing, potentially escalating, harm. I accept that evidence.*

Hayden J's conclusion was therefore, whilst reached reluctantly, inevitable:

> *29. This is a young woman whose life and hopes have been extinguished by this insidious virus. It is a tragedy of almost unbearable dimension. A young family split apart prematurely; their grief is raw and palpable. It is almost beyond human empathy; the pain is so obvious and visible that there is an instinct to seek to recoil from it. As I have set out, the care plan contemplates that NZ and her family will be together at the end. It is structured to avert further pain and its central premise is to promote NZ's dignity at the end of her life. The objective here is not to shorten her life, but as Mr H has, in my judgment correctly identified, to avoid the prolongation of her death. NZ will have her husband and family with her at the end. That is a right that many have, of necessity, been denied in the last 12 months. Their loss has underscored the importance of this final contact for those for whom it can be achieved. I should like to say finally, that RZ and MA could not have expressed themselves more forcefully, sincerely or with greater eloquence. They could have done no more for their wife and sister and I hope that brings some peace for them.*

Comment

Over and above the personal tragedy at the heart of this case, it shows not just the extraordinary measures (in every sense of the word) being required to meet the needs of patients with COVID-19, and how even those measures cannot guarantee success. It also reinforces the extent to which law and ethics run side by side in intensive care. As in *TW*, Hayden J's decision in this case shines a spotlight on a clinical dilemma that arises very frequently (although normally under less fraught circumstances than at present) – i.e. the point at which continuing treatment is felt by the doctors not just to be doing no good, but actively to be causing harm. In the majority of these cases, a resolution is ultimately reached without the need to come to court – and here is a good place to highlight that mediation can play a hugely important role – but ultimately, a judge may need to be involved. The court can, and will, probe the reasoning of the medical team, and should challenge their decision-making if and to the extent it is based (for instance) upon incorrect assumptions about the patient's wishes and feelings or how the patient would judge the quality of their own life. Ultimately, however, and just as would be the case with a patient able to speak for themselves, the fact that the patient's voice is being relayed by others on their behalf does not mean that the team can be required to act against their clinical conscience.

Vaccination – confirmation of the centrality of the person's wishes and feelings

SD v Royal Borough of Kensington And Chelsea [2021] EWCOP 14 (Hayden J)

Best interests – medical treatment

Summary

In a further judgment concerning vaccination for COVID-19, Hayden J has amplified the approach that he set out in *E (Vaccine)* [2020] EWCOP 14. In this case, the applicant, SD, was the daughter of a woman in her 70s living in a care home in the South-West of England. She brought an application, unrepresented, for a declaration that

it would not be lawful to administer her mother, V, with a vaccine against Covid-19, or indeed, any other vaccine, on the basis that to do so would be contrary both to her best interests and to what SD contended would be her wishes. The application was resisted by a London local authority (the judgment does not make clear why it was this local authority, given that V was not resident there). Interestingly, Hayden J was content to appoint SD as her mother's litigation friend, perhaps reflecting the fact that he was sufficiently confident that she was able to relay V's wishes and feelings, central to his determination of her best interests.

Hayden J's judgment contained a succinct pen-picture of V's life which was very relevant to the best interests decision to be made in relation to her. More widely, Hayden J expressed his concern as to how the matter had come to court. On 13 December 2020, SD – who lived in New York – had told the care home that her mother was not to receive any vaccine on the basis that she did not think that the vaccines had undergone sufficiently rigorous safety trials and, in her view, there were unacceptable risks of side effects which contraindicated the taking of the vaccine. On the day the care home was set to vaccinate its residents, V had followed the other residents into the room where the vaccinations were being dispensed. She knew nothing of her daughter's position. Her main carer at the care home had to tell her that she was not to receive the vaccine. She waited for about twenty minutes in the room, and then drifted away. Her general level of functioning meant, it appeared, that the issue had now gone from her mind and she had not returned to consider it. Hayden J considered that there was no question that V did not have the capacity any longer to evaluate the question of receiving the vaccine for herself.

On 14 January 2021 – i.e. a month later, the care home informed the local authority of the situation. The local authority then considered what to do, but does not appear to have made any application – the application brought, nearly a month later, was brought by SD. Hayden J indicated that he considered that the delay was unsatisfactory, noting at paragraph 14 that:

> *When an issue arises as to whether a care home resident should receive the vaccination, the matter should be brought before the court expeditiously, if it is not capable of speedy resolution by agreement. This is not only a question of risk assessment, it is an obligation to protect P's autonomy. In the intervening period, Mr A told me that there was a suspected Covid-19 risk in the care home, which happily came to nothing. It is axiomatic that if Covid-19 had entered the home, V would have been at considerable risk. It is important that I record that every other resident and staff member has now been vaccinated.*

Hayden J identified the specific risks to V as follows (at paragraph 22):

> *i. If V were to become infected with Covid-19, she possesses a number of characteristics which make her particularly vulnerable to severe disease or death. She is 70 years of age, she carries significant excess weight, and she has dementia resulting from her Korsakoff's syndrome;*
>
> *ii. most importantly, she lives in a care home. It is an inescapable fact that in the UK, more than a quarter of the deaths due*

> *to Covid-19 have occurred within care home settings;*
>
> *iii. V's particular care home, by virtue of its specialism, deals with a unique category of risk. V has been described as 'a wanderer', though far less frequently of late. In consequence of her short-term memory problems, it is impossible for V to follow the principles of social distancing and preventative hygiene measures. Evidence from Mr A demonstrates that she is very sociable, and it would not be feasible within the setting of this care home for her to self-isolate if she contracted Covid-19;*
>
> *iv. Every member of staff, and every other resident of V's care home, has now been vaccinated. Mr A told me that, while they are not free from the risk of contracting Covid-19 until we are all free from that risk, because no vaccine is 100% effective, this fact nevertheless will result in the care home's residents having greater contact with the outside world in due course. Providing it is safe to do so, he hopes that the residents will be able to venture outside and go for walks, so that they will have something of their basic liberty restored to them. Accordingly, just as the risk to all other residents of the home diminishes, V's risk of contracting the virus will elevate as the outside world gradually returns.*

In terms of V's wishes and feelings, Hayden J rejected the argument advanced by SD that he should place little weight upon the fact that she had received the influenza vaccine every year for the past nine years, because she was simply "following the herd" when she lined up and received her flu vaccine and similarly when she put herself forward for the Covid-19 vaccine. At paragraph 24, Hayden J noted that "*SD suggests this was attributable to her mother's cognitive impairments and a facet of her Korsakoff's syndrome*." However, "[p]*aradoxically in the light of the evidence that SD gave, I do not consider that V's compliance should be attributed to her condition. As SD told me, her mother was, while capacitous, readily compliant with the advice of her doctors. Her response both to the flu vaccines and to the Covid-19 is consistent with her earlier capacitous behaviour*."

SD's views, it emerged, were driven in substantial part by her interest in exploring "other solutions." As Hayden J noted at paragraph 29, "[s]*he was, to put it mildly, extremely enthusiastic about the viability and potential for an anti-parasitic drug that she had read about, namely 'ivermectin'. She was in no doubt that this would most effectively protect her mother from the Covid-19 virus*." However, Hayden J continued:

> *30. Ivermectin has not, at least as yet, achieved credibility with any public health authority, as a treatment for Covid-19; oral ivermectin appears to be an unlicensed treatment for some forms of scabies and other parasites. I found it striking that SD rejected the overwhelming view of the public health authorities in relation to the certified vaccines, speculating about the risks of unforeseen side effects or adverse reactions, yet wholeheartedly embraced the unquantifiable risks of an unlicensed and unendorsed drug.*
>
> *31. I explained to SD that it is not the function of the Court of Protection to arbitrate medical controversy or to provide a forum for ventilating speculative theories. My task is to*

> *evaluate V's situation in light of the authorised, peer-reviewed research and public health guidelines, and to set those in the context of the wider picture of V's best interests.*

In the circumstances, Hayden J had little hesitation in finding that:

> *32. Though she has argued her case forcefully, I have been left with the impression that SD is unable to disentangle her own anxieties about the vaccines and her personal scepticism relating to the process of endorsement, from her analysis of her mother's best interests. SD's advocacy for the use of ivermectin is both logically unsustainable and entirely inconsistent with her own primary position. I have no doubt that SD's opposition to her mother receiving the vaccine is generated by real concern and distress. This, however, is not shared by her mother and does not reflect V's own authentic view. None of this is to question SD's sincerity, it is simply a reflection of the fact that filial love and concern can sometimes occlude rather than focus objective decision making.*

It will not come as a surprise, therefore, to find that Hayden J concluded that it was in V's best interests to have the vaccine administered. Importantly, perhaps, he made clear that this was the result of a decision on the individual facts of V's case:

> *33. […] In cases such as this, there is a strong draw towards vaccination as likely to be in the best interests of a protected party (P). However, this will not always be the case,* ***nor even presumptively so****. What it is important to emphasise here, as in so many areas of the work of the Court of Protection, is that respect for and promotion of P's autonomy and an objective evaluation of P's best interests will most effectively inform the ultimate decision. It is P's voice that requires to be heard and which should never be conflated or confused with the voices of others, including family members however unimpeachable their motivations or however eloquently their own objections are advanced.* (emphasis added)

Comment

If the decision in *E* gave helpful guidance as to the (relatively) straightforward issues at stake in considering capacity to consent to the administration of a COVID-19 vaccine, this decision reinforces the centrality of the wishes and feelings of the individual concerned if they do, indeed, lack that capacity.

The decision is also helpful in confirming that situations where agreement cannot be reached cannot be allowed to languish. What the judgment does not address in terms is **who** should bring the application to court in the event that one is required, nor (in this case) why it was the local authority who were the respondent, as opposed to a clinical body. The local authority (at least the local authority for the area) has a statutory 'backstop' responsibility as regards safeguarding obligations, and issues relating to vaccination could, in some circumstances, be seen as a safeguarding matter. However, the normal expectation is that it would be the body with clinical responsibilities towards the person who should bring any application that is required.

Vaccination – considering all the relevant circumstances

Re CR [2021] EWCOP 19 (HHJ Butler)

Best interests – medical treatment

Summary

This COVID-19 vaccination case, decided by HHJ Butler, differed to the previous two (both decided by Hayden J) because it concerned a much younger person, who never – it appears – had the capacity to make their own decisions about vaccination. The person in question, CR, was 31; he had been diagnosed with a lifelong severe learning disability, autism and epilepsy. He was classed as 'clinically vulnerable' as opposed to 'clinically extremely vulnerable' as a result of his epilepsy and severe learning difficulties. He was also overweight, weighing an estimated 22 stone. He fell within the priority group for a vaccination. He was, at that point, in a care home, although it appears that this may only have been a temporary placement.

His father opposed vaccination on a number of bases. The CCG brought an application for a decision that it was in CR's best interests to have the vaccination (supported by his RPR, acting as his litigation friend). In response to questions from HHJ Butler, CR's father

> *1.5.* […] *stated that he had no objections to the vaccination in principle, but that this was not the right time for his son. This was based (mainly) on the lack of data as to the consequences of such a vaccine for those who fell into the same category as his son. He (and his family) did not think that there had been enough testing for those with learning disabilities (and as a result of which the relevant evidence was absent). He was also concerned that the contents of the vaccine itself might interact with the other medication that his son is receiving and in particular those that were used to control his epilepsy, and treat his ADHD. He agreed that (in part) his concerns were linked to the (now) discredited theories proposed by Dr Andrew Wakefield as regards the link between autism and the MMR vaccine, and which he still believed were accurate.*
>
> *1.6. Thus, it appears that the autism which CR has, is attributed by SR to an MMR vaccination that he received at birth. He has had no vaccinations at all since that time.*

CR could communicate via a limited range of Makaton and will respond to physical cues. It was said that he could be resistant to intervention, including medical intervention, and there was a reference to him having a phobia of hospitals and health interventions. However, in January 2021 he did permit blood samples to be taken from him, and with staff at the care home to provide him with reassurance. The court was informed that at that time CR was sedated (as a result of medication for one of his conditions) but that physical intervention was not needed and nor did CR pull away.

The CCG made clear that it would not administer the vaccination if any form of physical intervention was required.

As there was no suggestion that CR had capacity to make the decision for himself, HHJ Butler identified that the question was purely one of what was in CR's best interests, continuing:

3.3. In this instance, it is not possible to determine what CR's views or wishes might be. He is still a young man, but his condition has endured throughout his 31 years. His ability to communicate is compromised, and he is not able to understand the consequences of not having a vaccination, or having a vaccination.

3.4. As I have determined that it is not possible to reasonably ascertain his wishes, it seems to me that the position is akin to that proposed by the Law Commission and also referred to by Baroness Hale in ***Aintree University Hospitals NHS Trust v James*** *[2013] UKSC 67 at [24] 'but the best interests test should also contain 'a strong element of substituted judgment (para 3.25) taking into account both the past and present wishes and feelings of patient as an individual and also the factors which he would consider if able to do so (para 3.28)'.*

3.5. What factors would he be able to consider if he were able to do so? On the basis of the actual evidence in existence it would be as follows (and as summarised in the helpful skeleton argument provided on behalf of the Applicant and First Respondent):

(a) That the vaccination has MHRA approval in the UK;

(b) There are no contra-indications for the use of this vaccine which apply to CR;

(c) Astra Zeneca vaccines significantly reduce the risk of sustaining serious illness requiring hospitalisation (an 80% reduction in those over the age of 80) (cf The Lancet 3.2.21)

(d) a 75% reduction of asymptomatic infection (University of Cambridge 24th February 2021);

(e) that he is living in a care home (albeit covid 19 free at present) and where there have been more than 25% of deaths caused by Covid 19;

(f) he has a relevant underlying health condition and which places him in a vulnerable group;

(g) he is unable to comply with social distancing and hygiene measures;

(h) the UK has one of the highest per capita death rates in the world;

(i) he does not appear to have any anxiety about a medical intervention and which has involved the use of something sharp as recently as January 2021 (albeit that this was whilst he was sedated with a medication that is now not being administered as a part of his treatment);

(j) the documented common side effects are mild;

(k) if he did contract Covid 19 then the consequences for his health due to the health conditions that he does have might be serious illness or death;

(l) he is overweight.

It was accepted that CR fell outside:

> *3.6* […] *what might be termed the more conventional cohort of individuals who live in care homes. He is, for example young and other than his epilepsy has no conditions that cause him to be frail. There is no Covid 19 in the care home at present, but as visiting becomes more relaxed then unvaccinated visitors from outside the care home will increase the risk of such contagion. I was also told at the hearing that the vaccination programme for other residents at the care home has started.*

HHJ Butler found that, although CR was not elderly, there was still a risk, and that:

> *3.8.* […] *the consequences of infection are also still high, and engage his rights pursuant to Article 2 of the ECHR ('Everyone's right to life shall be protected by law'). CR, of course, has the same rights as everybody else who has capacity. So, notwithstanding that CR has the advantage of youth on his side, in my judgment CR still faces a real and significant risk to his safety if the vaccination is not administered. For the avoidance of doubt this applies to both doses. I am also reminded by Mr Wenban-Smith that 'There is a very strong presumption in favour of taking all steps to prolong life, and save in exceptional circumstances …. The best interests of the patient will normally require such steps to be taken. In the case of doubt, that doubt has to be resolved in favour of the preservation of life' (Munby J* ***R (Burke) v GMC*** *[2004] EWHC 1879 (Admin) and which was approved in the Court of Appeal).*

HHJ Butler found that the views of CR's father (which were apparently shared by his mother and twin brother) were genuinely held, were not intrinsically illogical, and certainly not deliberately obstructive:

> *3.10. However, the reasons for opposing the administration of the vaccine have no clinical evidence base. In particular the objections (and this is subjectively understandable) are based on objection to this vaccination for his son as a result of what SR believes were the consequences of the MMR injection and the autism of his son. Objectively, however, this is based upon the discredited theories of Dr Andrew Wakefield (advanced in 1998) and which were (a) found to have no basis in science; (b) were formally retracted by Dr Wakefield in 2020 and (c) resulted in Dr Wakefield being struck off the Medical Register.* (emphasis in the original)

HHJ Butler considered that CR would have been likely to have considered the factors which pointed towards the "*evidence based advantages of having a vaccination*" (paragraph 4.4), and that the "*relevant circumstances*" for purposes of s.4(11) must include "*the specific vulnerability of this man (notwithstanding his relatively young age), together with the overwhelming objective evidence of the magnetic advantage of a vaccination*" (paragraph 4.7).

HHJ Butler therefore found that it was in CR's best interests to have the vaccine, but with the specific caveat that he was not endorsing physical intervention to secure it.

Comment

Of note in this case is the fact that HHJ Butler delved more deeply into the scientific evidence than had Hayden J in either *Re E* or *SD*, in large

part because there was not the same evidence as to what CR might have done based upon his own actions in order to guide the decision. Hayden J in *Re E* had made clear that it was "*not the function of the Court of Protection to arbitrate medical controversy or to provide a forum for ventilating speculative theories*" (paragraph 31), but in this case given that such a clear plank of CR's father's objection were the claims of Andrew Wakefield, HHJ Butler was on very sound ground finding that, even if they were subjectively understandable, they were simply ill-founded.

One other point of note is that amongst the factors that HHJ Butler considered CR would have taken into account was the report from the University of Cambridge that the vaccine gave rise to a 75% reduction of asymptomatic infection (University of Cambridge 24th February 2021 (nb, this report actually relates to the Pfizer, not Astra Zeneca vaccine). Questions of the potential of securing against risk of harm to others are likely increasingly to feature in considerations of best interests as matters go forward, which will, as discussed in our guidance note, make matters increasingly challenging to 'house' within ss.5-6 MCA 2005 in the event that any suggestion arises of the use of restraint.

Finally, on a procedural point, this case makes clear that decisions around COVID-19 vaccination are not being viewed by the Court of Protection automatically as serious medical treatment decisions requiring allocation to a Tier 3 (High Court) judge.

A right to family life does not mean an obligation to endure one

ZK (Landau-Kleffner Syndrome: Best Interests) [2021] EWCOP 12 (HHJ Burrows)

Best interests – mental capacity – contact – residence

Summary

In this case, the court considered the residence and contact arrangements for a 37 year old man, and the place within those decisions for his wishes and feelings.

ZK had, as a child, developed Landau-Kleffner Syndrome (also known as acquired aphasia with epilepsy). ZK was not deaf but not unable to understand aural language. Until September 2020, he lived with his mother. In 2017, concerns had been expressed about whether he was to be married, leading to a Forced Marriage Protection Order application. This led to proceedings before the Court of Protection, during which it became clear that, despite ZK's profound communication difficulties, it was possible for him to make progress in language development.

By September 2020, ZK was consistently expressing a wish to leave the home he shared with his mother. He expressed the wish to leave quickly. He did not wish his mother or family to have notice of his move. The Local Authority conducted a best interests meeting on 11 September 2020, having assessed ZK as lacking the capacity to make the decision. The decision was to move him out. In his evidence, ZK's nephew, HM, described the shock and sadness it caused to the family when, on the day of the 'removal.' ZK "*just did not return from his community activities*." HHJ Burrows indicated that he understood that,

> *14.* […] *and I can also see how that has caused ill-feeling towards the local authority and SLP, and its personification, the Managing Director, (MD).*
>
> *15. However, I am not satisfied on the basis of the evidence I have read and heard that the removal was improper, either in the fact that it happened at all, or the in the way it happened. There is clear evidence that ZK wanted to move from his mother's house and into a supported arrangement of some sort. He was assessed as being incapable of making that decision and a best interests decision was made. Consultation with, and notification to, the family would have been ideal as well as compliant with the provisions (and philosophy) of the MCA. However, there were good reasons why that could not and did not happen in this case.*

The separation after removal was sanctioned by the court (it is not clear from the judgment why an application was not made in advance).

The case then returned to HHJ Burrows for him to consider whether it was in ZK's best interests to remain away from his family home and, indeed, to move to a new placement, or for him to return to his family home and their care. By that point, it was clear that there had been a big improvement in ZK's communication skills, a view "*shared by everyone who knows ZK and has known him for some time, except his family. In evidence given by HM, ZK's nephew, he was unable to see the improvement in his uncle's ability to communicate, his engagement with others or his happiness. I do not think HM was being wilfully blind or churlish in what he said. I am quite sure that he and the rest of ZK's core family genuinely believe him to be unchanging, entirely incapable of anything but the most basic communication, and that he will remain the same in the future*" (paragraph 13).

HHJ Burrows was at pains to emphasise that whilst there was before him sufficient evidence to displace the statutory presumption of capacity, capacity was in ZK's case a subject requiring "*serious consideration and scrutiny in view of* [his] *progress*," and the court would be returning to revisit the situation with the benefit of a jointly instructed expert.

HHJ Burrows was able to dispose of the question of deprivation of liberty easily, identifying that the arrangements for him at the placement crossed the line to confinement to which ZK could not consent (but also noting that "*even if he were to reside at home with a package of care provided mostly or entirely by his family, he would also be deprived of his liberty there*" (paragraph 22).

In terms of ZK's best interests, the position was starkly set out. On behalf of the local authority and the Official Solicitor (for ZK) it was argued that "*ZK is doing extremely well where he is, doing what he is, and he wants to remain there. To deny him that wish and send him back to his family would be a serious blow to his confidence and self-esteem, as well as a serious restriction on him continuing to do what he wishes to do*" (paragraph 26).

On behalf of the family, three points were made.

First, that the removal had been illegal. HHJ Burrows did not accept that this was the case:

> *28. An assessment was made of his capacity to make that decision and he was found to be lacking. The Local*

> *Authority, with statutory responsibility for ZK's social care then had to decide what was in his best interests. ZK's clearly expressed wishes and feelings were given considerable weight alongside the other factors outlined in the evidence. They then had to decide whether and if so, how they would put into effect what they decided was in his best interests- namely, to leave his mother's home. In the circumstances as I see them, from the evidence, their actions were entirely in keeping with the MCA. There was an element of subterfuge because that was what was demanded by ZK himself. It was regrettable. It caused and continues to cause rancour. However, it was not unlawful.*

Second, the removal was the cause of a lack of trust towards the family towards the statutory body. HHJ Burrows identified that this was right, but that the law was clear:

> *29.* […] *Where a decision has to be made about care arrangements for a person who is unable to make a choice for himself, that decision must be made in* ***his*** *best interests. It is plain to me that, objectively viewed, ZK benefits hugely from his engagement with SLP. It is also clear to me that he enjoys that engagement. It would be a significant blow to him if he were suddenly spending considerably less time with the carers and support workers than he presently does. This is not just about recreation or even learning a language. To ZK it is obvious that BSL is the way in which he has been able to engage with and participate in the world. His inquisitiveness, humour and the way he behaves underline the sheer excitement he derives from the world. That should come as no surprise since that was promptly removed from him by his disorder when he was a young child, the MD drew the analogy with a 3-year-old, learning about the world and endlessly asking "why? why? why?" to every new puzzle that experience brings. That seems to me to be an accurate and useful comparison.*

Third, it was submitted that the question to be asked was "why not home?":

> *30.* […] *She referred me to FP v GM & A Health Board [2011] EWHC 2778 (COP) at paragraphs [20] and [25] in support. That case was about an elderly man with dementia who was in hospital. The issue before the Court was whether he should go home or to an EMI Nursing Home. Mr Justice Hedley considered how Article 8 of the European Convention was relevant to the interpretation of the role of the Court of Protection when making best interests decisions about residence. A person is entitled to family life unless the deprivation of family life can be justified under Article 8(2). In that case, the person at the centre wanted to go home. Hedley, J. thought the starting point in that case was "why should [P] not go home?" As I read the judgment, what Hedley, J was doing was to formulate the question he had to answer in that case, on its facts, in a simple and straightforward way. In this case, the situation is very different. ZK has been enabled to leave his family home, at his own request in order to have a more independent life, and he expresses clear wishes to remain where he is. To formulate the question as Ms Jackson suggests serves no practical purpose. To regard it as a legal presumption in this case would be entirely wrong. With regard to Article 8 of the convention, ZK has a right not an*

> *obligation to have a family life* (emphasis added)

HHJ Burrows found, in looking at all the relevant factors as required by the best interests test, that he was "*unable to shift the focus of my considerations of ZK's best interests from the fact that his wishes and feelings seem so clear and consistent. Or, put another way- using Ms Jackson's terminology "why not let him do what he wants?*" He continued:

> *32. Mr Karim, Q.C.* [for ZH] *refers me to Article 8 of the European Convention as well as the UNCRPD and the need to maximise individual autonomy. He is right. The whole purpose of the MCA is to enable those whose capacity is absent, seriously inhibited, or just emerging to be a participant in making decisions for themselves as much as possible. In this case, ZK is learning how to communicate with the wider world. He seems to like what he sees. He now has the linguistic tools to comprehend things, to ask questions, to express his views, to reflect, to ruminate, to agree and disagree and to make light of things. He is learning how to be autonomous.*
>
> *33. It is my firm view that if ZK were to be ordered to return home to whatever package of care could be put together for him at his family home at the present time, it would not serve his best interests. There is suspicion and hostility towards the local authority and SLP. I am quite sure that the family does not really comprehend what has happened to ZK, and the extent of his actual and potential abilities. Within a home environment, overseen by family members, the care plan involving SLP (or any equivalent body) would soon turn to conflict.*

HHJ Burrows was at pains to emphasise that this was not to rule out a future move home. Indeed, it might well be that with the development of ZH's communication skills, along with his sense of autonomy, there could come a time when he would be able to make that decision for himself. That was, however, some way down the line.

As regards contact, HHJ Burrows identified that the family's access to ZH should be regulated by what ZH wanted, with regular reviews of the contact plan in light of his wishes and feelings.

A procedural point arose as to expert evidence. HM, a litigant in person, raised the issue of whether he should be required to fund part of the jointly directed expert report, as he asserted he had too little income and capital. HHJ Burrows accepted his evidence, and directed that the cost should not be split so as to include a contribution from him. More fundamentally, however, HHJ Burrows identified that he could not see why he needed to be a party, because he was "*simply another person putting forward the same arguments as his grandmother. I am minded to discharge him as a party, but direct that he be provided with documents in the case, that he be invited to attend future hearings, and to contribute his views on his uncle's best interests by email in advance of the hearing as he has done until now*" (paragraph 37).

Comment

This judgment is of very considerable interest for a number of reasons. The first is that the court was led so squarely by ZH's wishes and feelings which were being asserted, it seems, despite strong familial pressure to the contrary. The second is the neat formulation of a point

sometimes forgotten, namely that Article 8 ECHR gives a right to (respect for) family life – it does not impose an obligation upon the person to have a family life with those who they may not wish to. The third is the extent to which the court identified that ZH was on a trajectory towards greater autonomy, and considered it its duty to seek to support that trajectory.

The fourth point is HHJ Burrows' rejection of the argument that ZH had been unlawfully removed from his home. Not least in light of some observations of Sir James Munby faced with one too many situations where the person had been removed against their will without any application to court, there has been a distinct degree of fuzziness as to whether (and when) such applications are required. This fuzziness is discussed here; this case reinforces the point reached in the paper that an application is not required (even if it may well be very advisable if there will otherwise be an impact upon ongoing relationships) if the primary reason for removal is to give effect to the person's wishes and feelings.

The last point which bears highlighting is HHJ Burrows' unfeigned disgust for the fact that at least some of those who had in the past worked with ZK had taken the attitude that a General Practitioner had in March 2017, namely that he wished to confirm that ZK is "*mentally retarded, deaf, dumb, unable to speak and unable to express his feelings due to Landau Kleffner Syndrome*" (paragraph 4). HHJ Burrows was at pains to record his (remote) judicial visit, the detail of which merit reproduction to show just how wrong this was. Whilst ZK might be unable to understand aural language, HHJ Burrows was clear that:

> *5.* […] *is certainly not unable to express his feelings. With the benefits of learning a non-aural language, ZK has developed a curiosity and inquisitiveness which is matched by his appetite to communicate with others including, on that occasion, me. He seemed to me to derive great pleasure from communicating and to enjoy the company of those who were with him.*
>
> *6. ZK's communication was, on the face of it, hard work for him. It consists of a combination of methods: he signed (using British Sign Language- BSL); he used a pen on paper to write messages- he is literate. He occasionally referred to the screen of his mobile phone, where he would display a relevant image. All of this was relayed to me by his intermediary and a signer. When I met him I wondered how frustrating it must be to have to go through all that just to communicate. On reflection, however, I realise that for someone who for many years, before he was introduced to sign-language, was unable to communicate very effectively at all, this process is intensely liberating.*
>
> *7. Having discussed a number of subjects with ZK for around 30 minutes I was, and remain, entirely unconvinced that the term "mentally retarded", ignoring its offensiveness, applies to him.*

Capacity and sex – the Court of Protection grapples with the move from 'consent to' to 'engaging in' sexual relations

HD (Capacity to Engage in Sexual Relations)[2021] EWCOP 15 (Cobb J)

Mental capacity – sexual relations

Summary

In *HD* Cobb J has grappled with the impact of the Court of Appeal's decision in *Re JB* [2020] EWCA Civ 735, in which the Court of Appeal had made clear that the question of capacity with regard to sexual relations should normally be assessed by reference to the question of whether the person has capacity to decide to engage in sexual relations, rather than (as had previously been understood) to consent. The Court of Appeal in *JB* identified (at paragraph 100) that the relevant information for purposes of deciding to engage in sexual relations may include "*the fact that the other person must have the capacity to consent to the sexual activity and must in fact consent before and throughout the sexual activity*."

In the case before him, concerning a 29 year old woman with what was described as a mildly severe learning disability, Cobb J found that:

> *27. […] on the ultimately undisputed evidence and on the application of the test propounded in Re JB, I am driven to the conclusion that while HD understands the need for a sexual partner to consent to engage in sexual relations, it is clear from the evidence that she cannot currently understand the need for a sexual partner to have capacity, to consent to sexual relations. I might add that had the question of HD's capacity to engage in sexual relations been listed before me several months earlier, i.e., prior to the Court of Appeal's decision in Re JB, I would probably have reached the opposite conclusion (i.e., that HD had capacity).*

Cobb J identified that Leading Counsel for HD (via the Official Solicitor) had reflected more widely upon whether it was possible to tailor, or disapply any of, the relevant information contained at paragraph 100 of *Re JB*, in an assessment of capacity to engage in sexual relations. However, at paragraph 28, Cobb J noted that:

> *[n]otwithstanding the inevitably distressing implications for HD of the conclusion to which the parties were drawn on the evidence, Mr McKendrick accepted that the circumstances did not exist here for the court to tailor or disapply the application of any of the relevant Re JB information. I agree. In short, there is no proper basis for distinguishing HD's case from the ordinary run of cases which it seems to me were contemplated by Baker LJ, and I could not therefore but conclude that the information relevant to HD's decision should be those set out in [100] of Re JB.*

One of the experts before him was of the view that it would not be possible to enable HD to learn how to assess the capacity of her sexual partner to consent to sexual relations. Another was more optimistic, and Cobb J considered that "*there is nothing to be lost, and possibly much to be gained, by providing HD with a package of further education to see if she can so learn. In view of Dr. Carritt-Baker's pessimism about the outcome, I do not propose to adjourn these proceedings now to await the outcome of any such education offered; I would however be very willing to reserve any further application for determination of this issue to myself*" (paragraph 29).

Cobb J noted that he had been asked to consider the analogous position of 'consent' under the criminal law:

> *31.* [Leading Counsel for HD] *drew attention to the commission of the*

offence of rape if the alleged perpetrator "does not reasonably believe [their partner] consents" – see section 1(2)and 3(1)(d) of the Sexual Offences Act 2003 (the 'reasonable belief' defence). He argued that an anomaly may well arise where the capacitous may lawfully reasonably believe their partner has capacity to consent to sex, and does consent, as a matter of criminal law, whereas in the context of welfare proceedings in the Court of Protection P must understand, retain, weigh up and use the fact her partner must have capacity to engage in sex. He submitted that the Court of Appeal in Re JB does not explain why a heightened civil test is required beyond that needed by the criminal law. His submission in this regard chimed with the observations of Macur LJ in R v GA [2014] EWCA Crim 299 in which she said this:

> *"The judgment of the Court of Appeal recognises and adopts the principle of the obvious desirability that civil and criminal jurisdictions should adopt the same test for capacity to consent to sexual relations by reference to various first instance judgments, amongst others Re MM (Local Authority X v MM and KM) [2007] EWHC 2003.*
>
> *We agree. ……"*

Cobb J gracefully declined to decide these points, however, as they did not arise on the case before him. He did though, note that Baker LJ in *Re JB* was clear that the jurisdiction of the Court of Protection has a distinctly different focus from the criminal law and that it was not "*appropriate to view these issues through 'the prism of the criminal law'*" (paragraph 106). On the contrary:

> *What is needed, in my view, is an understanding that you should only have sex with someone who is able to consent and gives and maintains consent throughout. The protection given by such a requirement is not confined to the criminal legal consequences. It protects both participants from serious harm.* (paragraph 107)

Cobb J was well aware of the interference in the life of HD that he was going to flow from his declaration that she lacked capacity to engage in sexual relations.

> *33.* [She] *is soon to be 30 years old and for the first time in her life will be living in her own apartment. She is at a crucial stage in her future development and has much to look forward to. She has met a partner (Z) with whom she appears happy. No assumptions can be made about the strength of her feelings for Z, or his for her, simply because they are both learning disabled; I value his and her achievements in finding happiness in a relationship in the same way as capacitous non-learning-disabled couples.*

Comment

It should be noted that the Supreme Court may yet pronounce further in *JB*'s case, the Official Solicitor's application for permission to appeal not yet having been determined.

Cobb J was clearly driven to the conclusion that he reached in this case reluctantly, and it is difficult to avoid the thought that, yet again, the tension between potentially incompatible public

policy aims: (1) the securing of the importance of consent as meaning consent; and (2) the securing of the right of those with cognitive impairments to express themselves sexually is singularly poorly-served by the statutory law in this area.

One further, unrelated, point is of note – Cobb J observes, in passing, the fact that there was some uncertainty about how HD had been fitted with a contraceptive implant given her apparent lack of capacity to be able to consent to the procedure. One can see the judicial eyebrows being raised in the footnote where he noted that it appeared that her father had signed the relevant document – in 2018…

The Court of Protection and obstetric decisions – two contrasting stories

X NHS Foundation Trust & Anor v Ms A [2021] EWCOP 17 (Cohen J) and *East Lancashire Hospitals NHS Trust v GH* [2021] EWCOP 18 (MacDonald J)

Best interests – medical treatment

Summary

In two decisions which came out simultaneously, the Court of Protection had to consider how to approach obstetric decisions, in both a planned (albeit relatively compressed) fashion and an unplanned emergency.

In *X NHS Foundation Trust & Anor v Ms A* [2021] EWCOP 17, Cohen J was concerned with Ms A, a woman in her 30s, who was 38 weeks pregnant, and who suffered from paranoid schizophrenia. She had been in hospital on at least 5 occasions in 2007, 2011, on two occasions in 2015 and now. The admissions in 2007 and 2011 were respectively after the birth of her two children. It appeared that those admissions might have been after she ceased taking medication. There have been other referrals to mental health services not requiring hospitalisation. In September 2019, Ms A stopped taking medication as she was well and wanted to try for another child. Various concerns about her mental health and functioning were raised in 2020, particularly in the last few months of the year. In early 2021, at her appointment with Dr B, her consultant obstetrician, she formed the view that Ms A lacked capacity with regard to her mental health care and treatment as she was demonstrating no insight into her previous illness. Ms A stated then that she was hoping for a normal vaginal birth at home.

In early 2021, Ms A's mental health deteriorated, and she was detained, first under s.2 and then s.3 MHA 1983. Simultaneously, it became clear that her baby was breech, which, if not corrected, meant that the risks in a vaginal delivery were significantly greater, and potentially fatal. Attempts to undertake a procedure to turn the baby were stymied, in part by Ms A's anxieties which initially led her to decline it. The choice was therefore between a vaginal breech birth or a planned caesarean section.

The Trusts responsible for Ms A's physical and mental health applied to the court for declarations and decisions about her birth arrangements. The solicitor instructed by the Official Solicitor as Ms A's litigation friend saw Ms A. Ms A said she would not be happy and would want to have it under any circumstances, the material part of the note being set out at paragraph 12 as follows:

> *When asked what she would say if there were signs of distress during labour from the baby, and the medical team said that they needed to move to an emergency caesarean section, Ms A said she didn't like thinking of the worst scenario, and didn't like to say anything about that. Her position was summarised helpfully in the Official Solicitor's agent's note in these terms:*
>
> *i) You don't agree that you are unwell;*
>
> *ii) You think you do have capacity to decide yourself how to give birth;*
>
> *iii) It is important to have a vaginal birth;*
>
> *iv) You don't feel like you have been listened to;*
>
> *v) You don't feel like everything has been done to exhaust the option of a vaginal birth;*
>
> *vi) You think that, for you, the cons of a C-section outweigh the pros.*

On the evidence before him, Cohen J was in no doubt that Ms A: (a) lacked capacity to conduct the proceedings and make decisions regarding her obstetric care and treatment and (b) that she was not able to retain and weigh up the information, including the risk that the course of action that she wished presented both to herself and the foetus, and also the increased risks engaged by an emergency caesarean section rather than a planned caesarean section.

As regards her wishes, Cohen J identified (at paragraph 18) that:

> *There is no doubt that in her more rational moments, Ms A wants the best for her child. It is why she came off medication in 2019. At a different point of her interview with the Official Solicitor's agent she says that "I would just like us to be healthy and well and return home safely". She stated that the single most important thing to her is "for me and baby to be healthy, well and safe". And indeed, it was in this sense, her being able to put the fetus first, that she presented until her relapse at the end of 2020. I am in no doubt that if she regained capacity, that it would be her wish to have a safe delivery of her child.*

Cohen J made clear that he considered that Ms A's expressed views were of great significance. However, at paragraph 22, he made clear that he was "*in no doubt that the views expressed by Ms A are not in her best interests, and it is the test of her best interests which I must apply*."

Cohen J therefore endorsed the plan for transfer, including by restraint if required, to the maternity unit at the physical health hospital to undergo the planned caesarean section (although he also authorised an emergency one in the event that Ms A went into labour before the date for the planned procedure).

In *East Lancashire Hospitals NHS Trust v GH* [2021] EWCOP 18, MacDonald J was concerned with an evolving emergency – an application made in the case of GH, a 26 year old woman who suffered from anxiety, depression and acute agoraphobia and who had gone into labour at home nearly 72 hours earlier but who had thereafter suffered an obstructed labour. Within this context, it became apparent that GH required urgent in-patient obstetric treatment and a possible emergency caesarean section. GH was, however, refusing to agree to that

course of action. An urgent application was made, the hearing starting at 22:00. The Official Solicitor, herself, acted as GH's litigation friend, under her (relatively new) out of hours scheme, and MacDonald J was at pains to express his gratitude to her for testing the evidence of the Trust by way of cross-examination and making, by way of closing submissions, a considered recommendation to the court regarding GH's best interests.

MacDonald J identified at the outset of his judgment that:

> *As Mr Wenban-Smith fairly acknowledged in his opening, in An NHS Trust and Anor v FG (By Her Litigation Friend, the Official Solicitor) [2014] EWCOP 30 Keehan J made clear the heavy burden on Trusts to engage in early and thorough planning in cases of this nature in order to prevent the need for urgent applications to the out of hours judge. However, I accept Mr Wenban-Smith's submission that this case is distinguished by the fact that up until late yesterday afternoon GH was assessed to have capacity with respect to decisions concerning the management of her pregnancy and birth and indeed had agreed to admission to hospital in the event that admission was required during the course of her labour. It was only during the latter part of the day yesterday that it became clear that GH's anxiety and agoraphobia had become the dominant feature in her decision making and that a subsequent capacity assessment revealed that she lacked capacity to decide whether to agree to be admitted to hospital for obstetric treatment and a possible emergency caesarean section. Within this context, and as the Official Solicitor pointed out, there were options that might have been considered in order to endeavour to avoid the need for an urgent hearing following that assessment, I was satisfied that this case met the criteria for the urgent out of hours service. I make clear however, that nothing said in this judgment should detract from what should be the ordinary approach in cases of this nature as set out by Keehan J in An NHS Trust and Anor v FG (By Her Litigation Friend, the Official Solicitor).*

In his judgment, given after the event (having indicated his decision at the end of the out of hours hearing), MacDonald J was clear that:

> *30.* […] *GH's current agoraphobia and anxiety is preventing her from using or weighing information in deciding whether to agree to be admitted to hospital for obstetric treatment and a possible emergency caesarean section.*
>
> *31. Despite clearly and carefully presented information that unless she is now admitted to hospital both her and her baby are at increasing risk of serious injury or even death, GH has chosen, without acknowledging and considering the reality of those risks, to stay in what she considers her "safe space", which she considers will allow her to give birth in a manner safe for both herself and her unborn child. Within this context, this is not a case in which GH has acknowledged the risk of serious injury or death, weighed that risk and then rejected that risk it in favour of an unwise course of action but rather a case in which GH simply does not acknowledge the risk of serious injury or death or accept that the risk of serious injury or death is relevant to her as long as she remains in her "safe space". I am satisfied that this*

> *demonstrates that GH's agoraphobia and anxiety has overwhelmed her ability to use and weigh the information required to decide whether to agree to be admitted to hospital for obstetric treatment and a possible emergency caesarean section. Within this context, I am further satisfied GH's inability to use and weight information is clearly the result of an impairment of, or a disturbance in the functioning of, GH's mind or brain.*
>
> *32. I am also satisfied that in her current circumstances there is no evidence before the court that GH is likely to regain capacity to make the decision regarding admission to hospital before it becomes necessary for her safety and the safety of her unborn child for that admission to take place.*

As regards her best interests, MacDonald J held that it was in GH's best interests to be conveyed from her home to hospital by ambulance, with use of reasonable force if necessary, and for the medical and midwifery practitioners attending GH to carry out such treatment as may in their opinion be necessary for the management of GH's pregnancy and delivery, as outlined in the Obstetric Management Plan. In this, he gave

> *34.* […] *significant weight to the fact that, at a time when all involved accept that GH had capacity, she had indicated that whilst she wished for a home birth, she agreed to be admitted to hospital should that be required. I am satisfied that this is cogent evidence regarding her wishes and feelings at a time when she had capacity with respect to the decision in issue. Further, I have also weighed in the balance in assessing GH's best interests the fact that she was clearly looking forward to the birth of the child and wished for the birth to go smoothly and safely. If GH had retained capacity with respect to the decision in issue, I am satisfied that it is likely she would have remained in agreement with being admitted to hospital should that admission have become necessary during the course of her labour, which it now has.*

He noted the risks attendant on admission to hospital, particular in circumstances where one of the options contemplated is a caesarean section under a general anaesthetic. A caesarean section carries with it the risks associated with a general anaesthetic and an increased risk of bleeding. As he observed, "[t]*he transportation of GH to hospital will also inevitably increase her levels of anxiety at a time when her body is already stressed by her pregnancy and obstructed labour, particularly if it is necessary to use reasonable force to facilitate the transfer*" (paragraph 35). Those risks were, however, outweighed by the risks to GH (and to the health of her unborn baby) by a home birth in her particular circumstances.

MacDonald J sought to consider the position from GH's point of view:

> *38.* […] *In this regard, I am once again assisted by fact of GH's consent to admission when she had capacity to consent to that course and before she was overborne by her agoraphobia and anxiety. As I have stated, for the reasons I have given I am satisfied that this would remain her position if she had capacity in light of the fact this this view was taken by her as recently as a few days ago. I am further satisfied that GH would also take counsel of relatives and family who seek for her to go to hospital and would likely*

> *place weight on that counsel, particularly in circumstances where it is plain that GH was desirous of a safe birth for her second child. Within this context, I have of course also borne in mind that, having heard the evidence in this case, the considered recommendation of the Official Solicitor, as litigation friend for GH, that it is in GH's best interests now to be admitted to hospital for obstetric and postnatal care.*

The order was therefore made. MacDonald J noted that:

> *40.* […] *it is a very grave step indeed to declare lawful medical treatment that a patient has stated she does not wish to undergo. It is a graver step still compel, possibly by means of the use of sedation and reasonable force if further gentle persuasion fails, the removal of a person from their home to ensure their attendance at hospital for such medical treatment. Parliament has conferred upon the court jurisdiction to make a declaration of such gravity only where it is satisfied that the patient lacks the capacity to decide whether to undergo the treatment in question and where it is satisfied that such treatment is in that patient's best interests.*
>
> *41. In this case I am satisfied that the Trust has discharged the heavy burden resting upon it in demonstrating that GH lacks capacity to decide whether to agree to be admitted to hospital for obstetric treatment and a possible emergency caesarean section and that the course of action proposed by the Trust is in GH's best interests. Within this context, I make the order in the terms appended to this judgment.*

In light of the foregoing, it may come as a (happy) surprise to discover the postscript to the judgment that:

> *43. Ahead of this judgment being formally handed down, the court was informed that GH had given birth to a healthy baby boy. In the event, following the out of hours hearing and the decision of the court, GH's labour began to progress quickly and she delivered her son at home before it was possible to execute the arrangements authorised by the court regarding her transport to hospital for obstetric and postnatal treatment.*

Comment

Cases concerning birth arrangements are always – and rightly – ones which cause concern, both to the courts, and to practitioners. In both of these cases, it is striking the extent to which the court founded themselves on what they understood to be evidence that the woman in question in fact would have wished to have been delivered safely of their baby, even if the means now being proposed were ones that they were objecting to. Their will, in other words, was being prioritised over their preferences. These cases are a crucial reminder of the importance in this setting (above almost all others) of ensuring that proper steps are taken by way of advance care planning to ensure the recording of the evidence required to determine that will.

GH's case is also a reminder of how quickly the Court of Protection can be summoned to help where required (and also of the importance of the fact that the Official Solicitor is now able to offer an out of hours service so as to ensure that the person in question is represented). As MacDonald J reminded us, the power to go out

of hours should only be used as a last resort, especially in circumstances where contingency planning is possible. But it is very important that it is there. The decision is also, thankfully, another reminder of the fact that planning for the worst is quite often the best guarantor that the best will in fact occur.

Human Rights in Care Homes Survey

The Essex Autonomy Project wants you (if you are a professional working in or with care homes in England and Wales!) for a survey, which you reach via here, details of which are below:

- Human Rights in Care Homes: A Survey-Based Study
- We are inviting you to participate in this survey so we can learn about the experiences of professionals working in or with care homes during the Covid-19 pandemic.
- This survey is part of a larger research project, "Human Rights in Care Homes", focusing on the impact of the Covid-19 pandemic on respect for human rights in care homes. Our goal is to help care professionals and policy makers protect human rights in care homes going forward. By completing this survey, you will help us understand the situation on the ground and what support may be needed.
- Though the survey is primarily targeted at people working in England or Wales, we welcome responses from professionals working elsewhere.

The survey closes at midnight on 3 April 2021.

LPS steering group meeting – February 2021

The minutes of the most recent LPS steering group meeting are now available. The discussion focused upon the impact assessment published in January 2021, key points of feedback being:

- The training strategy and plans for 'workforce readiness' have moved on significantly
- since the Act, and the next IA needs to reflect that.
- Plans for LPS, and assessment of its impact on the sectors who will implement it need to take account of the short- and long-term impacts of Covid-19.
- The IA should assess the impact of the transition year between the Deprivation of Liberty Safeguards and LPS.
- Data on deprivations for the 16 and 17-year old group and in unregulated settings is limited. This could be improved for future updates of the IA.
- Future assessments could say more on how central Government will support sectors who will implement LPS, for example on workforce readiness and training.
- The estimated costs of assessments under LPS may need to be refined.

X – permission refused

The Court of Appeal has refused permission to X to appeal the decision of Sir James Munby ([2020] EWHC 65 (Fam)) that the decision of a competent (pre-16) or capacitous (16- or 17-) year old child to refuse life-sustaining medical treatment will not be determinative. Refusing permission, Peter Jackson LJ held that an appeal from the conclusions of Sir James:

> *would not have a real prospect of success. The arguments were thoroughly analysed by the Judge and his conclusions were correct. It is settled law, before and since the HRA 1998, that the court may countermand the decisions of mature minors in their best interests. Section 8 FLRA 1969 cannot be interpreted so as to confer upon mature minors an absolute right to refuse treatment. The ECHR does not suggest or mandate that conclusion either. The Canadian authorities do not have the effect contended for. Indeed paragraph [2] of* ***AC*** *(incompletely cited at paragraph 39 of the applicant's skeleton argument) arises from the fact that the Canadian legislation expressly creates a presumption in favour of the decision of a mature minor over 16: that state of affairs, which falls short of the absolute autonomy argued for in this case, supports the conclusion that such a radical change in the law must be a matter for Parliament.*
>
> *There is no compelling reason for this court to hear an appeal. The arguments have been exhaustively considered at first instance. They make a case for a change in the law: they do not sustain a case about what the law is.*
>
> *Lawful medical treatment decisions in relation to mature minors already require very great weight to be given to the view of the patient. Allowing for differences of expression, there is much common ground between the approach identified in* ***AC*** *and that explained by Balcombe LJ in* ***Re W*** *at 88. The fact that there is some divergence in academic opinion in a matter of this kind is not surprising. Even if this court was entitled to revisit its earlier decisions, there is no indication that there is any uncertainty in the settled law, nor that any subsequent developments (including the HRA and the passage of time) require it to be revisited by the courts.*

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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.

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

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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.

Adrian is speaking at a webinar organised by RFPG on 25 May at 17:30 on Adults with Incapacity. For details, and to book, see here.

Advertising conferences and training events

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