MENTAL CAPACITY REPORT: THE WIDER CONTEXT

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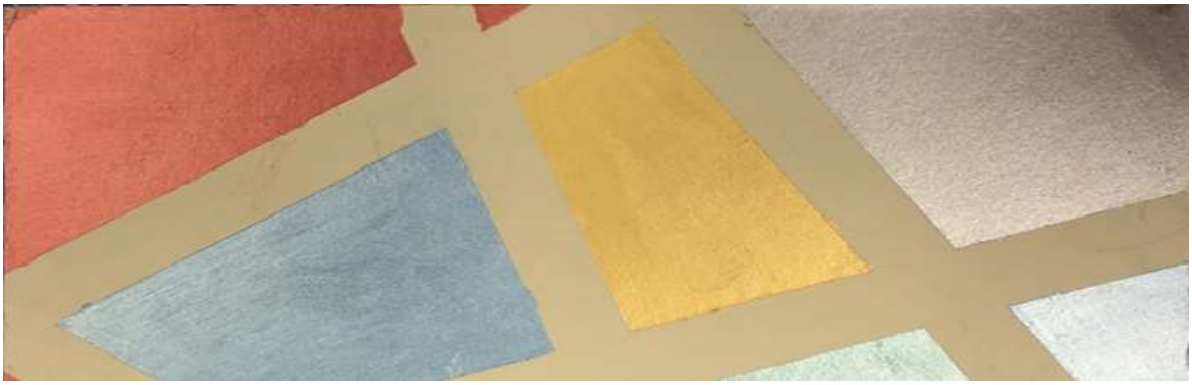

Welcome to the March 2021 Mental Capacity Report. Highlights this month include:

(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

A reminder – respond to the White Paper!

A reminder that the consultation contained in the White Paper on reforming the Mental Health Act 1983 closes on 21 April 2021. It poses significant, and wide-ranging questions – including many as to the place of capacity in any future legislation (as to which see further Alex's shedinar here). The consultation can be found here, and Neil's analysis of the White Paper here.

DNACPR decisions – new guidance and letter

Responding to a judicial review claim compromised in the summer of 2020, new guidance on DNACPR decisions has now been published on the NHS website. It addresses a range of scenarios, including:

- Where the person wishes to refuse CPR, making clear that whilst the doctor can complete a DNACPR form to indicate this, it will only be legally binding if it is made as an Advance Decision to Refuse Treatment;
- Where the doctor decides in advance. The guidance emphasises, importantly, that this a medical treatment decisions that can be made even if the patient does not agree. Doctors must tell patients that the form has been completed (unless doing so would cause the patient physical or psychological harm, the test set out in *Tracey*), but the doctor does not

need consent to complete one;

- Where the person does not have capacity to make decisions about CPR, at which point it is said that a health and welfare attorney with the correct authority has the power to refuse CPR on the same basis that the person might do themselves,[1] otherwise (unless an ADRT is in place), the decision is a best interests one.[2]

The guidance emphasises that:

> *DNACPR decisions should not be made for a group of people at once. For example, DNACPR decisions should not be made for everyone living in a care home or for a group of people over a certain age. This is unlawful, irrespective of medical condition, age, disability, race or language.*

The guidance also has a useful section on what you should do if you are concerned about a DNACPR form in your medical record or someone else's.

The importance of DNACPR decisions being made on an individual, not a blanket basis, is also emphasised The importance of good practice in Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) and people with a learning disability and or autism was emphasised in the letter from the NHS National Medical Director and others dated 4 March 2021, including this key message:

> *The NHS is clear that people should not have a DNACPR on their record just because they have a learning disability, autism or both. This is unacceptable. The terms "learning disability" and "Down's syndrome" should never be a reason for issuing a DNACPR order or be used to describe the underlying, or only, cause of death. Learning disabilities are not fatal conditions. Every person has individual needs and preferences which must be taken account of and they should always get good standards and quality of care*

Specific recommendations for care homes directed at identifying abuse and neglect

On 26 February 2021, NICE published a guideline document on keeping adults in care homes safe from abuse and neglect in order to make a number of recommendations to improve safeguarding residents in care homes. It is targeted principally at care home providers, managers, staff and volunteers because safeguarding practices and procedures vary significantly at the local level notwithstanding the legal framework and associated statutory guidance. It is noted, in particular, that care

[1] It is suggested that this is in fact, not the case. An attorney has the power to make a decision **at the time** that CPR is not to be carried out. It is not obviously the case that an attorney has the power to decide, **in advance**, that CPR should not be carried out. Rather, the attorney's indication that the donor would not wish CPR is a factor that should carry very significant weight in the decision whether to make a DNACPR recommendation.

[2] Whilst this follows the decision in *Winspear* case, it should be noted that it is not, in fact, obviously a best interests decision because as the guidance has already made clear, the decision whether or not to recommend CPR is a decision of the doctor's not the patient's, and best interests decisions are decisions that the person themselves can take. In any event, it is undoubtedly a decision which should be taken in the spirit of a best interests decision, in particular involving consultation with those interested in the person's welfare.

homes often struggle to understand: (i) the difference between safeguarding issues and poor practice; and (ii) when and how to make safeguarding referrals to the local authority.

The recommendations are specific and clear, covering the following topics:

- *Safeguarding policy and procedure;*
- *Whistleblowing policy and procedure;*
- *The respective roles of care home providers, local authorities, clinical commissioning groups and other commissioners;*
- *Staff training;*
- *Care home culture, learning and management;*
- *Identifying abuse and neglect;*
- *Steps to take if abuse and/or neglect is identified (including immediate protective measures, investigations, reporting and responding to reports, as well as providing the necessary support).*

The guidelines consider, in a helpful level of detail, the indicators of different types of abuse and neglect at both an individual and organisational level. It is necessary reading not just for care home providers (and their staff), but also those involved in safeguarding investigations as well as adults living in care homes, their family, friends and advocates.

Supporting people who have eating and drinking difficulties: new guidance from the Royal College of Physicians

The Royal College of Physicians has published (10 March 2021) a guide to practical care and clinical assistance. Its particular focus is on the complexities that can arise around nutrition and hydration towards the end of life.

The guidance, applying the law within England & Wales but offering clinical principles which will also be applicable within different legal frameworks in Scotland and Northern Ireland, updates the previous *Oral feeding difficulties and dilemmas* published in 2010, particularly in relation to recent changes in the law governing procedures for the withdrawal of clinically assisted nutrition and hydration (CANH) and other life-sustaining treatments.

It was developed by a working party with representation from a wide range of specialties, including neurology, dietetics, speech and language, gastroenterology, law, ethics, and care of older people. (Alex was one of the two lawyers involved)

Eating and drinking are essential for maintenance of nutrition and hydration but are also important for pleasure and social interactions. The ability to eat and drink hinges on a complex and coordinated system, resulting in significant potential for things to go wrong.

Decisions about nutrition and hydration and when to start, continue or stop treatment are some of the most challenging to make in medical practice. The newly updated guidance aims to support healthcare professionals to work together with patients, their families and carers to make decisions around nutrition and hydration that are in the best interests of the patient. It covers the factors affecting our ability to eat and drink, strategies to support oral nutrition and hydration, techniques of clinically assisted nutrition and hydration, and the legal and ethical framework to guide decisions about giving and withholding treatment.

The guidance is primarily for medical and healthcare professionals, particularly those involved in caring for people who have eating and drinking difficulties, including gastroenterologists, ward nurses, geriatricians, dietitians, speech and language therapists, neurologists, palliative care teams, care home and community nurses.

Updated throughout, it includes a new chapter on dietary modifications and a series of illustrative examples of patients to help guide practice. From Alex's perspective, one of its most important innovations is that it includes practical guidance to address one of the most difficult areas that other guidance in this area has all too often shied away from: what to do where the patient's wishes (either capacitous or incapacitous) are to be provided with food and drink in a way which professionals feel that they cannot accommodate because of the risk. The framework proposed seeks to assist in securing against undue risk aversion on the one hand whilst on the other hand recognising that professionals have their own rights.

Film review

In a first for us, but keeping up with the times, Simon Edwards reviews I Care a Lot (2020), now streaming on Amazon Prime (in the UK)

Rosamund Pike puts in a stellar performance as the malevolent court appointed guardian who looks after the affairs of helpless elderly "inmates" of conniving care homes in Massachusetts.

She relies on falsified doctors' reports and a rather negligent judge to take over and fleece her victims, picked for their isolation from friends and relatives. Unfortunately for her, one of her victims has rather unsavoury connections.

The court room scenes will strike a chord to the initiated with a desperate son pleading that the guardian has prevented all contact with his mother and sold her home to pay care fees with the retort that the son has behaved in a disruptive manner abusing and assaulting care home staff and represents the type of relative whose only interest is preserving their inheritance.

Direction, by Jonathan Blakeson, is taut, time never drags and there is a thrill, and a laugh, coming round every corner. He also wrote the script and shows a keen eye for the detail of the process.

Pike steals every scene and there is a terrific twist at the end.

Short note: ordinary residence, deeming and deputyship

R (Lancashire County Council) v JM & Anor [2021] EWHC 268 (Admin) concerns a dispute between two local authorities as to which one was responsible for funding P's accommodation at a Transitional Rehabilitation Unit ("TRU") under the National Assistance Act 1948 ("1948 Act"). The authorities had referred their dispute to the Secretary of State for determination – the challenge was brought to his decision that P was ordinarily resident in Lancashire County Council ("Lancashire") and therefore that authority was responsible for funding his accommodation.

P had sustained a serious brain injury as child and received a personal injury damages award in the sum of £3.1million. Part of that sum was used by his deputy to purchase a property in Edenfield in Lancashire. P came to the attention of Lancashire due to allegations of financial and emotional abuse as well as self-neglect in 2010. It was agreed that P would move to the TRU with a view to finding another residential placement (his house was in a poor condition).

HHJ Eyre QC considered the legislative framework, pursuant to the National Health Service and Community Care Act 1990 ("1990 Act") and the 1948 Act, in respect of assessing P's needs for the provision of community care services and providing for those needs. He observed that the effect of, the National Assistance (Assessment of Resources) Regulations 1992 and of the National Assistance (Residential Accommodation) (Disregarding of Resources) (England) Regulations 2001, meant that the funds derived from personal injury damages were to be disregarded when considering the duty to provide residential accommodation, particularly as to whether such accommodation would otherwise be available to the individual.

He noted that it was common ground that, but for the potential effect of section 24(5) of the 1948 Act, P would fall to be ordinarily resident in St Helens (the other authority) while living at the TRU. That statutory ("deeming") provision provided that:

> *Where a person is provided with residential accommodation under this Part of this Act, he shall be deemed for the purposes of this Act to continue to be ordinarily resident in the area in which he was ordinarily resident immediately before the residential accommodation was provided for him*

In analysing the deeming provision and ordinary residence, HHJ Eyre QC considered the cases of *R (London Borough of Greenwich) v Secretary of State for Health* [2006] EWHC 2576 (Admin) and *R (Barking & Dagenham LBC) v Secretary of State for Health* [2017] EWHC 2449 (Admin). The two main principles were that:

1. If arrangement should have been made pursuant to s 21 of the 1948 (following the relevant assessment), then the deeming provision should be applied and interpreted on the basis that those arrangements had actually been put in place by the appropriate LA ("*Greenwich* principle"); and,

2. If the deeming provision does not apply, then, if the individual has capacity, the question of ordinary residence falls be determined on the principles laid down in the leading case of *R v LB Barnet, ex parte Shah* [1983] 2 AC 309, namely *"abode in a particular place …which he has adopted voluntarily and for settled purposes as part of the regular order of his life for the time being …"*

The key question on the facts was whether the s 24(5) came into operation by virtue of the application of the Greenwich Principle. The Secretary of State had decided that Lancashire should have assessed P's needs pursuant to s 47 of the 1990 Act. The *Greenwich* principle applied, which meant that for the purposes of invoking s 24(5), Lancashire should be treated as having undertaken that assessment. If they had done so, they would have found that he was in need of care and accommodation in a residential

setting; and that such care was not '*otherwise available*'. Accordingly, Lancashire would have been required to fund a placement for P.

HHJ Eyre QC was satisfied that the Secretary of State approached the determination in the correct manner, which had been summarised on behalf of the Secretary of State as follows:

> *By definition, application of the Greenwich principle requires the [Secretary of State] to engage in what [Lancashire] characterises as an exercise of 'speculation'. It is impossible for the [Secretary of State] to apply the deeming provision to the arrangements that 'should have' been made, without reaching a view on the facts as to what arrangements would have been made if the local authority had complied with its duties at the 'trigger date'.*

HHJ Eyre QC was satisfied that the conclusions reached by the Secretary of State were those that he was properly entitled to reach on the material before him. The claim was therefore dismissed.

This case further emphasises the importance of local authorities ensuring that they properly discharge their statutory obligations with regards to assessing needs and putting arrangements in place in accordance with their community care duties. If they fail to do so, and are found at a later date to have acted unlawfully, then the application of the *Greenwich* principle could mean they have a much larger bill to foot by virtue, most obviously, of interest. The case should be considered alongside the judgment of Thornton J in *Surrey County Council v NHS Lincolnshire CCG* [2020] EWHC 3550 (QB) (on which we have previously reported) where it was found that the CCG had been unjustly enriched to the extent of the care fees paid by the LA to the care home.

Controlling or coercive behaviour – review and amendment to the Domestic Abuse Bill

Following a review of the Controlling or Coercive Behaviour Offence Research Report 122 March 2021, the offence in s.76 Serious Crime Act 2015 is to be amended (by the Domestic Abuse Bill) so that it is no longer a requirement for the abuser and victim to live together, where they have previously been an intimate personal relationship. The review highlighted that those who leave abusive ex-partners can often be subjected to sustained or increased controlling or coercive behaviour post-separation. This is a very welcome development, but the offence still will not include the situation where the abuser and victim are not in either family members or (currently or previously) in an intimate relationship, so it will still not be a tool which can be used in situations of what Alex has called 'proximity abuse,' a phenomenon often encountered in the case of those on the cusp of capacity who all too often fall between the cracks in safeguarding terms.

Autonomy does not always equate to a 'good' outcome

In a (short) report, the Prisons and Probation Ombudsman considered the care given to a prisoner, Brian Daniels, who died of a stroke aged 74 at HMP Durham.

> *13. Throughout his time in prison, Mr Daniels regularly refused food and medical treatments, including going to*

hospital. This was sometimes a form of protest, but more frequently he said it was because he wanted to hasten his death. He said on many occasions that he wanted to die in prison.

14. In 2020, Mr Daniels' health deteriorated. A significant contributory factor was his increasing resistance to all forms of treatments, including refusals to go to hospital on several occasions. On 12 August, he agreed to go to hospital after falling ill. However, once there he refused treatment and said once more that he wanted to die. On 21 August, prison and healthcare staff met with hospital staff, including palliative care consultants at the hospital. Mr Daniels had requested that all care should stop, and his carers agreed that he had the mental capacity to make that decision. He returned to prison on 24 August, under a palliative care treatment plan (care with the focus on optimising the quality of life and reducing suffering).

The PPO's independent clinical reviewer concluded that, overall the clinical care Mr Daniels received at Durham was equivalent to that which he could have expected to receive in the community. We note this report to make the short point that accepting treatment refusal – where such refusal is properly considered to be capacitous – does not amount to clinical failing, even for those detained in prison.

Distinguishing capacity and autonomy – the criminal law perspective

R v Rebelo [2021] EWCA Crim 306 (Court of Appeal (Criminal Division) (Dame Victoria Sharp P, Davis and Picken JJ)

Other proceedings – criminal

Summary

In a very unusual criminal case, fascinating – essentially existential – questions arose as to the interrelationship between capacity and autonomy. Mr Rebelo ran a business selling a chemical, DNP, as a food supplement which was claimed to promote weight loss. On 4 April 2015, a 21-year-old student, Eloise Aimee Parry, purchased a quantity of DNP capsules from the appellant's business via the internet. On 12 April 2015, after taking eight of the capsules, tragically, she died. DNP was not licensed as a medicinal drug, and ingestion by a human is to be regarded as hazardous and its toxic effects various and serious, including, inter alia, kidney failure, liver failure and cardiac arrest.

Ms Parry was a woman with a complex mental health history. When she encountered the DNP on Mr Rebelo's website, she described (in emails and messages to university friends) what she had taken and how she could not control her use of DNP. Despite appreciating that DNP was causing her harm, she continued to order further supplies from the appellant's business. She was repeatedly warned by her GP, social worker and friends of the danger from taking DNP, including the potentially fatal consequences. On 10 April 2015 a friend of Ms Parry, warned her that she was going to die if she did not stop taking DNP to which Ms Parry replied: *"I wish I wouldn't too but the psychological desperation to take the pills is so hard to fight. They make everything feel okay. They give me control. Which I know is delusional but I feel it so overwhelmingly!*"

At trial, the prosecution case was that the supply of these tablets for human consumption constituted an unlawful act which was dangerous and led to death (unlawful act

manslaughter); it also constituted a gross breach of the duty of care owed to Ms Parry, crossing the criminal threshold, in circumstances which created an obvious and serious risk of death (gross negligence manslaughter).

Mr Rebelo's defence was that, whilst he accepted placing DNP on the market, he did not so do with the intent or reasonable expectation alleged by the prosecution. Rather, he contended that:

> *Ms Parry was an autonomous woman who decided to make a foolish decision in the exercise of her free will and killed herself, as she was entitled to do. The appellant's act of placing DNP on the market was too remote. Putting DNP on to the market did not cause her death and he bore no responsibility for Ms Parry ingesting it. It was not possible for him to have foreseen the possibility that she would take a handful of the capsules.*

In 2018 Mr Rebelo was convicted of both unlawful act manslaughter and gross negligence manslaughter, together with the offence of placing an unsafe food on the market contrary to Article 14 of Regulation (EC) 178/2002 and Regulation 19 of the Food Safety and Hygiene (England) Regulations 2017. He appealed against his manslaughter convictions. In April 2019, the Court of Appeal quashed the conviction for unlawful act manslaughter because it concluded, by analogy with the approach taken to the supply of heroin in *R v Kennedy (No 2)* [2007] UKHL 38, [2008] 1 Cr App R 19, that placing unsafe food on the market, of itself, was not a dangerous act; and that to place DNP on the market could not, therefore, amount to a dangerous act sufficient to amount to an unlawful act for the purposes of unlawful act manslaughter. The Court of Appeal rejected the submission that the trial judge ought to have acceded to a submission of 'no case to answer' in respect of gross negligence manslaughter. In that connection, the appellant had argued that there was insufficient evidence that DNP created an obvious and serious risk of death, the only risk being when there was an overdose; alternatively, because there was "*a break in the chain of causation as a consequence of the voluntary (that is to say free, informed and deliberate) act of the deceased herself*." In rejecting that submission, the Court of Appeal said, that there was "*clearly enough material to justify leaving the issue of serious and obvious risk of death to the jury*." The conviction for gross negligence manslaughter was quashed, however, because the Court of Appeal concluded that the direction given by the judge to the jury on the issue of causation was defective:

> *74. In that part of the route to verdict dealing with autonomy the judge asked whether the prosecution had proved that Eloise Parry lacked capacity or was vulnerable and unable to exercise her free will when making the decision to take DNP. The reference to capacity came from the evidence of Dr Rogers applying the criteria set out in s. 3 of the Mental Capacity Act 2005. Thus, the question posed in the route to verdict in relation to gross negligence manslaughter did not reflect sufficiently clearly the issue that arose which was not merely whether it was not so unreasonable that it eclipsed the defendant's acts or omissions but which also depended on whether Eloise Parry's decision to take DNP may have been free, deliberate and informed*

> *decision, as Ms Gerry argued. Her capacity would be relevant to that issue.*
>
> *75. In that regard, it is important to underline that capacity is not the same as autonomy. To direct the jury that provable lack of capacity as defined in the 2005 Act would be sufficient to demonstrate lack of autonomy was a misdirection particularly given the emphasis thereafter placed on the evidence of Dr Rogers. The second limb of the direction – the reference to Eloise Parry being 'vulnerable and unable to exercise her free will' – failed to assist the jury with what was meant in that context by the word vulnerable and how it interacted with any exercise of free will. Admittedly the judge was only using the term adopted in Kennedy (No 2). But in that case the issue of capacity did not arise on the facts and there was no suggestion that the victim was suffering from a mental disorder that might deprive him of capacity. Further, the use of the word vulnerable was not discussed further. The direction should have required the jury to consider only the question of Eloise Parry's free, deliberate and informed decision.*

Mr Rebelo was retried in February 2020. His case, again, was that "*Ms Parry was an adult woman suffering from an emotionally unstable personality disorder and an eating disorder who made a fully free, voluntary and informed decision to take the DNP; she was not acting under any compulsion, nor was she vulnerable to feeling compelled. She was someone who wanted to take the DNP and so did. She was a bright and able university student who had conducted internet research and was well informed about the risks of DNP.*" He did not give evidence, his sole witness being Dr Richard Latham, a consultant psychiatrist. His evidence was given "back to back" with that of the prosecution experts. Dr Latham said that, in his opinion, there was insufficient evidence to displace the presumption under section 23 of the Mental Health Act,[3] that Ms Parry had capacity. At paragraph 22, his evidence is recorded as follows:

> *In his opinion, Ms Parry's mental health issues influenced the way in which she made decisions, but she retained capacity. He explained that, where capacity is an issue, people can fluctuate from hour to hour. In the present case, Ms Parry was capable of understanding the information on DNP. When she took DNP for the last time, she was repeating something that she had done on previous occasions. However, Dr Latham also said:*
>
> > *"The decision every time she took DNP; that was likely to be because of the cycle of behaviour associated with her mental disorder. She was bingeing, purging and using DNP. These were compensatory behaviours. I don't believe you could ever describe the situation of her taking DNP as fully free because this was part of her disorder and was driven by the symptoms of her disorder. Similarly with voluntariness, I do believe that*

[3] This must be a typographical error in the judgment (rather than Dr Latham's report) for ss.2-3 Mental Capacity Act 2005.

her mental symptoms meant that her decision was not fully voluntary. The mental symptoms that she had; they do have an impact on her ability to resist the compulsion, so whilst I said before there is still likely to have been some degree of choice … that choice was very significantly impaired by her mental disorder."

After this evidence, the appellant apparently lost confidence in his legal team and dispensed with their services. A newly instructed legal team sought an adjournment to prepare but were only granted a short time so as not to derail the trial. They also sought permission for an adjournment to accommodate the holiday commitments of a new expert as to Ms Parry's capacity, which the judge refused on the basis that, in effect, it was very unlikely that the expert would add anything.

The judge gave written directions to the jury on causation, as follows, the material parts of which are as follows:

21. In relation to the question of causation, the Prosecution must make you sure that Eloise Parry did not make a fully free, voluntary and informed decision to risk death by taking the 8 tablets of DNP on the morning of 12 April 2015: this is the 'decision' you must think about. If this was a fully free, voluntary and informed decision, or may have been, that means that as a matter of law, her death was caused by her free choice, because in those circumstances, the Defendant only set the scene for her to make that decision, but he did not cause her death.

22. What does a fully free, voluntary and informed decision mean? Lawyers sometimes refer to a person's ability to make a fully free, voluntary and informed decision as 'autonomy'. Whether a decision is fully free, voluntary and informed will be a matter of degree. It will be for you to judge whether all the relevant factors in this case, including her eating disorder and her mental health generally, were such that you can be sure that her decision to take the DNP was not fully free, voluntary and informed, as the Prosecution alleges.

23. It is important that you look at each element separately although there is likely to be some overlap between 'fully free' and 'voluntary'.

24. You will appreciate that a state of mind may fluctuate and just because some decisions Eloise Parry made at some times in her life may not seem to be fully free, voluntary and informed, it could still be the case that when she made the decision to take DNP on 12 April 2015, that decision was fully free, voluntary and informed. It is that decision you must think about.

25. When considering whether it was 'fully free' you will want to consider in particular the effect of any mental health condition. In ordinary language, you might talk about someone being vulnerable because of their mental health issues. This might include, as the Prosecution say, that the person's ability to protect themselves from significant harm was impaired. The Prosecution say that Eloise Parry was vulnerable because of her mental health problems and her psychological addiction to DNP, because those problems stifled her ability to make a fully free decision. The Defence say that she was able to protect herself; they say that an adult woman suffering from an

emotionally unstable personality disorder and an eating disorder can, and in this case did, make a fully free, voluntary and informed decision to take the DNP.

26. When considering whether the decision was 'fully voluntary' you will want to consider whether she was acting under any compulsion, whether caused by her mental health problems or any psychological addiction she may have had to DNP. Here too, you will consider whether she was vulnerable, which in this context would mean that her ability to resist feeling compelled to take the DNP was impaired. The Prosecution say that there is clear evidence that she was acting under an element of compulsion because of her psychological dependence on DNP combined with her mental health problems. The Defence say she was not acting under compulsion, nor was she vulnerable to feeling compelled; she wanted to take the DNP and so she did.

27. When considering whether she was 'fully informed' you will want to consider whether she knew the risks that she was taking. The Prosecution say that she was not fully informed as the references she makes to 'safe' doses are nonsense and not supported by science. The Defence say that she had conducted substantial research so knew full well what risks she was taking."

As to capacity, the judge directed the jury:

33. You should ask yourselves whether taking account of all the evidence in the case, Eloise Parry made a fully free, voluntary and informed decision to take the DNP? If you conclude that her decision was, or may have been, fully free, voluntary and informed, then that decision was the cause of her death, because as a matter of law, that decision supersedes or overtakes any grossly negligent act by the Defendant in supplying the DNP in the first place. The Defendant is not guilty of manslaughter.

34. If, on the other hand, you are sure that Eloise Parry did not make a fully free or fully voluntary or fully informed decision to take the DNP, then, if the defendant was in gross breach of his duty of care owed to her, his negligence remains a substantial and operative cause of her death, even if it was not the sole cause of her death. He is guilty of manslaughter.

Mr Rebelo appealed on a number of grounds. For present purpose, the materially interesting one is the assertion that the judge had misdirected the jury on the question of causation. Specifically, he asserted that the judge had failed to direct the jury that that even if they concluded Ms Parry's decision was not fully free and voluntary, they still had to assess whether the decision to take the amount of DNP that she did was such that it could be said "to eclipse" the appellant's gross negligence. It was said that, in light of the decision given on the first appeal in 2019, this further step was required in order to establish the necessary link between the appellant's supply of DNP and Ms Parry's death, and that Ms Parry's action in taking the amount of drugs that she did, did not break the chain of causation.

Dame Victoria Sharp P, giving the judgment of the Court of Appeal, held that this was misconceived. On a proper interpretation of the first appeal judgment, the requirement that Mr Rebelo sought to add did not exist:

34. […] *the key issue was whether Ms Parry had or might have made a fully free voluntary and informed decision to take DNP; if that was the case, the jury could not be sure that the appellant's breach of duty was a cause of her death. We repeat the following passage from the Court of Appeal's judgment:*

> *"In relation to the question of causation, the prosecution must make you sure that the victim did not make a fully free, voluntary and informed decision to risk death by taking the quantity of drug that she ingested. If she did make such a decision, or may have done so, her death flows from her decision and defendant only set the scene for her to make that decision. In those circumstances, he is not guilty of gross negligence manslaughter."*

35. What followed was an explanation of what is meant by "fully free, voluntary and informed"("What does a fully informed and voluntary decision mean?"). It is in that context, that the "starting point" taken is "the capacity of the victim to assess the risk and understand the consequences"; and then of her "ability to assess the risk and understand the consequences relating to the toxicity of the substance and her appreciation of the risk to her health or even grossly negligent breach of the duty of care". As Sir Brian Leveson P said at para 77, what is required is a "balancing exercise" in order to decide whether the prosecution has established that a defendant's breach of duty is a substantial and operative cause of death, even if it is not the sole such cause, bearing in mind, of course, that the jury would only be considering the causation issue at all if they have already concluded that the appellant's conduct amounted to gross negligence and required criminal sanction.

Dame Victoria Sharp P noted that the trial judge had given a much fuller direction than had been suggested by Sir Brian Leveson P in the first appeal, but that was not surprising because she had to relate the legal direction given to the evidence called in the trial. She commended the judge's direction as a model of clarity, and held that the jury were accurately directed on the issue of causation and their approach to the core issue of "*free, voluntary and informed consent*." Further, the word 'eclipsed' had, in fact, been used when taken the jury through her written directions in the course of her summing up. It followed that the appeal against conviction on this ground had to be dismissed.

In the course of dismissing the other grounds of appeal, Dame Victoria Sharp P noted that the final report of the new expert upon which the defence wished to rely had been internally contradictory in stating that "*whilst* [Ms Parry's] *urge to take the drug at times overcame her decision not to take the drug, this decision was in my view still under her control*."

Comment

Questions of self-control arise often in the context of addiction, and are discussed (and compared to the approach taken to anorexia) in this fascinating article by Jill Craigie and Ailsa Davies. They pose deep questions as to the meaning of autonomy and its interaction with capacity. This case shows how this interaction is not merely of theoretical interest, but has real consequences – and the reality of those consequences (in this case criminal liability on

the part of Mr Rebelo) mean that the courts, and indeed two juries, had to roll their sleeves up and try actually to disentangle the different elements.

Legal capacity and decision-making: the ethical implications of lack of legal capacity on the lives of people with dementia

The latest Alzheimer Europe Ethics Report is a fascinating, nuanced and significant report on legal capacity and decision-making. Its focus on the ethical implications of the issues (including the ethical implications of the 'hard-line' approach advocated by the (former) UNCPRD Committee) is very welcome. It also does not shy away from the complexities of the issues involved in the following areas: (1) guardianship; (2) treatment, care and support; (3) advanced care planning and advance directives; (4) participation in research; (5) coercive measures; and (6) civil and political life.

Book reviews

Clustered Injustice and the level green (Luke Clements, Legal Action Group, 2020, ebook/paperback, £20)

In some ways, it is ironic that this book is published by the (wonderful) Legal Action Group, because one reading of its 124 pages of densely argued and righteously furious central text is that many of LAG's most dedicated readers could be seen as part of the problem for peoples whose lives are disadvantaged. By working within a legal system that focuses on legal problems as divisible, personal issues, and by mounting judicial reviews against specific decisions, or discrimination actions against particular policies, lawyers could be seen as reinforcing the fundamental clustered injustices that the system as a whole inflicts upon individuals whose lives are disadvantaged.

Indeed, Luke Clements, the Cerebra Professor of Law & Social Justice at Leeds University and a solicitor himself, in his concluding chapter expressly makes a strong case (in the context of creating the sort of problem-solving organisational cultures he sees as necessary) for less "heavy lifting" to be done by lawyers – and more by social care professionals, at least within administrative systems that are non-managerialist. That the final substantive chapter does seek to offer solutions is welcome, as the tenor of the first 6 are so unremittingly (and groundedly) grim in their delineation of the problem that it is difficult to see any possible light at the end of the tunnel.

It is very much to LAG's credit that they should be publishing this book, which serves as so important a reminder that legal action (two of the three words within the publisher's very title) is not, and should not just be, limited to taking action **within** the law as it stands, but also taking action **about** the law. And to do that requires precisely the sort of detailed, careful, and empirical analysis of and challenge to the wider system within the law sits that this book offers.

Power of Attorney: All you need to know: granting, it, using it or relying on it (Sandra McDonald, Souvenir Press, 2021, paperback/Kindle: £10.99)

In this book, the former Public Guardian for Scotland, Sandra McDonald, brings a huge weight of expertise to bear in the lightest

touch way possible upon almost all issues that might be relevant for those thinking about granting/making a power of attorney, being an attorney, or working with an attorney. Drawing, in part, upon her own experiences as attorney for her father, she seeks (as she puts it in the introduction) to empower people to make and use powers of attorney as effective instruments. In this, I would suggest she succeeds magnificently.

The book is avowedly not a legal textbook, but rather a practical guide. Nonetheless, it does a masterful job of bringing the law home – including a particularly elegant chapter 7 on (in effect) implementing the UN Convention on the Rights of Persons with Disabilities as an attorney through supporting decision-making and respecting the person's rights, will and preferences. Even if a pedant might quibble as to whether attorneys are, in fact, bound by the UNCRPD, this chapter represents a model of how the sometimes rather abstract discussions about the right to legal capacity in Article 12 CRPD can be brought down to earth in practical, grounded, and principled fashion.

One very striking – and important – feature of the book is that it is not limited to one of the three different jurisdictions within the UK, but rather seeks to cover Scotland, England & Wales and the (future) regime in Northern Ireland. This has several advantages, not least because it allows for commonalities in approach to be identified underneath differences in language (I particularly appreciated the way in which the differences between the English concept of 'best interests' and the Scottish concept of 'benefit' are dismissed as, ultimately irrelevant "as long as you place the individual at the centre of your consideration, when acting under either law.").

Seeking to cover all three regimes in one book does, however, mean that there are a few bits where this English lawyer twitched for fear that a reader in England & Wales might be led astray, and which I'll list here so that in the next edition – as I hope this book will be regularly updated given its value – they can be addressed. The first is that, sadly, there is no prospect in England & Wales that you could get legal aid to assist in making an LPA, as this is specifically excluded by the relevant legislation. The second is even if (which I have to say I find challenging as a concept) you could empower your attorney in Scotland to authorise the deprivation of your liberty, you definitely cannot in England & Wales. The third is that an attorney cannot instruct an IMCA, as is suggested might be possible as one way of resolving a dispute: only an NHS body or a local authority can instruct an IMCA – an attorney could potentially instruct (if this was within the scope of their powers) someone who was independent and was an advocate, but this would not be an IMCA. The fourth is that, whilst the book makes clear that it is giving only a very light touch discussion of advance decisions, it is important to emphasise that in England & Wales the 'sequencing' of advance decisions to refuse treatment and the making of LPAs governing medical decision-making has to be got right so as not to get into real difficulties.

Lastly, and whilst this book follows the Code of Practice to the MCA in suggesting that the test for capacity is a two stage test starting with a diagnostic element, it is clear from

subsequent case-law that, at least in England and Wales, the test starts with asking whether the person is able to make their own decision. Only if they cannot does consideration progress further. An ironic feature of this book is that it reinforces why the test should be approached in this fashion (over and above the fact that the MCA provides this): if they follow the advice set down here, which does not focus on the impairment, but on the ability of the person, attorneys should find themselves more often in the zone of supporting the person to make their own decisions than stepping into their shoes.

As the book makes clear, it is not intended to be a legal textbook, and provides at the back all the resources that could be hoped for to direct those who are going to be actually making / granting and using powers of attorney in the different jurisdictions. So the points of detail noted above do not detract materially from the importance or utility of this book, nor the achievement of bringing so much wisdom home to bear in 328 pages without a single footnote!

Alex Ruck Keene

[Full disclosure, I was provided with a copy of this book by the publishers. I am always happy to review books in the field of mental capacity and mental health law (broadly defined).]

Irish Mental Health Act reform

A public consultation on the ongoing review of the Mental Health Act 2001 is now open (until 31 March 2021), details of which can be found here.

Australian Royal Commissions

Two Royal Commissions have reported in the past month in Australia on areas which will be of interest to readers of the Report, both for what they say (and recommend) in relation to the Australian position, and for potential wider implications for other jurisdictions:

- The Royal Commission into Victoria's Mental Health System, of particular wider interest being Volume 4: "the fundamentals for enduring reform," and the proposals in Chapter 26 for a new Mental Health and Wellbeing Act which goes beyond legislation which simply relates to compulsory treatment and assessment.
- The Royal Commission on Aged Care Quality and Safety: of particular interest more broadly may be the section in Volume 3A at 1.3.1 discussing the success (or otherwise) Charter of Aged Care Rights that has been in force since 2014, and the discussion at 1.3.2 of the proposed rights of people both seeking and receiving aged care.

Research corner

This month we highlight two articles which report upon trials which produced results perhaps opposite to those which were hoped for.

The first is an article in PLOS Medicine: Advance care planning in patients with advanced cancer: A 6-country, cluster-randomised clinical trial. The trial involved 23 hospitals across Belgium, Denmark,

Italy, Netherlands, Slovenia, and United Kingdom in 2015–2018. Somewhat depressingly, the authors report that:

> *Our results show that quality of life effects were not different between patients who had ACP conversations and those who received usual care. The increased use of specialist palliative care and AD inclusion in hospital files of intervention patients is meaningful and requires further study. Our findings suggest that alternative approaches to support patient-centred end-of-life care in this population are needed.*

The second is an article in Age and Ageing, *The effectiveness and cost-effectiveness of assistive technology and telecare for independent living in dementia: a randomised controlled trial*. As the authors note, the use of assistive technology and telecare (ATT) has been promoted to manage risks associated with independent living in people with dementia but with little evidence for effectiveness. Their randomised study (in England, between 2013 and 2016, suggested that time living independently outside a care home was not significantly longer in participants who received full ATT and ATT was not cost-effective in terms of days lived in the community or securing quality of life. The researchers conclude that

> *Our data suggest that it would be premature to conclude that more extensive ATT systems to support independent home living for people with dementia are clinically important or cost-effective compared to more basic systems. This may be because basic ATT such as carbon monoxide and pendant alarms are themselves effective in preventing harms, or because more extensive ATT systems are inadequately supported by providers, or inadequately tailored to the needs of people with dementia and their caregivers.*

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

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

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

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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.

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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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