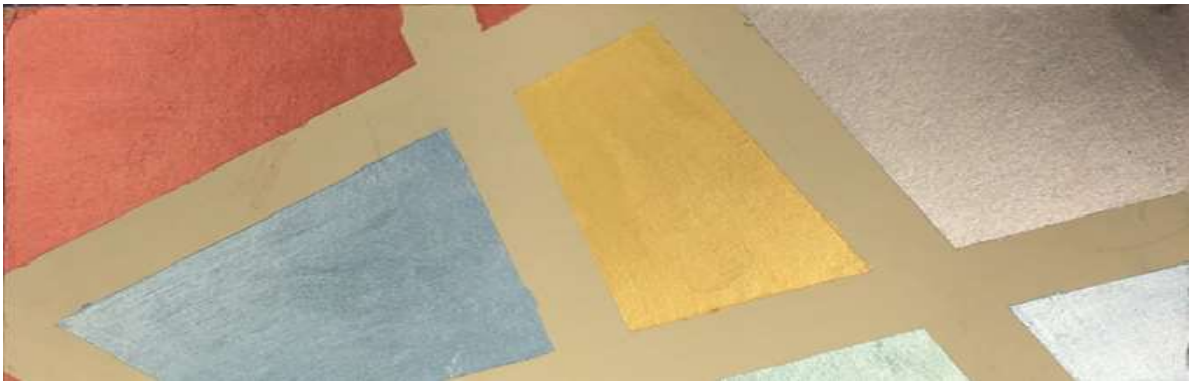
MENTAL CAPACITY REPORT:
HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

May 2020 | Issue 104



Welcome to the May 2020 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: the Court of Protection, COVID-19 and the rule of law; best interests and dying at home; and capacity and silos (again);

(2) In the Property and Affairs Report: further guidance from the OPG in relation to COVID-19 and an unusual case about intestacy, minority and the Court of Protection;

(3) In the Practice and Procedure Report: the Court of Protection adapting to COVID-19; remote hearings more generally; and injunctions and persons and unknown;

(4) In the Wider Context Report: National Mental Capacity Forum news, and when can mental incapacity count as a 'status?';

(5) In the Scotland Report: further updates relating to the evolution of law and practice in response to COVID-19. We also note that 9 May 2020 was the 20th anniversary of the Adults with Incapacity (Scotland) Act 2000 receiving Royal Assent.

You can find our past issues, our case summaries, and more on our dedicated sub-site here. Chambers has also created a dedicated COVID-19 page with resources, seminars, and more, here.

If you want more information on the Convention on the Rights of Persons with Disabilities, which we frequently refer to in this Report, we suggest you go to the Small Places website run by Lucy Series of Cardiff University.

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

Scottish Contributors
Adrian Ward
Jill Stavert

The picture at the top, "*Colourful*," is by Geoffrey Files, a young man with autism. We are very grateful to him and his family for permission to use his artwork.

Contents

The Court of Protection, care homes, the rule of law and deprivation of liberty

The Vice-President of the Court of Protection, Hayden J, has written to Directors of Adult Social Services (in a letter which can be shared more widely) to highlight a number of key points relating to the operation of the MCA 2005 in the context of COVID-19 and care homes.

The wide-ranging letter takes in remote assessments and a protocol for managing DoLs prepared by Lorraine Currie, MCA/DoLS lead for Shropshire County Council; it notes that:

> *It was expressed to me, at the Hive group, that there appear to be some who believe that careful adherence to proper legal process and appropriate authorisation may now, at times, be required to give way to other pressing welfare priorities. I understand how this view might take hold in establishments battling to bring calm and reassurance to intensely distressed people, both in the Care Homes and within their wider families. It is important, however, that I signal that whilst I am sympathetic to the pressures, I am very clear that any such view is entirely misconceived. The deprivation of the liberty of any individual in a democratic society, holding fast to the rule of law, will always require appropriate authorisation. Nothing has changed. The Mental Capacity Act 2005, the Court of Protection Rules and the fundamental rights and freedoms which underpin them are indispensable safeguards to the frail and vulnerable. (emphasis in original)*

The letter also notes that:

> *There has been a striking and troubling drop in the number of Section 21A (MCA 2005) applications which has occurred, in some areas, alongside a significant reduction in referrals to advocacy services. It needs to be emphasised that where there has been a failure properly to authorise deprivation of liberty one of the consequences is that, in the absence of authorisation, there will be a loss of entitlement to public funding and inevitably an obstruction to the individuals absolute right to challenge the deprivation of liberty. For the present I simply highlight my concern and restate the importance of the statutory requirements.*

In terms of remote assessments, this document prepared by Lorraine Currie is of considerable assistance; she also contributed to a webinar for the National Mental Capacity Forum (chaired by Alex) on the subject, which can be found here.

COVID-19, care homes, and remote assessments

BP v Surrey County Council (No 2) [2020] EWCOP 17 (Hayden J)

Article 5 – Deprivation of liberty

Summary

This is the second decision concerning an 83 year old man, BP. It follows the earlier one on 25 March 2020, the first time that the Court of Protection had to consider the impact of COVID-19 in the care home setting. At the earlier hearing, Hayden J had refused the application made by BP's daughter and litigation friend (FP), for a declaration that it was in his best interests to return home and into her care. At that stage, Hayden J had identified that there:

> *were fundamental difficulties with FP's plan. FP had been unable, due to the present health crisis, to identify any package of professional support. BP's lack of understanding of his own health issues occasionally causes him to overestimate his practical abilities and, as such, puts him in physical danger. Plainly FP would not have been able to care for and supervise her father in such circumstances for any length of time. BP's wife, Mrs RP, did not, at that stage, support the plan.*

However, and perhaps slightly surprisingly given the above, the matter came back before Hayden J on 17 April, by which agreement had been reached that:

> *BP would be able to move to his daughter's care. This will require assessment of BP's needs within his home and some adjustments to his accommodation. I have been told that it has been possible to identify carers who will assist FP. There was some debate as to how long this process would take but it is ultimately a balance between a comprehensive assessment of BP's needs and a recognition that his best interests now lie in a return home as soon as possible.*

It appears that – thankfully – the care home was, at the time of the judgment, still COVID-19 free. The judgment also shows the (understandable) impact upon BP, and others in his position, of social distancing. At paragraph 6, Hayden J noted that all agreed that "*BP has struggled to cope with or understand the social distancing policy which it has been necessary to implement. FP said that she believes her father thinks that he is being punished in some way. This, to my mind, reinforces the view of Dr Brett Du Toit that BP has little insight into his own health and his dementia. It is thought that the deprivation of contact with his family has triggered a depression. BP has been prescribed anti-depressant medication.*" Neither the care home nor the family had tried to instigate video conferencing, because FP had attended (it appears) daily, to sit outside the French windows of her father's room, communicating with him as best she could. The staff at the Care Home told FP that her father derived comfort from her visits, though FP was uncertain about this herself.

At the previous hearing, Hayden J had held that the outstanding assessment of capacity (required for purposes of the s.21A application) could be completed remotely. However,

> *8. On the 6th April 2020, Dr Babalola indicated that he was not prepared to assess BP's capacity using remote means. The challenges presented by the potential arrangements are self-evident and I entirely understand why Dr Babalola felt uncomfortable. The Care Home was not prepared to accede to Dr Babalola's suggestion that he attend and wear suitably protective clothing. I make no criticism of that decision indeed, it strikes me as entirely appropriate. The Care Home has remained Covid free (in so far as it is possible to be sure) thus, the risk was not to Dr Babalola from the residents but the risk he might have presented to them. In my Guidance, dated 19th March 2020, I addressed some of the concerns identified by the professions and observed the reality that for the time being many, perhaps most, capacity assessments would require to be undertaken remotely. I stated, "there is simply no alternative to this, though its general undesirability is manifest". I further emphasised that with "careful and sensitive expertise" it should be possible to provide sufficient information. I specifically contemplated that video conferencing platforms were likely to play a part in this process as they now do in so many other spheres of life and human interaction. If BP had remained at the home it would have been necessary to instruct a different assessor. I remain of the view that creative use of the limited options available can deliver the information required to determine questions of capacity. It may be that experienced carers well known to P and with whom P is comfortable can play a part in facilitating the assessment. Family members may also play a significant role in the process. I am aware that in many areas of the country innovative and productive approaches of this kind are proving to be extremely effective.*

Hayden J also took the opportunity to clarify observations that he had made in his earlier judgment about derogation from the ECHR, making clear that he had intended to – and in fact – had notified the Government in order that the Government might itself might decide whether to issue a notification of derogation.

Comment

That (assuming that all goes to plan) BP will be able to move to his daughter's care (it appears, although it is not entirely clear, in his own home) is undoubtedly hugely significant for him, although the precise basis of the arrangement is specific to the facts of his case. Of broader significance – beyond the recognition of the impact of social distancing on individuals with dementia – is the reinforcement of the message by Hayden J that assessments (of capacity, but also other relevant assessments) will have to proceed, even if by increasingly pragmatic/creative methods.

Best interests, death at home and the Court of Protection

VE v AO & Ors [2020] EWCOP 23 (Lieven J)

Mental capacity – medical treatment – residence

Summary

In this case, Lieven J was asked to determine whether it was in the best interests of a terminally ill woman to leave the care home where she was residing to move to live with her daughter and her family. The circumstances of the woman, AO, had been before the Court of Protection in 2010, at which point an order had been made to the effect that it was in her best interests to live in a care home, and to have staying contact with her daughter, VE. When AO was staying with VE over Christmas 2019 VE became concerned about her mother's health and her swollen abdomen. She took AO to the GP who referred her to King's College Hospital for a scan. She was diagnosed with advanced terminal ovarian cancer which had spread to her other vital organs. AO had stayed with VE for some six weeks over Christmas. She was admitted to King's College Hospital (KCH) in mid-January 2020.

VE was very concerned about the care of her mother at the care home and applied for the 2010 order to be discharged and for AO to be allowed to move to live with her. On 6 March 2020, she issued an application for personal welfare orders in respect of her mother seeking AO's discharge from hospital into her care. Within those proceedings VE issued a further application on 9 April 2020 and the proceedings were reconstituted as a s.21A Mental Capacity Act challenge to AO's deprivation of liberty.

On 20 March 2020, an order was made to the effect that it was in AO's best interests at that stage to be discharged back to the care home, with a further hearing listed to determine whether it was in her best interests to move to live with her daughter and family. It was on that same day that, in the light of the emerging COVID-19 pandemic, the Department of Health and Social Care produced guidance described by the judge as "*preventing family members from visits to care homes except in exceptional situations such as end of life*."

AO was discharged to the care home on 23 March, and, as the judge described it:

> *Since that date she has not had any face to face contact with her family. TO, for very understandable reasons in the light of the current pandemic, is not allowing any visits from family members to residents. Some contact has been maintained by telephone calls and, on one occasion, a video call using a carer's mobile phone but, given AO's condition, this is not an effective way of maintaining contact with the family. There was some suggestion at the first hearing of AO using an iPad or similar device to maintain contact but, again, given her mental state, this was not a practical or effective solution in the longer term. Therefore, adequate contact could not be maintained at the present time between AO and her family, and this was accepted by all parties by the hearing of 20 April 2020.*

Lieven J heard this matter on 16 April 2020 and ordered that further statements be produced for the second hearing (20 April 2020) and that the AO's representative (Ms Hobey-Hamsher) speak with the manager of TO and produce a note of that conversation:

> *17. Ms Hobey-Hamsher talked both to the manager of TO and the staff member who has had the most contact with AO. In terms of AO's condition, it seems that she is significantly more dependant than when she was admitted to Hospital. It*

was not clear the degree to which her condition had changed since she had returned to TO in March. There were slightly conflicting views as to how ill AO currently is. However, it appears that she is not yet entirely bed bound and she can communicate. There was also a somewhat unclear situation at the time of the hearing on 20 April 2020, by which Ms Hobey-Hamsher had been told that AO had a cough and was being isolated within the home.

18. The Manager told Ms Hobey-Hamsher that TO had not accepted any residents who had tested positive for Covid 19 and none of the existing residents had themselves tested positive. However, this is in the context where none of the existing residents were being tested. She said that there were residents who were showing symptoms which could indicate they had Covid 19 and they were being cared for in isolation. There were residents who had recently died who might have had the virus, but it was not possible for the carers to know given that they had not been tested for Covid 19. The Home is doing everything it can to prevent infections and to stop any spread within TO. TO is in lockdown with no outside visitors. Bio-security measures are being taken including handwashing, and separation/isolation of residents within the Home. It has to be said however that it is inevitably going to be extremely difficult to prevent spreading the disease within a home such as TO.

The court also had evidence before it from the CCG, from a Ms Clegg, in the following terms:

21. Ms Clegg gave oral evidence at the second hearing. She is an Associate Director of Integrated Commissioning within the South East London Clinical Commissioning Group (the CCG), previously the Lambeth Clinical Commissioning Group. The CCG had not assessed AO's needs so necessarily what she said about care that could and would be provided to AO was in general rather than specific terms. She said that staff, such as district nurses, were still visiting people in their own home and that staff had access to Personal Protective Equipment (PPE) where appropriate. The service to those being looked after at home has not changed with the current pandemic, and in fact the CCG has commissioned additional capacity. In terms of the care that a district nurse would provide to AO, Ms Clegg said that there would be support for the family, ensuring that AO had the right equipment and any basic nursing care that AO needed at home. It was clear from Ms Clegg's answers that there was no reason to believe that AO would not get appropriate support from the CCG if she went home. At the moment the only pain relief that AO is receiving is paracetamol and obviously that can be provided at home.

22. The other important area covered by Ms Clegg was the end of life care that AO would receive. Ms Clegg said that the CCG were very familiar with providing that type of care for people at home, including people lacking capacity. End of life care would be provided through St Christopher's Hospice, and a community based palliative care service. Pain relief can be provided, as appropriate, through pain relief patches and subcutaneous infusion and the district nurses can set this up. The district nurse service is familiar with, and sensitive to, issues around the patient's dignity towards the

> *end of life including respecting cultural beliefs and privacy. Mr Paget asked Ms Clegg about the levels of support that could be provided, and Ms Clegg said that it was difficult to answer such questions without a full assessment. She initially said that an assessment would take 4-6 weeks, but it was quite clear from her evidence that if there was a need an assessment could be carried out more quickly. She said that she could not rule out the need for AO to be in a 24 hour residential setting at the end of her life, but said that could be left open as an option and the CCG would endeavour to do its best for her to remain at home.*

Lieven J considered the case of *BP v Surrey CC* [2020] EWCOP 17,[1] in which Hayden J had found that the plans for BP to return to live at home, cared for by family members, was not in truth a realistic option, and therefore the consideration of the court focused on the issue of contact with the family. As Lieven J noted:

> *28. The principal factual difference from AO's case to that of BP is that AO has been diagnosed as having terminal cancer and is likely to have something between a few weeks and 3-6 months to live. This case concerns, as BP did not, questions as to whether it is in AO's best interests to be allowed to live with her family in the last period of her life. The ability to die with one's family and loved ones seems to me to be one of the most fundamental parts of any right to private or family life. That how a person dies can fall within the ambit of article 8 is now well established, see as but one example Pretty v UK [2346/02] at [65]. I have not been able to find any case law on the degree to which an inability to die with one's family engages article 8, but it would seem to me self-evident that such a decision by the state that prevents someone with a terminal disease from living with their family, must require a particularly high degree of justification under article 8(2). Wider public health considerations, such as the protection of the community by restricting visits to a care home were considered in BP, but are not the issue in the present case. It was not argued that there was any public health reason to prevent AO leaving TO to live with her family.*
>
> *29. In this case the central question concerns whether it is in AO's best interests, as a person without capacity, to be allowed to leave TO to go to her family to die. In respect of a best interests decision in similar circumstances in A NHS Trust v DU and others 2009 COPLR 210 Hedley J said as follows;*
>
> > *[10] This case illustrates the breadth of the concept of best interests which the court is bound to apply. The focus of the case was very much on treatment and where she should be. But, of course, the introduction of the possibility of Nigeria adds a new dimension. It is an integral part of the concept of best interests when dealing with a person of this age that the court recognises the imminent possibility of death and the importance of making arrangements so as to secure that the experience of death may be in a context which is the most congenial and peaceful that can be*

[1] The second judgment in the case not yet having appeared.

> *devised. Also implicit in the concept of best interests is the importance of the country and culture of origin and the whereabouts of the family. They will often take precedence over, for example, the question of risk avoidance or the exact quality of care that may be available. It is not possible to travel without some incidence of risk, but that is a risk that may be easily outweighed by the benefits of successful travel. It may be the case, insofar as it is remotely the business of the court to investigate it, that the quality of care at the point of destination may not be the same as the quality of care at the point of departure. Those are matters also which may easily be overcome by the benefits of relocation, and it is in consideration of those matters that the question in principle of this lady's transfer back to Nigeria is no longer controversial. It is clearly in her interests, having regard to her condition, her background and the whereabouts of her family, that she should if possible be transferred to Nigeria, and the evidence suggests that that is probably practicable.*

Lieven J made the decision at the end of the second hearing that it was in AO's best interests to leave TO and go to live with VE immediately. The order took immediate effect and AO moved on the evening of 20 April 2020. She emphasised that:

> *34.* […] *the arguments before me turned on the fact that AO had terminal cancer and was going to die within a relatively short time. Nobody argued before me that I should not allow AO to leave TO because of the risk of Covid 19, or that any possible public interest in not allowing her to move outweighed her best interests, or her article 8 rights. At the time I made my decision it was not clear whether or not any of the other residents at TO had Covid 19, and it was not being said that AO had Covid 19, but this is a possibility given some accounts of her current symptoms. This is important because this judgment is solely about what is in AO's best interests in circumstances where she had terminal cancer and her family wanted her to die at home with them.*

In her analysis of the position, Lieven J started with:

> *35.* […] *the basic proposition that most people would strongly wish to die with their family around them. I entirely agree with what Hedley J said in DU that the court should seek to ensure circumstances of P's imminent death that are as peaceful and dignified as possible. Given the Covid 19 pandemic, the need to minimise the spread of the virus and the current Government guidance if AO were to stay at TO, then the most contact that she would be likely to have would be one short visit from one family member at or around the time of her death.*

On the evidence before her, Lieven J concluded that "*if AO was capable of expressing her wishes and feelings it is highly likely that she would say that she wished to leave TO and spend the time left to her with VE.*" She was satisfied that AO could be properly cared for if she moved to live with VE, because she had been staying regularly with them, including for a period about 6 weeks before she was admitted to KCH. Lieven J was:

> *39.* […] *was much more concerned about end of life palliative care, and in particular pain relief. However, Ms Clegg made clear that the CCG could commission such care, and this would include visits by district nurses who could ensure appropriate palliative care was provided. I am very grateful to Ms Clegg for the very straightforward and realistic evidence she gave, and the efforts the CCG is going to in these most difficult of times, to continue to provide end of life care to people at home. In those circumstances I have no hesitation in finding that AO can be fully and properly cared for at home, and I am no longer concerned that she will suffer unnecessary pain at the end of her life.*
>
> *40. In the light of Ms Clegg's evidence, I saw no benefit to AO in acceding to* [the submission by the local authority that there should be] *a delay so that further assessments could be carried out. To the degree further assessment was necessary it could be done once AO was living with VE.*

Lieven J emphasised that, whilst all concerned were conscious of the risk of AO contracting COVID-19 – and, potentially, spreading it to her family if she moved to live with them, it was unquantifiable and not raised as a factor for her to take into account at the hearing:

> *42. The approach I took at the hearing was simply to assess what was in AO's best interests, and to conclude it was in her best interests for her to go to live with VE and to spend her last days with her family. Other considerations of wider public interest which might have arisen in another case were not raised in this case.*

Finally:

> *44. It was necessary to consider the Health Protection (Coronavirus Restriction) Regulations 2020 (SI 2020/350) in order to ensure that in allowing VE or a family member to collect AO from the care home I was not inadvertently allowing a breach of the Regulations. Regulation 6(1) prohibits any person from leaving home without a reasonable excuse. Regulation 6(2) lists, apparently non-exhaustively, matters that would amount to a "reasonable excuse". At regulation 6(2)(d) these include providing care or assistance to a vulnerable person. For a family member to collect AO from TO is to provide assistance to a vulnerable person and thus falls within that sub-regulation. It would in any event also accord with the order of the court. I therefore made the order sought so that AO could move on the evening of Monday 20 April 2020.*

A postscript made clear that AO died very much more quickly than might have been anticipated from the judgment – some 2 days later. It is not clear where she died, what she died of, or whether she had, indeed, contracted COVID-19.

Comment

As with the earlier judgment of Hedley J in *Re DU* which also – coincidentally – concerned a Nigerian person, this judgment is significant for recognising the importance of where and surrounded by whom you die, Lieven J recognising that "[t]*he ability to die with one's family and loved ones seems to me to be one of the most fundamental parts of any right to private or family life*." Although Lieven J was at pains to make clear that the direct risks of COVID-19 to AO (or, via her, to her family) were not factors in

her decision, it is doubtful whether she would have made the order that she did – to take effect with immediate effect – if the consequences of COVID-19 had not been to limit contact at the care home so dramatically.

The postscript to the judgment does raise a lurking concern. Given what was described as the "straightforward and realistic" evidence of Ms Clegg as to what the CCG could arrange as regards palliative care, it does not appear that the commissioning of such care had, in fact, taken place at the point when Lieven J (presumably almost immediately after hearing that evidence) ordered that AO be discharged from the care home. In the ordinary course of events, one would have anticipated that the court would wish to have seen, at a minimum, a plan for such care – it is not entirely clear whether Lieven J had such a plan before her. It is, further, not entirely clear whether such plan or arrangements as the CCG could commission had been implemented by the time that AO died.

These are undoubtedly not ordinary times, and from the judgment it is clear why Lieven J felt she was both in a position, and indeed effectively compelled, to order discharge at the point of the hearing. However, more broadly, the importance of dying at home surrounded by one's family must be weighed in the balance alongside the importance of dying with effective symptom and pain control.[2]

Capacity and silos (again)

London Borough of Tower Hamlets v A & KF [2020] EWCOP 21 (Senior Judge Hilder)

Mental capacity – assessing capacity – residence

Summary[3]

This case was concerned with whether A – a 69 year old woman who had suffered a stroke and been diagnosed with Korsakoff's dementia – had capacity to make decisions about her residence. It was agreed that she lacked capacity to make decisions about her care, and the court did not revisit this agreement.

A had been admitted on an interim basis to a care home after a hospital stay, but wanted to return to her flat. There was no dispute that she required care to maintain her nutritional status, to ensure compliance with her medication regime and to provide the opportunity for some sort of structured social activity. It was also agreed to be essential that A continued her abstinence from alcohol.

The dispute between the local authority and the Official Solicitor on behalf of A boiled down to whether one could properly separate the issue of A's capacity to make decisions about her residence and care. The local authority argued that "*an understanding of the kind of care required is fundamental to any decision on residence*", relying on the Court of Appeal case of *B v A Local Authority* [2019] EWCA Civ 913 in which the court had (at paragraphs 63-4) accepted the criticisms of the first instance judge's approach of analysing B's capacity in respect of different decisions as self-contained "silos" without regard to the overlap between them. In

[2] Whilst the case was not about COVID-19, Baroness Finlay has written a guide for family members who are looking after a person who is dying at home with COVID-19, which may be of relevance in circumstances where community palliative care teams may be very stretched.

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

particular it was, in B, said that the first instance judge's conclusion on capacity in relation to residence "*was fundamentally flawed in (1) failing to take into account relevant information relating to the consequences of each of those decisions, and (2) producing a situation in which there was an irreconcilable conflict with his conclusion on B's incapacity to make other decisions, and so (3) making the Local Authority's care for and treatment of B practically impossible.*"

Thus it was argued by the local authority in this case that, as A could not recall and *"does not accept her historical difficulties, and therefore cannot use and weigh that information in making decisions about the care she requires or, as a consequence, the place in which she needs to live in order to receive such care*" (emphasis added)

The Official Solicitor, on the other hand, argued that assessing care and residence separately did not mean they had been separated into silos. Rather what was required was "*an individualised assessment that best interests decision will be made in respect of an appropriate care package and, in those circumstances, A is able to understand, retain, use and weigh the relevant information in coming to a decision on residence.*"

The court rejected the local authority's approach, reminding itself that in "*cases which come to the Court of Protection for determination, decisions about where a person lives and decisions about what care a person receives are usually considered as individual domains of capacity*" and that such "*an approach is clearly in keeping with the Act's 'issue-specific' approach to decision-making.*" Accordingly. Senior Judge Hilder found, there "*is ample authority for considering residence and care as individual domains of capacity.*" She accepted that there was an overlap between the two, but resisted the idea that lacking capacity in one domain (here, care) means that one also lacks capacity in another (here, residence). That amounted to conflating the two domains. In other words, "*it is not necessary to make a capacitous decision about care in order to make a capacitous decision about residence.*"

On the evidence before her, and applying this approach, Senior Judge Hilder found that A had capacity to decide upon residence, even though she lacked capacity to decide upon her care arrangements.

Comment

This case lays bare the real difficulty in reconciling the decision- and time- specific structure the MCA requires when assessing capacity with the approach of the Court of Appeal in the *B* case.

In the case of B, it was perhaps more obvious that in concluding B had capacity to make decisions about her residence but lacked capacity to make decisions about contact with Mr C, in circumstances where she was choosing to live with Mr C, the judge produced "*a situation in which there was an irreconcilable conflict with his conclusion on B's incapacity to make other decisions, and so … making the Local Authority's care for and treatment of B practically impossible.*"

However in the case of A, as:

- there was a difference in the kind of care that she was going to receive between the two different available residence options – her own flat and the care home – and this was likely to impact on her functioning and well-being;

- the court accepted that the care that she would receive in both places (at least in broad terms) was part of the relevant information A was required to understand to make decisions about residence; and
- A lacked the capacity to make decisions about her care needs,

it is arguably difficult to see how A could be said to be able to weigh the different care regimes in the balance when choosing between the two options, and hence difficult to see how she could properly be said to have capacity to decide upon her residence.

The Supreme Court have given conditional permission to appeal in the *B* case, and so it is likely that there will be more on this issue to come – so watch this space…

It is also worth noting that Senior Judge Hilder observed, almost in passing at the end of the judgment, that a determination that a person lacks capacity to determine the care that they should receive necessarily means that they lack capacity for purposes of the DoLS regime. This observation is logically impeccable, but it is, on one view, odd that a person could have capacity to decide upon residence – i.e. where they live – but nonetheless still meet the capacity requirement for DoLS.

In due (but at the time of writing unknown) course, when the Liberty Protection Safeguards come into force, this particular oddity may be removed because the focus of the question will not be tied up with residence and/or care, but upon capacity to consent to the arrangements that confine the person for purposes of enabling their care and treatment.

Best interests, contraception and participation

Oxford University Hospitals NHS Foundation Trust v Z [2020] EWCOP 20 (Knowles J)

Mental capacity – best interests - contraception

Summary

In this case the court considered whether the implantation of an intrauterine device ('IUD') into a 22 year old woman against her wishes would be in her best interests. Z was a 22 year old woman with a chromosomal abnormality, chromosome 17q12 microdeletion, as a result of which she had mild learning disabilities and a bicornate or heart shaped uterus. Z was 35 weeks pregnant with her fifth child at the time of the application. Of her four previous children, one had died in the first week of life and the three others had been taken into care. Due to the risks in a natural birth as a result of her bicornate uterus, Z had been booked for a pre-term caesarean section to which she had been assessed as capacitous to consent.

The application was brought by the treating NHS Trust for a declaration on capacity and best interests that would authorise the insertion of an IUD at the same time as Z's C-section was carried out. Z did not want an IUD fitted although she did agree to having long-term contraceptive injections. Nonetheless, the application was unopposed by her litigation friend, the Official Solicitor.

This was one of the first remote hearings following the Covid-19 "lockdown". Arrangements were made for the parties to attend by Skype. For reasons that are not made clear in the judgment, it was not possible for Z to

join the Skype hearing. She did, however, contact the Trust once the hearing had begun, and arrangements were made for her to participate by means if a doctor at the Trust holding his mobile up to the Skype hearing while on the phone to Z.

In terms of capacity, the court heard that Z had mild learning disabilities and an IQ of between 60 and 69. She had been assessed as having capacity to make decisions regarding her antenatal care and mode of delivery. As to contraception, however, the court heard that there was "*an extremely high-risk individual where any future pregnancy would carry with it a significant risk to her and her baby's health*" and that Z had a history of annual pregnancies which pointed to poorly controlled fertility.

Knowles J noted Bodey J's test for capacity to decide on contraceptive treatment in *Re A (Capacity: refusal of contraception)* [2011] Fam 61 that is:

> *… the test for capacity should be so applied as to ascertain the woman's ability to understand and weigh up the immediate medical issues surrounding contraceptive treatment ("the proximate medical issues" per Mr O'Brien), including; (1) the reason for contraception and what it does (which includes the likelihood of pregnancy if it is not in use during sexual intercourse); (2) the types available and how each is used; (3) the advantages and disadvantages of each type; (4) the possible side effects of each and how they can be dealt with; (5) how easily each type can be changed; and (6) the generally accepted effectiveness of each.*

She further noted (para 25) that

> *Given the medical evidence, both parties accepted that the information relevant to the decision in respect of contraception included the risks to Z's health if she were to become pregnant again. However, both parties differed as to whether the social consequences of any future pregnancies should be considered as information relevant to Z's decision about contraception. I did not need to resolve that difference of view given the overwhelming evidence about the risks to Z's physical health if she were to become pregnant once more.*

Knowles J concluded that the evidence of three different clinicians demonstrated that:*"Z did not have a sufficient understanding of her own health status to enable her to relate the generic risks and benefits of contraception to her individual circumstances."* (para 26). Further:

> *when asked to explain why she had decided a contraceptive injection was best, Z was unable to do so, saying "I just have. I'm having the injection". She lacked any understanding that her compliance might be in issue, saying "I will have the injection", when Dr Camden-Smith pointed out to her that she was not complying with her other medication for diabetes, anaemia and nutritional deficiencies. Z was unable to remember any factors, other than that she might die, which those involved in her care might be concerned about and appeared to be dismissive or unable to remember when Dr Camden-Smith suggested people might be worried about her losing blood, developing diabetes, the death of her baby or the need for life-altering surgery such as a hysterectomy.*

In fact, the only real reason that Z could articulate for not wishing to have an IUD was because *"it's my body"* (paragraph 12).

Knowles J had little difficulty in concluding that Z both lacked capacity to make decision regarding contraception and that it would be in her best interests to have an IUD inserted, despite her objections, holding:

> *Whilst I accept that the use of an injectable contraceptive accorded with Z's wishes and took account of the least restrictive approach set out in s.1(6) of the Act, it did not in my view effectively achieve the purpose for which contraception was sought, namely to prevent the very serious risks to Z's physical health which further pregnancies would undoubtedly bring. Z's poor compliance with not only past injectable contraceptives but with medical treatment in this pregnancy militated against me endorsing Z's wish to have an injectable contraceptive.*

Comment

It is perhaps important to note that, unlike as sometimes has been the case, there was no suggestion that the insertion of the IUD should be carried out covertly. We do not know how Z responded to the court's determination that she have a contraceptive device inserted into her womb against her express wishes, because when Knowles J informed her of her decision, Z hung up the telephone.

It is possible, however, that Z might have felt disempowered by a process in which she could legitimately have contended that no one saw fit to argue her case before the court. Whilst the evidence to Z's capacity might have been compelling, and the medical evidence in favour of the insertion of an IUD being in her best interests equally compelling, there is – as we have had cause to note on a number of occasions (not infrequently in the context of reproductive rights) – a real difference between the outcome and the process by which that outcome is reached. If that process does not involve an actual argument being advanced on behalf of P in support of their expressed wishes and feelings, then, whatever the outcome, there must remain lurking concerns as to the nature of that process.

Editors and Contributors

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

Alex is recommended as a 'star junior' in Chambers & Partners for his Court of Protection work. He has been in cases involving the MCA 2005 at all levels up to and including the Supreme Court. He also writes extensively, has numerous academic affiliations, including as Wellcome Research Fellow at King's College London, and created the website www.mentalcapacitylawandpolicy.org.uk. To view full CV click here.

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

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

Neil Allen: neil.allen@39essex.com

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

Annabel Lee: annabel.lee@39essex.com

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

Nicola Kohn: nicola.kohn@39essex.com

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

Editors and Contributors

Katie Scott: katie.scott@39essex.com

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

Katherine Barnes: Katherine.barnes@39essex.com

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

Simon Edwards: simon.edwards@39essex.com

Simon has wide experience of private client work raising capacity issues, including *Day v Harris & Ors* [2013] 3 WLR 1560, centred on the question whether Sir Malcolm Arnold had given manuscripts of his compositions to his children when in a desperate state or later when he was a patient of the Court of Protection. He has also acted in many cases where deputies or attorneys have misused P's assets. To view full CV click here.

Adrian Ward: adw@tcyoung.co.uk

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

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

Jill Stavert is Professor of Law, Director of the Centre for Mental Health and Capacity Law and Director of Research, The Business School, Edinburgh Napier University. Jill is also a member of the Law Society for Scotland's Mental Health and Disability Sub-Committee. She has undertaken work for the Mental Welfare Commission for Scotland (including its 2015 updated guidance on Deprivation of Liberty). To view full CV click here.

Conferences

At present, most externally conferences are being postponed, cancelled, or moved online. Members of the Court of Protection team are regularly presenting at webinars arranged both by Chambers and by others.

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

Advertising conferences and training events

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

Our next edition will be out in June. Please email us with any judgments or other news items which you think should be included. If you do not wish to receive this Report in the future please contact: marketing@39essex.com.

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

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

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

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

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

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

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

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

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

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