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MENTAL CAPACITY REPORT: COMPENDIUM

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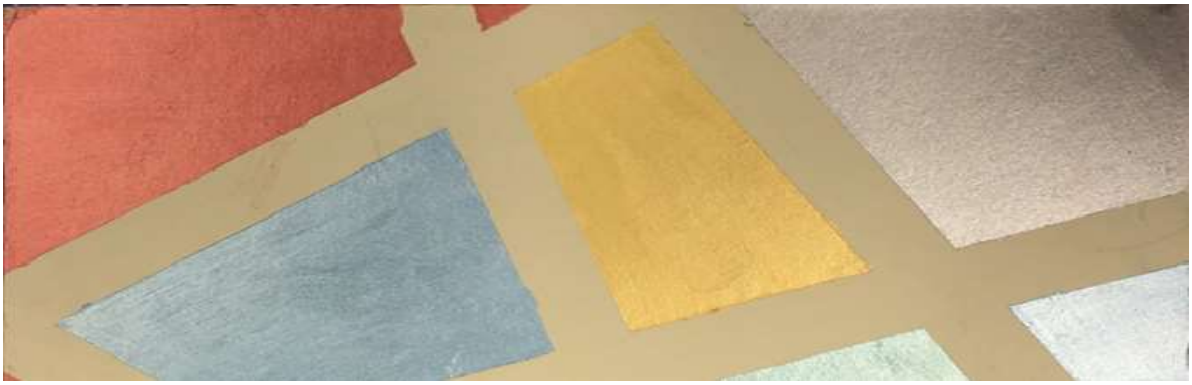

Welcome to the May 2021 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: a judgment looking beyond the diagnosis, paying for sex and the Court of Protection, navigating autism and indoctrination and relevant updates about visiting guidance in relation to care homes;

(2) In the Property and Affairs Report: a staunch judicial defence of *Banks v Goodfellow*, Child Trust Funds and capacity, and updates from the OPG;

(3) In the Practice and Procedure Report: discharging a party without notice, the white leopard of litigation capacity and CoP statistics;

(4) In the Wider Context Report: DNACPR decisions during COVID-19, litigation capacity in the civil context, and the interaction between capacity and the MHA 1983 in two different contexts;

(5) In the Scotland Report: the new Mental Welfare Commission practice guidance on capacity, rights, and sexual relationships. Our Scottish team has been too busy making law in different countries to write more this month, but will bring updates next month about legislative developments on the cards as the new Scottish administration finds its feet.

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.

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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.

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HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

Re JB: Supreme Court grants permission

On 13 April 2021, the Supreme Court granted permission to the Official Solicitor to appeal the decision of the Court of Appeal in *A Local Authority v JB* [2020] EWCA Civ 735. This will be the first time that the Supreme Court considers the vexed, and vexing question of capacity and sexual relations. No hearing date has yet been fixed.

A judgment as tribute: finding the person behind the prognosis

London NHS Trust v CD & Ors (Withdrawal of Life Sustaining Treatment) [2021] EWCOP 23 (Williams J)

Best interests – medical treatment

Summary[1]

It is difficult to do better in introducing this decision than to use the words of Williams J:

> *1. I am concerned with a young woman, CD, who I shall call Lilia for the purposes of this judgment. As a judge assigned to the Family Division but also nominated to sit in the Court of Protection the facts of this tragic case bring painfully into the spotlight for me one dimension of the potential consequences of prolonged parental conflict for the children at the heart of a family dispute.*
>
> *2. On 18 January 2021 Lilia tied a sheet around her neck, tied it to the taps of a sink and attempted to kill herself. She left a suicide note. Part of it reads*
>
> > *"I have always done my best to take care of you all, I'm so sorry for the pain this will cause you. You can be angry if you want, I understand. But most likely, you'll just be devastated. I won't be there to comfort you, I'm sorry. …….Please use the money to hire grief counsellors. It's the last thing I can do for you. Please don't blame yourselves, I'm the one that can't cope in this world. I love you all so much.*
>
> *3. Lilia was discovered by staff at the unit she was a patient at, CPR was administered, and she was taken to a London Hospital where she has remained in intensive care since. Her father commenced proceedings on 26 January 2021 seeking to be appointed her welfare deputy. On 15 February 2021 her mother applied to be appointed along with others as Lilia's welfare and property and affairs deputy. At an initial hearing, Mr Justice Newton approved consent orders joining Lilia and appointing the Official Solicitor to represent her and for the NHS trust to file evidence.*
>
> *4. The dispute between her parents that had dogged the lives of the family and most importantly their*

[1] Note, Tor having been involved in the case of Pippa Knight, also discussed in this note, she has not been involved in the writing of this summary.

> *children at least since their separation therefore continued into this court but now on quite literally a matter of life and death. I simply note that as a fact; I express no views on who is responsible for the parental conflict; that is not the purpose of these proceedings, is not justiciable within them and would probably serve no purpose. Almost inevitably Lilia's mother and father must have been asking themselves could they have done anything differently which might have altered Lilia's trajectory in life which has led here. I doubt that they will find any answer to those questions and it is highly likely that the causes of Lilia's psychiatric and psychological conditions and her attempt to end her life are complex and multi-faceted; it seems that Lilia's psychological and psychiatric well-being was also significantly affected by the pandemic generated lock-down. Only the parents can have some sense of whether they might have done things differently and given Lilia a childhood less complex and troubled than that which she lived. They certainly owe it to their other daughter to try.*

When the matter first came before Williams J, the evidence before him from Dr A, Lilia's neuro critical care consultant, Dr B, her consultant neurologist and an external second opinion from Dr Andrew Hanrahan Consultant in Neurorehabilitation and Clinical End of Life Care Lead at the Royal Hospital for Neurodisability, was that Lilia had sustained extensive hypoxic brain damage as a result of the attempted suicide and was either in a persistent vegetative state or the lower level of a minimally conscious state.

Lillia's treating team supported by her mother and sister had reached the conclusion that it was not in Lilia's best interests for life sustaining treatment, specifically clinically assisted nutrition and hydration ("CANH"), to continue to be provided. Indeed, the Trust's real position (although not pushed to its logical conclusion) was not just that treatment was not in her best interests, but in reality was futile, considering that "*continued respiratory support, provision of CANH and/or treatment and ICU interventions are invasive and burdensome for Lilia who has no real prospect of recovery. They are concerned that continued treatment would be unethical*" (paragraph 9).

Her father believed that there was some chance that her condition would improve and wished to seek a further opinion. He also believed that Lilia's wishes would be to continue to live.

Williams J permitted the father to instruct an independent expert, Dr Chris Danbury, a consultant intensive care physician who subsequently saw Lilia and provided a report which confirmed the conclusions reached by the treating team and the second opinion.

Directing himself as to the law, Williams J made the following observations about the best interests test:

> *17. Whether or not a person has the capacity to make decisions for herself, she is entitled to the protection of the European Convention on Human Rights. The fundamental principle of the sanctity of human life is enshrined in Article 2 of the Convention: everyone's right to life shall be protected by law. Further in the present context, Article 3 (protection from inhuman or degrading treatment) is relevant. In addition, it is an aim of the UN Convention on the Rights of Persons with Disabilities to secure the full enjoyment of human rights by disabled people and to ensure they have full equality under the law. In cases such as Lambert-v-France (20160 62 EHRR 2) the European Court of Human*

Rights has confirmed that the withdrawal of life sustaining treatment engages a State's positive obligations under Article 2 but that permitting withdrawal and the circumstances under which it was permitted and how the balance was struck between the right to life and the protection of their right to respect for their private life and autonomy were within the margin of appreciation of states. The ECtHR retains a right to review whether in any particular case an individual's Article 2 rights had been infringed or were within the margin of appreciation.

18. In Aintree University Hospital NHS Trust v James [2013] UKSC 67*, the Supreme Court considered the first case to come before it under the MCA. Baroness Hale, giving the judgment of the court, stated at paragraph [22]:*

> *'[22] Hence the focus is on whether it is in the patient's best interests to give the treatment rather than whether it is in his best interests to withhold or withdraw it. If the treatment is not in his best interests, the court will not be able to give its consent on his behalf and it will follow that it will be lawful to withhold or withdraw it. Indeed, it will follow that it will not be lawful to give it. It also follows that (provided of course they have acted reasonably and without negligence) the clinical team will not be in breach of any duty toward the patient if they withhold or withdraw it.'*
>
> *'[39] The most that can be said, therefore, is that in considering the best interests of this particular patient at this particular time, decision-makers must look at his welfare in the widest sense, not just medical but social and psychological; they must consider the nature of the medical treatment in question, what it involves and its prospects of success; they must consider what the outcome of that treatment for the patient is likely to be; they must try and put themselves in the place of the individual patient and ask what his attitude towards the treatment is or would be likely to be; and they must consult others who are looking after him or are interested in his welfare, in particular for their view of what his attitude would be.'*

19. At [44-45] it is said that the purpose of the best interests test is to consider matters from the patient's point of view. Where a patient is suffering from an incurable disability, the question is whether she would regard her future life as worthwhile. As was made clear in Re J [1991] Fam 33, it is not for others to say that a life which a patient would regard as worthwhile is not worth living. Likewise, dignity in life and death is a difficult subject which is not readily susceptible to objective definition. What one woman with her own subjective values and beliefs regards as undignified may not be regarded as so by another with a different set of values and beliefs. Thus, an intense focus on the patient concerned and understanding how they would likely view the situation is important rather than the imposition of some societal or cultural norm.

20. Where the patients' condition may improve a best interests decision may be based on an evaluation which incorporates consideration of the 'best case' scenario. A person who is in a vegetative state and has no awareness can still suffer physical harm.

[...]

25. Therefore, a host of matters must all go into the balance when the judge seeks to arrive at his

> *objective assessment of whether this treatment is in this patient's best interests. In particular I must consider the values and beliefs of Lilia as well as any views she expressed when she had capacity that shed light on the likely choice she would make if she were able to and what she would have considered relevant or important. Where those views can be ascertained with sufficient certainty, they should carry great weight and usually should be followed; as they would be for a person with capacity who did express such views.*

Having considered the substantive law and the medical evidence, Williams J was satisfied that:

> *54.* […] *the totality of the evidence points to the conclusion on the balance of probabilities that Lilia will remain in a vegetative state and that this could be for a period of many years. There is a remote possibility of neurological change that would place her in the minimally conscious state minus, but this would involve neurological change that would not result in Lilia's becoming aware of anything other than the most basic physiological sensations. There may even be an unquantifiable possibility of her demonstrating neurological change that would move her along the spectrum into the MCS plus; they cannot be completely ruled out because nothing is impossible. However even this seems to me to be largely theoretical and illusory possibility would still not bring her into the category described by Dr Hanrahan of neurological consciousness functional consciousness.*

Williams J dealt with the position of Lilia's father thus:

> *55. The father considered that Lilia if she improved to MCS- or even more so if she moved to MCS + that she might have the capacity to gain some benefit from being in the company of her family or having music played to her or the familiar voices or being held by them. I can understand why he would wish to believe this possible. It must be almost impossibly difficult to contemplate the annihilation of the person that Lilia was and thus one clings to a hope that because one cannot know for certain that this allows for the possibility of Lilia continuing to have the capacity to exist in some familiar domain. I was left unsure at the conclusion of his evidence whether the father simply did not understand the effect of the evidence of the treating clinicians, Dr Hanrahan and Dr Danbury or whether it amounted to a conscious refusal or subconscious inability to accept the overwhelming weight of the evidence because it was inconsistent with what he wished to believe. Regrettably though, his position is not supported by the medical evidence and his insistence on maintaining the possibility of Lilia regaining some awareness of any sort which would be recognisable to who she was before, is to deny the reality that confronts his daughter. To make decisions on the basis of his own wish as to what he wants her position to be rather than on the basis of what her position actually is, inevitably is likely to lead to flawed decision making.*

Williams J then turned to a sensitive analysis of whether it was possible to identify Liliia's wishes and feelings as regards future treatment:

> *56. Thus the evidence establishes that the likelihood for Lilia is that she will remain in a vegetative state entirely unaware of anything; her body will live but no residual part of who she was as a personality will return, nor even will she have the ability to experience the most basic sensations that a body can be aware of such as pain or discomfort, still less the more developed sense of the touch of a warm hand. She will never be capable again of enjoying the beat of the music she loved, of*

appreciating the majesty of a giant redwood, being entertained by anime or feeling a loved one hold her hand and speak to her. Her body and thus to that extent Lilia will be alive. Life is of value. Lilia appears to have been an atheist and so probably would accept this life is her only life. What would Lilia likely think about that life? What would she think about a life with somewhat more neurological activity – an MCS minus life or even an MCS + life.

57. However, to remain alive will on a balance of probabilities require on-going medical interventions. A tracheostomy, a PEG to enable her to be fed, she will likely require anti-biotics to deal with chest or urinary tract infections. Dr A said that she is currently experiencing a raised temperature and her bloods suggest an infection. She will need washing and moving. Although she may not be aware of these treatments and may not suffer discomfort whilst in a vegetative state this does not mean they are not being done to her and certainly in respect of some aspects are causing physical injury and harm to her. How would she feel about this? How would she feel about the possibility of her life encompassing some basic sensations including pain or discomfort or better but even then with medication which would assist with those negative sensations also probably eliminating any possible positive aspects.

58. In contrast how would she feel about the discontinuation of life sustaining treatment. Dr AA has set out both her prognosis for Lilia and the palliative medical treatment that might be required. Although she identified that Lilia sometimes requires assistance from her ventilator to support her breathing she thought on balance that Lilia would maintain spontaneous breathing if taken off the ventilator and would not die suddenly but rather her body would slowly pass into renal failure and eventual death as a consequence of her not receiving nutrition or hydration. This might take 3-4 weeks during which she would be in receipt of opiate or benzodiazepine medication to relieve the discomfort or pain. How would she likely feel about this?

59. It is not possible to know what Lilia would want for herself now. There is no categorical statement from her upon which heavy reliance can be placed. She has not made an Advance Decision. No one had an in-depth conversation or repeated conversation with her about the profound issues engaged here which would shine a spotlight on her views.

However, Williams J continued (at paragraph 60): "*there are many sources of information about her character and her views that throw beams of light on what her views are likely to have been and which ultimately for me appear to illuminate them to my mind clearly and reliably. Save for the father's interpretation of her views on the absolute sanctity and value of life, the sources of light all point to Lilia's likely wish being not to be given treatment to prolong her life for she would see it as a life without quality or purpose and a burden to her and to those she loves*." Williams J then detailed those sources of information, before reaching the conclusion that:

67. Taking into account all of the medical components of her situation and what I conclude are her likely wishes I'm satisfied that she would not have wished to continue life-sustaining treatment but that she would have opted for its cessation and for the implementation of a palliative care regime which would enable her to pass from this life leaving her family to make the best that they could of theirs. I do not believe that she would have wished to live the attenuated existence of a vegetative state or a minimally conscious state minus, to endure the profound limitations on her autonomy

> *including what I believe she would have perceived as the indignity of being cared for in every component of her personal care, unable to take decisions or act on them, to impose the burden of her attenuated life on her family and friends. I believe she would have wished to end the treatment.*

Williams J therefore held that:

> *68.* […] *objectively the medical evidence of her current condition and prognosis, even allowing for the limited and remote possibilities of neurological improvement and the absence of any meaningful quality of life, the harm that further medical treatment will inevitably involve (albeit probably not with any awareness for Lilia), what I'm sure would have been perceived by Lilia as the indignity of her condition and her need for lifelong physical care, and all of her wishes as analysed above, the views of her family and friends, the opinions of all her treating team and the independent experts, I'm satisfied that it is not in Lilia's best interests to administer life-sustaining medical treatment but rather that it is in her best interests to implement a palliative care regime the consequence of which (but not the aim) will be the end of her life but that I think will be an ending to her story essentially of her choosing and one which I feel confident she would endorse.*

Comment

The family tragedy played out in this judgment is one beyond editorial comment; however, the judgment is noteworthy for the acute and sensitive focus upon the young woman at its heart, personalised with a (fictional) name, and brought vividly off the page by Williams J's literary depiction of her. We use the term 'literary' here because there is a real sense in this judgment is intended to serve as Williams J's tribute to Lillia, reminding us of the many rhetorical purposes which judgments serve.

There is, perhaps, something of an irony here, though, because one purpose that the judgment did not serve was to identify that, in fact, this was a situation in which there was arguably no best interests decision to take at all. As in other cases recently (see, in particular, the decisions in *Re NZ* and *Re TW*), it appears that what the medical team was really saying was that they considered that further treatment was clinically inappropriate. In the circumstances, and given the difference of opinion as to whether Lilia would have actually asked for this treatment to be continued, it is perhaps understandable that Williams J focused upon the question of what she would have wanted. But it is hugely important to emphasise that if clinicians approach the court on the basis that a treatment is not in a patient's best interests, this is implicitly telling the court that they will provide it if the court comes to a different view. If they truly believe that further treatment is "unethical" (the word used here) it is arguably their ethical duty, both to the patient, but also to the team as a whole, to tell the judge that they are not prepared to provide it.

Williams J's – relatively brief – discussion both of the potential for harm to be suffered by a person even in a vegetative state with no awareness, and of the limited assistance to be gained by recourse to 'dignity' sits interestingly alongside the decision of the Court of Appeal in the case of *Pippa Knight* [2021] EWCA Civ 362, handed down just a few days previously. In that case, concerning an appeal

from a decision about life-sustaining treatment in respect of a young girl, Baker LJ rejected as "plainly wrong" the proposition that no physical harm can be caused to a person with no conscious awareness:

> *60.* […] *As I observed during the hearing, the law clearly recognises that physical harm can be caused to an unconscious person. In the criminal law, for example, an unconscious person can suffer actual or grievous bodily harm and it would be no defence to a charge under the Offences against the Person Act 1861 that the victim was unconscious. The judge was in my view entirely justified in citing examples from the law of tort in which it has been recognised that physical harm can be caused to an insensate person. As Mr Mylonas observed, if the proposition advanced on behalf of the appellant was correct, there would be no limit on a doctor's ability to perform any surgery upon any insensate patient. For my part, I fully endorse the judge's reasoning for rejecting the appellant's proposition at paragraph 76 of his judgment.*
>
> *61. The judge's approach is entirely consistent with the observations of my Lady in Re A. By focussing on the presence or absence of pain and failing to recognise the physical harm which an insensate patient may suffer from her condition or treatment, a decision-maker may fail to consider the child's welfare in its widest sense. Furthermore, so far as I can see, there is no support for the appellant's proposition to be derived from the judgment in Raqeeb. That case was decided on very different facts. Unlike Pippa, Tafida retained a minimal awareness, was in a stable condition, was not suffering life-threatening episodes of desaturations, and had received ventilation for a significantly shorter period. The level of support required by Tafida was not of the same degree of complexity and there was unanimity amongst all the doctors, including the treating clinicians, that she could be ventilated at home. Her condition and the treatments she received for it did not give rise to physical harm on the scale endured by Pippa in this case. In cross-examination, Dr Wallis acknowledged that the treatments given to Pippa were "on a spectrum of burdens". Furthermore, as demonstrated in the passages cited above from MacDonald J's judgment, the arguments advanced on behalf of the hospital trust in that case to the effect that it would be detrimental for Tafida to undergo the treatment proposed by her parents notwithstanding the fact that she could feel no pain were expressed in terms of dignity. In the present case, the Trust has not presented its arguments in those terms and the judge concluded that it would not assist him in this case to adopt any supposedly objective concept of dignity. In any event, it is worth noting that the argument presented to MacDonald J, as quoted in paragraph 176 of the judgment in Raqeeb,*
>
> > *"that even if Tafida feels no pain, further invasive treatment over an extended period of time will impose an unacceptable burden on her human dignity, which burden will be increased as she develops further debilitating physical symptoms"*
>
> *acknowledged that there would be "physical symptoms" which would be "debilitating" even though she could feel no pain.*
>
> *62. The judge was entitled to conclude Pippa could experience physical harm from her condition and medical treatment notwithstanding that she has no capacity to feel pain and no conscious awareness.* […]

In respect of "dignity," Baker LJ observed that:

97. […] *Although it was mentioned in the course of the judgment in this case, it was not a factor which the judge included as a reason for his decision.*

98. On behalf of the appellant, Mr Sachdeva observed in oral submissions that dignity was not, as he put it, the touchstone. In his submissions on behalf of the guardian, however, Mr Davy made extensive submissions about the concept of dignity and its role in decisions concerning the withdrawal of life-sustaining treatment. It was his contention that, in addition to the principle of the sanctity of life and principle of self-determination, the court in these circumstances should take into account the principle of the respect for the dignity of the individual. He submitted that the judge was correct to identify amongst the factors relevant to his decision both the burdens arising from the intensive and intrusive treatment required to keep Pippa alive and her grave loss of function and the potential benefits to be gained from treating her at home surrounded by her loving family rather than in hospital. Mr Davy submitted, however, that the real justification for including these burdens and benefits is that they are both aspects of the principle of respect for the dignity of the individual. He argued that this principle requires respect for an individual's value as a human being and encompasses both their psychological and physical integrity being deemed worthy of respect. Somebody who has no awareness of their circumstances can still be afforded dignity, or treated with indignity, by the manner in which they live and the way in which they are treated. Mr Davy submitted that, in Pippa's case, there is an innate indignity and burden associated with the intensive and intrusive treatment required to keep Pippa alive and her grave loss of function. Alternatively, if she were able to be cared for at home surrounded by her loving family, this would be a less undignified existence than her current care within the PICU. Notwithstanding these submissions, however, the guardian concluded that, when all the factors relevant to the decision are taken into account including the three principles of sanctity of life, self-determination and respect for the dignity of the individual, the potential benefit to Pippa from being cared for at home did not come close to tipping the best interests balance.

99. Mr Davy developed these arguments by reference to a number of reported authorities, in particular the decision of the House of Lords in Airedale NHS Trust v Bland [1993] AC 789. I commend him for the thought and care with which he has prepared those submissions and I intend no disrespect to him in saying that I do not think it necessary or appropriate on this occasion to embark upon a detailed analysis of the arguments he deployed. The judge declined to attach any weight to the concept of dignity in reaching a decision about Pippa's best interests, observing (at paragraph 86):

> *"there is obviously a high degree of subjectivity involved in describing someone's life or death as having dignity"*

and cited authorities in which the protection of dignity had been deployed to support decisions both to continue treatment and to withhold it. He concluded:

> *"given the very different ideas expressed to the court about what would constitute dignity for Pippa in life and in her dying, I shall not presume to adopt some supposedly objective concept of dignity to determine her best interests."*

Neither the appellant nor the Trust has sought to argue that he was wrong in adopting that course.

> *100. Other judges, dealing with cases involving different circumstances, have taken a different approach: see for example MacDonald J's decision in Raqeeb. In a future case, it may be necessary for this Court to address arguments akin to those put forward by Mr Davy about the role played by the concept of dignity in decisions of this sort. That necessity does not arise on this appeal.*

On 20 April 2021, the European Court of Human Rights held to be inadmissible the application by Pippa Knight's mother, observing that:

> *It was true that the test applied by the High Court had been that of "the best interest of the child', and that in Gard and Others the Court had not considered it necessary to determine whether that was the appropriate test or whether the courts should instead ask if there was a risk of "significant harm" to the child. However, in that case the Court had also acknowledged the existence of a broad consensus in international law that, in all decisions concerning children, their best interests must be paramount. More recently, in Vavřička and Others v. the Czech Republic [GC], the Court had rejected the applicants' contention that it should primarily be for the parents to determine how the best interests of the child are to be served and protected, and that State intervention could be accepted only as a last resort in extreme circumstances. Consequently, the decision to apply the "best interests of the child" test in a case such as the one at hand could not be said to fall outside the margin of appreciation afforded to States in striking a balance between the protection of patients' right to life and the protection of their right to respect for their private life and their personal autonomy.*
>
> *In any event, in determining the best interests of P.K., the judge had clearly found that, although she was unlikely to feel pain, both the constant invasions to her person required to keep her alive and the ongoing loss of freedom, function, and ability to enjoy childhood, had caused her continuing and ongoing harm.*

It would appear that Williams J is in the camp of those whom along with Poole J (and, arguably, Baker LJ) finding that dignity is a concept that obscures as much as it illuminates. Katie Gollop QC has given some very interesting thoughts on the Transparency Project's website about this issue. One way of thinking about this is that:

- The concept of dignity is not necessarily the answer to really difficult questions; but
- The **way** in which the dignity of the individual in question is spoken about will be very revealing of the person doing the talking.

Short note: paying for sex and the Court of Protection

In *A Local Authority v C* [2021] EWCOP 25, Hayden J had to consider the situation of C, a man **with** capacity to engage in sexual relations and to decide to have contact with a sex worker but **without** capacity to make decisions as to his care and treatment or to manage his property and affairs.[2] In August 2018, C told AB, his Care Act advocate and litigation friend, that though he wanted

[2] Note, Tor and Neil having been involved in the case, they did not contribute to this note.

to have a girlfriend, he considered his prospects of finding one to be very limited. He said that he wanted to be able to have sex and wished to know whether he could have contact with a sex worker. AB raised the matter with C's social worker, and, in due course, proceedings were commenced, by the Local Authority, to address the lawfulness of such contact.

The issues before the court were:

(1) Whether a care plan to facilitate C's contact with a sex worker could be implemented without the commission of an offence under the Sexual Offences Act 2003;

(2) If not, whether the Sexual Offences Act 2003 can be read compatibly with the European Convention of Human Rights, or whether the Court should make a declaration of incompatibility;

(3) If a care plan facilitating such contact is lawful, whether such a plan would be in C's best interests.

The potential offences under the SOA 2003 were: (1) that created by s.39 where a care worker causes or incites sexual activity where the person caused/incited has a mental disorder; and (2) s.53A, paying for sexual services of a prostitute subjected to force or other exploitative conduct. Hayden J found, however, that s.53A had little, if any, relevance to what is being contemplated for C in the particular circumstances of his case.

The positions of the relevant parties were summarised at paragraph 37 of the judgment thus:

> *Ms Butler-Cole and Mr McCormack [for C] contend that the kind of support contemplated above i.e. assistance with making practical arrangements to contact, visit and pay a sex worker, falls outwith the scope and ambit of Section 39 SOA 2003 and thus does not criminalise those offering the support. In this they are supported by Mr Allen, on behalf of the Local Authority. Ms Paterson, acting on behalf of the Secretary of State for Justice, who was joined as a party to the proceedings, contends that a construction of Section 39 which rendered lawful a carer's assistance to C in securing the services of a sex worker, would be to go beyond the wording of the legislation and "would amount to an amendment to the law, as opposed to an interpretation, be it purposive or Convention compliant". This, it is submitted, would be to "encroach upon the role of the legislature or Parliamentary sovereignty". The CCG submit that the lawfulness of the care plan must be determined by the Court. Mr Karim QC and Ms Campbell, on behalf of the Clinical Commissioning Group, properly highlight that whilst every step should be taken to promote C's personal autonomy, it is also important to protect him and those providing his care. Further, they emphasise that "it is imperative any package of care is lawful so as not to place any carers liable to criminal prosecution". All this is axiomatic.*

The judgment is detailed, careful and lengthy, and repays reading in full. Its conclusions are to be found at paragraphs 89 and onwards:

> *89. The central philosophy of the SOA is to protect those in relationships predicated on trust where the relationship itself elevates vulnerability. This essentially progressive legislation has been careful, in my judgement, to avoid constricting the life opportunities of those with learning disabilities or*

mental disorders. In contrast to earlier legislation it seeks to achieve protection of the vulnerable without resort to paternalism. The ambition of the Act is to empower, liberate and promote the autonomy of those with mental disorders. It signals a shift away from a regime which was recognised to be overly restrictive and not sufficiently understanding of the rights and liberties of those confronting life with mental disorders. Both the SOA and the Code for Crown Prosecutors (considered above at para 63) plainly take account of the UK's obligations arising from international conventions.

90. The Act brings a range of professionals within the ambit of the criminal law, if they abuse the power bestowed on them by the unequal nature of their relationships with vulnerable adults or children. As such the Act is both promoting free and independent decision taking by adults with mental disabilities, whilst protecting them from harm in relationships where independent choices are occluded by an imbalance of power. It is tailored to promoting the right to enjoy a private life, it is not structured in a way that is intended to curtail it. In the past legislation endeavoured to prevent those with mental disorders from engaging in sexual relations. The SOA plots a different course. At risk of repetition, I would emphasise the duality of approach in the SOA, in effect striking a balance between protecting those with mental disorders whilst enabling independent choices, in this most important sphere of human interaction. It follows, of course, that such choices are not confined to those which might be characterised as good or virtuous but extend to those which may be regarded, by some, as morally distasteful or dubious. Protection from discrimination facilitates informed decision taking. Those decisions may be bad ones as well as good. This is the essence of autonomy.

91. In C's case there is clear and cogent evidence that he has the capacity to engage in sexual relations and to decide to have contact with a sex worker. He understands the importance of consent both prior to and during sexual contact. He appreciates the link between sexual intercourse and pregnancy. He recognises the possibility of sexually transmitted disease. He lacks capacity to make the practical arrangements involved in identifying a suitable and safe sex worker and is unable to negotiate the financial transaction. What is proposed is that C will be assisted in these arrangements by carers who are sympathetic and content to help him. As I have set out above, this is delicate but not unfamiliar terrain (see para 10 et seq.) I reiterate, this requires to be addressed with both maturity and sensitivity.

92. Section 39 criminalises care workers who are found to be "causing or inciting sexual activity". Here however, the wish to experience sex is articulated clearly and consistently by C himself. He reasons that his overall presentation, the challenges he faces in his general functioning (into which he has some insight) and the circumstances in which he lives, all strongly militate against his being able to find a girlfriend. He lacks the capacity to make informed decisions in his use of the internet. His use of the internet is therefore restricted and monitored. This too closes opportunities for social interaction. C makes the utilitarian calculation that if he is to experience sex, which he strongly wishes to do, he will have to pay for it. C has repeated his wishes to his carers consistently and cogently over the course of the last 3 years. I met with him, via a video conferencing platform. He understands that I am considering what the law permits and that should I come to a conclusion that the law will not stand in the way of carers who are willing and able to help C achieve his wishes, any plans will have to await greater progress in the battle against the pandemic.

93. The mischief of Section 39 SOA 2003, as elsewhere in the legislation, is exploitation of the vulnerable. The provision is perhaps not drafted with pellucid clarity, but its objectives are identifiable.

It is intended to signal unambiguous disapprobation of people employed in caring roles (i.e. care workers) who cause or incite sexual activity by a person for whom they are professionally responsible. The legislative objective is to criminalise a serious breach of trust and, as I have commented, attracts a significant custodial sentence. The words of the statute need to be given their natural and obvious meaning. They are intending to criminalise those in a position of authority and trust whose actions are calculated to repress the autonomy of those with a mental disorder, in the sphere of sexual relations. Section 39 is structured to protect vulnerable adults from others, not from themselves. It is concerned to reduce the risk of sexual exploitation, not to repress autonomous sexual expression. The language of the section is not apt to criminalise carers motivated to facilitate such expression. In my judgement, the expanded interpretation of this provision, contended for on behalf of the Secretary of State, requires the language of the section to be distorted and the philosophy of the Act to be disregarded.

94. Though at risk of repetition, I reiterate that the proposals contemplated here strike me as being far removed from the identified mischief of the relevant provisions. To interpret them as encompassing the proposed actions of the care workers, requires both a distortion of the plain language of the statute and a subversion of the consistently reiterated objectives of the SOA itself. Indeed, given that the Act embraced an evolved understanding of the rights of people with learning disabilities and mental disorder, the more restrictive interpretation, suggested by Ms Paterson, would run entirely counter to its central philosophy. Ms Paterson, sensibly to my mind, recognises the force of the above. Instead, she concentrates her argument on general policy grounds, as I have set out. There is a logical paradox in the reasoning of the Secretary of State. He wishes to discourage prostitution, which many would think to be a laudable objective. Parliament, however, has recognised the futility of seeking to criminalise prostitution and, accordingly, it remains legal. Thus, the Secretary of State, in this instance, finds himself in the invidious position of trying to discourage, by guidelines and policy, that which the law allows. Where that discouragement has equal impact on society generally it may be a reasonable objective. Where it operates to restrict the autonomy of a particular group, as here, it cannot be justified.

94. It follows that, having applied the primary principles of statutory construction to arrive at the above interpretation, it is entirely unnecessary for me to deploy Section 3 HRA 1998 in order to construe a legal meaning which is compatible with Convention rights, see: Ghaidan v Godin-Mendoza [2004] 2 AC 557. These domestic provisions are entirely consistent with the fundamental rights and freedoms protected by the ECHR. However, it is important to record I consider that had I been required to have recourse to Section 3, I would have had little hesitation in concluding that the Convention required the construction that I had already arrived at. Any other interpretation would, in my judgment, go entirely 'against the grain' of the SOA.

Hayden J, therefore, found that what C was seeking was not in principle going to lead a care worker to be committing a criminal offence. That was not quite the end of the story, though, as he went on to note (at paragraph 96):

In due course I will have to consider whether it is in his best interests to pursue the course that he has set his mind on. As part of that evaluative exercise, I will have in mind that it will never be in C's interest to put himself or others at risk.

More immediately, in a separate judgment ([2021] EWCOP 26) handed down on the same day, Hayden J granted permission to Secretary of State to appeal his conclusion about the construction of the Sexual Offences Act, holding that:

> *Not without some hesitation, I have concluded that the tension between general policy considerations, identified on behalf of the Secretary of State, in relation to sex workers and my interpretation of the language of s. 39, falls within that small and discrete category of cases contemplated by rule 52.6(1) (b) [i.e. some other compelling reason for permission to appeal to be granted]. In the circumstances and for the above reasons only, I am prepared to grant permission to appeal.*

Because this case will shortly be considered by the Court of Appeal, we will (unusually) refrain from editorial comment, although we note that those who want to understand the issues in the round will find this 2015 article by Katherine Quarmby to be both interesting and (unlike some of the commentary on Twitter etc) nuanced.

Capacity, autism and indoctrination – a careful judicial navigation of a minefield

Re EOA [2021] EWCOP 20 (Williams J)

Best interests – mental capacity – contact – residence

Summary

This complex case relating to a 19 year old man, EOA, is of wider interest for the way in which the experts and the court had to navigate the interaction between EOA's autism and the extreme religious and anti-social indoctrination he had been subjected to by his parents. Along with his twin brother and two other siblings, EOA had been removed from their parents' care in 2015, as a result of ongoing concerns about the parents' treatment of the children, which included keeping them isolated from the rest of society, not allowing them to attend school or receive any medical treatment and subjecting them to extreme religious and anti-social indoctrination as well as emotional and physical abuse. Their parents played no part in the care proceedings and did not seek to have any contact with them; effectively they abandoned them.

In anticipation of EOA reaching the age of 18 on the 5 August 2019 on 23 July 2019 the local authority applied to the Family Division under the inherent jurisdiction and to the Court of Protection for a personal welfare order in respect of EOA. Following the commencement of proceedings various judges made interim orders in respect of EOA including interim declarations as to capacity. EOA case first came before Williams J on 16 October 2019. He attended and spoke of his very strong desire to be free of court proceedings and his wish to make his own choices in relation to where he lived and with whom he spent his time, in particular his brother but also his wider family. On that occasion Williams J decided that EOA should move to live from his foster placement in a residential placement. The nature of EOA's life at that placement was such that it would amount to a deprivation of his liberty and Williams J made further interim declarations and a deprivation of liberty order.

Expert evidence having been sought, it had been agreed by the local authority and the Official Solicitor that EOA lacked capacity to: (1) conduct these proceedings; (2) make decisions about his care and support; (3) make decisions about where he should live; (4) make decisions about his property and affairs; (5) and make decisions as to his foreign travel.

The local authority sought final declarations that EOA lacked capacity to make decisions in relation to: (1) foreign travel and holding a passport; (2) use of social media and the internet; (3) contact. The local authority also sought authorisation for a care and support plan which would give rise to a deprivation of liberty.

Capacity – what operative mechanism was in play?

At paragraph 47, Williams J considered that:

> *Despite the difficulties in carrying out a comprehensive assessment of EOA that Dr Layton* [a consultant psychiatrist]*, (as experienced by almost every other health professional) experienced as a result of the difficulties in securing EOA's engagement I am satisfied on the balance of probabilities that the diagnosis of autism is an accurate one. Dr Layton surveyed a broad landscape encompassing historic assessments of EOA, the views of his current carer's and EOA himself and given his degree of expertise in the area I accept his opinion. The particular feature of that condition which bears upon EOA's ability to make decisions is his fixed thinking which prevents him using or weighing information which is different to his preconceived and fixed ideas. This at the moment dominates his thinking in relation to very many important decisions that have to be made. That is not to say that there are not areas where he does show an ability to weigh and use information and where is thinking is not rigid but for the purposes of the decisions which have been put before me for adjudication it is this aspect of his condition which also in some contexts renders EOA unable to understand relevant information but most importantly prevents him using or weighing it as part of the decision-making process. I am therefore satisfied that EOA has an impairment of, or a disturbance in the functioning of the mind or brain within section 2 (1) MCA.*

Williams J also noted that, whilst he did not at this point need to decide the issue because he was satisfied that EOA's lack of capacity in the material domains was caused by his autism spectrum disorder, an issue which "*may at some stage need determining as to the role that other features of EOA's psychological condition may be playing in relation to questions of capacity and jurisdiction*" (paragraph 48). As he noted, there was clear evidence before him that:

> *48.* [….] *EOAs experiences had impacted on his psychological functioning or development. The definition of harm in the Children Act 1989 means ill-treatment or the impairment of health or development. Development means physical, intellectual, emotional, social or behavioural development and health means physical or mental health. District Judge Alderson* [in the context of the care proceedings] *accepted that EOA had suffered significant harm as a result of the abusive parenting he had experienced, and in particular the indoctrination into a way of life and belief system well beyond any norms in society; even giving due allowance for the very wide margins acceptable in a modern liberal society. It is well established that emotional abuse and neglect can have both*

physiological/neurological consequences in terms of brain development and psychological consequences. The absence of any specific diagnosis in relation to EOA of the effects of his neglectful and abusive childhood does not mean that they may not still be present and playing a part in his current functioning. In theory at least it seems to me possible that even if it were not possible to fit those consequences into any known diagnostic category that they would be capable of having caused an impairment of or a disturbance in the functioning of the mind or brain which would potentially bring them within the ambit of section 2(1) of the Mental Capacity Act. Of course, EOA's case is as a I have said far beyond any broad societal norms and within the spectrum where it can properly be characterised as indoctrination. Thus, even where the causes of incapacity caused by autism resolved that might still leave issues to be determined as to whether the consequences of his abusive indoctrination had consequences in terms of his capacity. Self-evidently it might also engage the protective Jurisdiction of the court in relation to vulnerable adults even if the consequences did not sound in capacity issues. However, given the evidence of Dr Layton that the autism itself is either substantially or entirely the source of EOA's inability to use or weigh information those are questions I do not need to resolve today. As Dr Layton said in evidence it is not possible to disentangle the effect of autism and the effects of the indoctrination in any way so as to quantify them but the fixed thinking which is a well-recognised aspect of autism, (but would also be consistent with indoctrination) establishes the causal nexus required by section 2(1) MCA.

Capacity – foreign travel

In relation to foreign travel and possession of his passport. Williams J was readily satisfied that EOA lacks capacity to make decisions as to his foreign *travel "given his lack of understanding of various issues relating to the practicalities of arranging foreign travel including managing the funds and the risks associated with foreign travel and his inability to use and weigh relevant information*" (paragraph 49).

Capacity – contact

Williams J identified in this context that it was necessary to break matters down to contact with: (1) family members who maintained the doctrine; (2) members who had left the doctrine; and (3) third parties or strangers. Williams J agreed that the third category raised different issues.

- In relation to family members who remained within the doctrine, "*the evidence establishes that EOA understands the contact with family he does not understand the risk they pose to him and is unable to weigh that in any decisions about contact with him. This rigidity of thinking arises from his autism although may also be impacted by indoctrination. He thus lacks capacity to make decisions in relation to those family members*" (paragraph 50);
- In relation to family members who were outside the doctrine EOA expressed no interest in seeing them. "*This may be because to do so he sees them in large groups which she does not like because of his autism but it may also be because they call into question his beliefs about the family. When POA attended court with EOA, he expressed his reluctance to see EOA because EOA's view of the family tended to undermine POA's separation from them. It seems to me that EOA lacks capacity in relation to these family members principally because he does not understand the benefits of seeing*

those who are outside the doctrine and he might be able to help him to understand the harm is indoctrination has done to him. As Mr Brownhill put it, he would need to understand something about the family dynamics and the differences that exist in order to make a capacitor's decision. Achieving this is part and parcel of the long-term three-pronged care and treatment plan. Thus, I am satisfied that EOA lacks capacity to make decisions in relation to contact with his family members" (paragraph 50). Williams J considered that it was appropriate to make a separate declaration in respect of this aspect of contact with others because it was a fact specific decision which arose and which had to be addressed;

- In relation to contact with strangers, Williams J noted that it was appropriate to "consider the established formulation of the relevant information" (paragraph 51). As he noted, "*Dr Layton identified EOA's lack of understanding of his own vulnerability arising from his lack of social awareness, social naïveté and autism which make him vulnerable to exploitation and abuse. His fixed thinking and unwillingness to consider these issues prevent him weighing issues relating to his vulnerability and he thus lacks capacity to make decisions about contact with strangers. There is an argument that in relation to contact with strangers that EOA might with the provision of information and support capacity to make decisions about contact with strangers in the way that he might with support regain be able to make capacitors decisions in relation to general social media and Internet use. However, I think there is a distinction. The issues of lack of understanding of his vulnerability and his susceptibility to exploitation by strangers in relation to contact our more profound than those which bear upon social media and Internet usage. There is some link in that one can lead to the other but the progress that EOA would need to make in understanding his vulnerability in face-to-face relationships with third parties or strangers are far more deep rooted and are likely only to be addressed through the three-pronged, long-term care and treatment plan. I am therefore satisfied that EOA lacks capacity in relation to making decisions about contact with strangers and that the final declaration should be made in this regard. I do not consider that an interim declaration is appropriate in this regard.*"

Capacity – internet and social media use

Williams J identified that in relation to general issues of access to the Internet and social media that decisions such as *Re A (Capacity: Social media and Internet use: best interests)* [2019] EWCOP 2 provided a proper route map to a decision in relation to this issue. The evidence established that EOA's capacity to use social media and the Internet is currently hampered by his lack of awareness of the possibility of deception and exploitation by third parties with interests adverse to his own. As Williams J noted at paragraph 52, this in Dr Layton's view amounted to a lack of understanding which meant he lacked capacity. Dr Layton thought EOA might gain capacity relatively easily with appropriate support and information in this area. However, Williams J was satisfied that this general approach:

> *53.* […] *does not assist in relation to the particular decision which arises in relation to use of the Internet and social media for the purposes of searching for his family or contacting them. In this*

> *regard the issue is far more closely aligned with the approach to contact with other named individuals where the courts evaluation should be decision specific. The use of the Internet or social media is merely one vehicle by which EOA might seek or have contact with family members who pose a risk to him and in respect of whom he lacks capacity to make decisions as to contact. Social media and the Internet today are the modern equivalent of a telephone directory or a letter of a previous era; they are simply a means of gathering information or communicating and in this case where there are clearly identified individuals whom EOA lacks capacity to make decisions in relation to contact seems to me that this should be recognised. The danger of not dividing these domains into more specific identifiable decisions would be to either apply an approach which was too restrictive in that it would apply a high bar in relation to strangers which in fact was only relevant to family members or alternatively it would apply too low a bar relevant to strangers to issues of contact with high risk family. I am satisfied that the statutory scheme and the jurisprudence does not require such an approach but requires a tailored and decision specific approach where that is appropriate on the facts. Thus, the order in relation to general internet and social media use should be an interim order which reflects the fact that further practicable steps to enable EOA to make capacious decisions in this regard. In relation to social media and Internet usage in the context of contact with family members that should be incorporated in the declarations addressing contact.*

Capacity and physical health

It appears (possibly of William J's own motion) questions of EOA's capacity in this regard were considered, as he identified a long-standing reluctance to engage with GPs. At paragraph 54, Williams J noted that:

> *As with other aspects of EOA's behaviour it seems probable that is refusal to engage with the GP is a complex interweaving of views derived from his upbringing and an inability to weigh information arising from that and from his autism. In relation to matters such as vaccination given to this. EOA is likely to refuse the vaccination as that has been his express position in relation to all forms of immunisation. It may be concluded at the relevant time that he lacks capacity in relation to vaccination but in welfare terms the issue of forcing a vaccination upon him would raise very sensitive issues of the balance between his physical health and the psychological impact which might be profound and would almost certainly have a significant impact on his trust in those around him and their ability to engage him in the sort of normalisation and desensitisation on work as well as any autism related work.*

Best interests

Williams J was clear that in the highly unusual case before him, the care and treatment of EOA needs to be bespoke:

> *55.* […] *The complex interplay between the psychological consequences of EOA's upbringing and the impact of autism requires a bespoke approach which has now been identified. Approaches which might be well established for individuals with autism have to be re-evaluated in the light of the indoctrination elements of EOA's psychological make up. It is clear that ABA is inappropriate, and that PBS needs to be tailored specifically to EOA as an individual; dynamic PBS as suggested by the*

> *Official Solicitor. The care and support plan drafted by the Local Authority subject to the amendments outlined by Ms Hendrick provides an appropriate for EOA's medium to long term care. He has settled into that placement and has begun to develop relationships with some of the staff. It is important that the stability and security that brings EOA continues and that he is able to regard it as a home. The proposals that have been made in relation to the treatment plan with its three psychological components now provides an appropriate foundation for the treatment element of EOA's future care.*
>
> *56. Taken in combination I am satisfied that the care support and treatment plans provide solid foundations on which EOA's medium to long-term future can be built.*

However, as Williams J noted, "[t]*he two factors which weigh in the scales against the adoption of that care support and treatment plan as being in EOA's best interests are his own strongly held wishes to be reunited with his family and the prognosis*" (paragraph 56). As he accepted, "[t]*he long held and firmly expressed wishes of a 19 year old young man warrant considerable attention*," but**:**

> *57.* […] *those strongly held wishes remain very much a product of the indoctrination that led to EOA's removal into care and given that EOA lacks capacity to make decisions as to where he lives, his care and his contact with his family I am satisfied that those wishes must give way to the general welfare benefits that the care, support and treatment plan provide. I wonder whether EOA himself recognises or has some awareness of the benefits to him of his current living arrangements but is unable to express those because of the his indoctrination which have a firmer hold on him than they have for instance on POA or TOA. The other issue which bears upon the decision as to whether it is in EOA's best interests to approve the care support and treatment plan is whether it is likely to achieve its goals and thus whether it is necessary and proportionate for the court to make the order is sought. EOA has been in care for five years and there is only modest evidence of change. Thus, is it proportionate to keep EOA from his family against his wishes if there is only modest prospects of success. For reasons which have not been fully explored it seems that EOA has not been able to access the sort of treatment that is envisaged under the three-pronged treatment plan now proposed. It seems from reading about EOA as he was in 2016 and now that there have been modest changes in his presentation and that his experience of life with his foster carer and in his placement have had some beneficial impact. It therefore seems probable that the bespoke care support and treatment plan proposed is likely to have a beneficial impact albeit over an extended period measured in years not months. Given the length of time EOA was exposed to indoctrination and the length of time that his autism has been untreated it may be that the changes that will be affected may be hard to predict and modest in extent but it is clear that the prognosis is positive if uncertain. That being so I am satisfied that and that it is a necessary and proportionate response to his situation. No lesser measure could be put in place to achieve the same ends.*

Deprivation of liberty

It was clear that EOA was subject to arrangements giving rise to a deprivation of liberty, and Williams J had little difficulty in holding that they were necessary and proportionate in the circumstances (paragraph 58). He agreed that it was unnecessary within the order to make expression provision authorising EOA's restraint:

> *59. Although he expresses a firm wish to be reunited with his family so far as anyone is aware, he has not made any attempt to leave TOA or even to search for his family. When he has left the GP surgery unaccompanied, he returned to the house and did not abscond. Nor is his behaviour in the home such as to have required the staff to use any form of restraint. Although he may be assertive in expressing himself, he is not violent and is generally compliant with the rules of the placement. It is therefore neither necessary or proportionate to authorise the use of physical restraint. Given the difficulties that have been encountered during the course of these proceedings in tracking down EOA's mother and father for the purposes of notifying them of these proceedings it seems clear that were EOA to locate them and to that if he were successful it might prove impossible to find him again. The frequency with which the family move and their ability to evade detection would mean that the consequences were EOA to abscond would be likely long term and thus serious. The placement needs to be aware of this, as I'm sure they are, and to be vigilant to any sign that EOA might be seeking to locate them or even more seriously that he might have located them and was seeking to leave to Join them. However, as Mr Brownhill submits the statutory framework would permit the staff to take steps to prevent EOA absconding even without express to restrain him.*

Best interests – contact

Williams J identified that there were concerns in relation to EOA continuing to see his brother JOA, who remained aligned with the family. However, there were clear benefits to the contact, and there was a concern that "*terminating would be perceived by EOA as punitive and confirming his negative perception of the Local Authority thus further undermining efforts to normalise and stabilise EOA*." So long as the contact, which was monitored by JOA's foster carers, continued to be 'innocuous,' Williams J was satisfied (at paragraph 60) that it continued to be in EOA's best interests.

Litigation friend for ongoing review

On the facts of the case, the Official Solicitor remained in place as EOA's litigation friend for purposes of the review of the deprivation of liberty order scheduled for the 12 month point.

Pathway plan

An issue emerged as to EOA's pathway plan:

> *62. The statutory scheme provides for the provision of a pathway plan to promote education and training for a care leaver. It emerged that unknown to EOA's current team that the children's team had in fact developed a pathway plan via his children social worker and they had monitored it. Although for a period of in excess of six months the pathway plan had not been reviewed as a result of the absence of the social worker seems to me that in reality this almost certainly had no impact on the ground. At present the benefit of a pathway plan is that if as a consequence of the treatment plan EOA expresses an interest in education or training that a pathway plan will mean there is a vehicle by which steps can be taken very rapidly to implement such a willingness to access education or training. Historically the evidence makes clear that EOA had almost no formal education. When he was received into care the educational psychologist suggested a special school for children with severe learning disabilities. I have not been able to unpick precisely what happened in relation to*

EOA's education between the making of the care order and his reaching his 18th birthday although it seems clear that home-schooling was attempted but was withdrawn when EOA did not engage. I entirely accept that for an individual in EOA's position nonengagement (as for autism itself) should not lead to the immediate conclusion that nothing can be done, and services be withdrawn. However, in EOA's case is nonengagement is not an aspect of his behaviour that is readily addressed; it permeates his whole personality and relates to far more than just education, but extends to health, engagement with almost any authority figure whether a social worker, a pathway adviser, his legal representatives or any other emanation of authority. Those who EOA engages with tend to be those he knows and has developed some trust in. A pathway plan and pathway adviser whether actively promoted or desultory promoted over the last 18 months would have gained no traction but would have represented another individual who EOA would have declined to engage with. I very much hope that the tripartite approach contained within the proposed care and treatment plan will open a window in EOA's mind to the potential benefits of education or training. Thus, the existence of a pathway plan which will allow rapid advantage to be taken of any such opening that the care and treatment plan creates in EOA's attitudes to society and normative behaviours. Although the issue has been rumbling along in the orders and position statements and it is right that the official Solicitor has identified the issue I do not think in practice in this case it is of real significance in the way it was in Re ND where Mr Justice Keehan did feel it appropriate to make a Declaration that the Local Authority had failed to fulfil their statutory duty. It is of peripheral relevance in this case and I declined to make any declaration. I accept that those involved in these proceedings and on the ground have done their best (with occasional shortcomings) to deal with a situation and individual that does not fit into any readily recognised categories and that has taxed even the minds of experts in their fields such as Dr Layton and Miss Meehan.

Letter to EOA

In passing at the end of the judgment, but of likely real importance in practice, Williams J noted that he would write a short letter to EOA explaining why he had reached the conclusions that he had done.

Comment

All cases before the Court of Protection are fact-specific, and this is no exception. The complex nature of those facts meant that the judgment inevitably had to be lengthy, to reflect the detailed, granular, analysis of EOA's capacity and best interests in the different domains. As noted at the outset, of wider potential relevance is the way in which Williams J had (with the benefit of the expert evidence) to seek to identify precisely why EOA was unable to understand, use and weigh the information relevant to the decisions in question. In this regard, paragraph 48 is of particular interest, even if Williams J did not on the facts of the case as they stood have to reach a definitive conclusion as to the potential operation of the effects of indoctrination. The discussion of EOA's capacity to make decisions in relation to contact is also of particular importance in reinforcing that capacity is decision-specific, that (as the Court of Appeal made clear in *PC & Anor v City of York Council* [2013] EWCA Civ 478) focus needs to be placed upon the actual decision to be made rather than a notional or generic decision, and, in consequence, it will often be necessary to determine questions of capacity to contact by either reference to specific individuals or categories of individuals. Finally, Williams J's approach to the

question of capacity in relation to the use of internet and social media is of wider interest for the way in which he (rightly) dug into the different reasons why EOA might be seeking to use it as relevant to the question of his capacity to make decisions and, especially, for identifying that, in reality, when it came to using the internet/social media for purposes of searching for his family, EOA was really making decisions about contact.

Visiting (out) and care homes

The DHSC has updated its guidance for visiting care homes with effect from 12 April, as well as the guidance in relation to visiting out from care homes. Alex's summary can be found here. The Joint Committee on Human Rights published a highly critical report on visiting restrictions (Alex was the special adviser) on 5 May 2021.

OPG webinar: LPAs in the BAME community

In April the OPG hosted their first health and social care event to discuss ways they can help bridge the gap in access to healthcare for BAME communities. The webinar, focusing on LPAs, can be found here.

PROPERTY AND AFFAIRS

Testamentary capacity – the judicial resistance against the MCA holds firm

Re Clitheroe [2021] EWHC 1102 (Ch) (High Court (Chancery Division) (Falk J)

Other proceedings – probate

Summary

This is the appeal against the decision of Deputy Master Linwood reported at [2020] EWHC 1185 (Ch) and digested in the June 2020 Mental Capacity Report. Deputy Master Linwood had had to decide on whether either of two wills should be admitted to probate. He described the dispute as a bitter family dispute that involved the surviving son and daughter of the deceased. The wills cut the daughter out of the estate and made the son the principal beneficiary. The daughter contested the wills on the grounds that her late mother had been suffering from a complex grief reaction or other affective disorder as a result of another daughter's death and that had led to her having insane delusions about the surviving daughter's character and behaviour which resulted in her being cut out of the will. In the result, the court decided in the daughter's favour and the wills were not admitted to proof.

The first ground of appeal was that the court had applied the wrong test, namely the *Banks v Goodfellow* test of capacity rather than that in the Mental Capacity Act 2005. The first hurdle the appellant had to overcome was that this point had not been raised below. In the end, the court refused permission to argue the point (see paragraphs 48-50) because the case might have been conducted differently and it was not in the interests of justice to allow the point especially as the estate was of modest value.

The court, however, then went on to give its views of what the position was, coming clearly down on the side of the *Banks v Goodfellow* test both on the grounds of principle and precedent, see paragraph 82.

The court rejected grounds based on a challenge to the assessment of expert evidence which left the appellant's grounds 2 and 3 which, amongst other points, challenged the deputy master's view that it was not necessary to show that the testator could not be reasoned out of her delusions.

The court indicated that perhaps the Master had not approached the matter correctly setting out at paragraphs 103 and 104 the following test:

> *103. As a matter of principle, it seems to me that the correct focus must be on the individual's state of mind. What is required to determine that the relevant belief has the requisite fixed nature must depend on the particular factual circumstances (which will include the nature of the belief and the circumstances in which it arose and was maintained), rather than itself being part of the test. A test based on proving a hypothetical proposition, namely that if an attempt was made to reason the individual out of the belief it would not succeed, seems to me to be not only an inherently difficult concept in the absence of an actual attempt being made, but also one that does not take account of*

the potential range of different factual circumstances that may exist. For example, if there is irrefutable evidence known to the individual that a particular belief is unfounded, but they still continue maintain it, I do not follow why further mental gymnastics should necessarily be required to prove a further hypothetical proposition. That risks, at the least, adding additional, and in my view unnecessary, complexity. It also gives rise to particular difficulties in a testamentary context, where the challenge of proving a hypothetical might mean that, in practice, issues of capacity could turn on the happenstance of whether the deceased was in fact challenged about a belief during his or her lifetime.

104. What I consider to be the correct approach would allow a holistic assessment of all the evidence. This would take account of the nature of the belief, the circumstances in which it arose and whether there was an evidential basis for it, whether it was formed in the face of evidence to the contrary, the period of time for which it was held and whether it was the subject of any challenge."

In the end, though, the court did not decide these grounds as there was a respondent's notice coupled with an application to adduce further evidence (see paragraph 142) and at paragraph 152 set out its conclusions which included a hope that the matter could be settled before more expense resulted.

In conclusion:

a) In the circumstances of this case, it would not be in the interests of justice to allow the question whether testamentary capacity should be determined using the MCA test rather than the Banks test to be pursued on appeal (although, if it were, I would have concluded that the Banks test continues to apply).
b) In order to establish whether a delusion exists, the relevant false belief must be irrational and fixed in nature. It not an essential part of the test that it is demonstrated that it would have been impossible to reason the relevant individual out of the belief if the requisite fixed nature can be demonstrated in another way, for example by showing that the belief was formed and maintained in the face of clear evidence to the contrary of which the individual was aware and would not have forgotten.

c) The Deputy Master did not give inadequate or irrational reasons for preferring the evidence of Professor Jacoby to that of Dr Series, and was entitled to conclude that there was a causal link between Debs' terminal illness and the delusions.

d) In relation to Grounds 2 and 3, I am adjourning the appeal for a period of three months to give the parties an opportunity to reflect on their positions and determine whether agreement can be reached without the expense of any further hearing. I trust that, in doing so, they will pay careful attention to the observations made at [145] to [152] above.

Comment

This case is another resounding confirmation of the continued applicability of the *Banks v Goodfellow* test regarding testamentary capacity when admitting wills to probate. As Falk J observed:

75. I appreciate that, to the extent that there are differences between the two tests, there is a potential

> *tension. As pointed out by the Chancery Bar Association to the Law Commission, at an extreme it might mean that no valid will could be executed if it were the case that a testator lacked capacity under the Banks test but was not demonstrated to lack capacity for MCA purposes.* […] *given that in my view the purposes of the MCA do not extend to determining testamentary capacity, any difficulties with the existing law are matters for the Law Commission and, ultimately, for Parliament, rather than for this court.*

OPG LPA delays

In a blog published on 10 May, the OPG has provided an update to the delays that are being experienced in registering LPAs, noting that:

> *While we're working to process applications as quickly as possible, please allow up to 15 weeks from receipt of your LPA for applications to be registered.*

The blog also points to tips as to how to make sure that the application is right first time, including this earlier blog post on common errors.

OPG rapid register search

The OPG holds a register of everyone who has:

- a lasting power of attorney (LPA)
- an enduring power of attorney (EPA)
- a deputy acting for them

This can be searched to find the contact details of those involved.

If professionals are making decisions about an adult at risk or are involved in a safeguarding investigation, they may need information urgently. The OPG has now launched a new rapid register search, aiming to respond to requests within 24 hours, Monday to Friday. Requests made over the weekend will be dealt with on Monday as a priority.

Requests that are not for safeguarding enquiries must use the OPG100 form.

Requests that are about COVID-19 patients should use the dedicated search.

For more details, see here.

Child Trust Funds when the child becomes 18 but lacks capacity

In January 2002, the government launched child trust funds as a way of encouraging saving to build up a nest egg when the child reaches 18.

A laudable aim, but what happens if the child, when 18 lacks mental capacity to manage its financial affairs even if the amount involved is small?

The law would require a LPA or a deputy. The former might not be possible for the self-same capacity issues and the latter results in expense, delay and bureaucracy. This against the background that most of the funds are worth less than £2,000.

This culminated in a proposed amendment to the Financial Services Bill in April 2021 which would, in essence, enable providers to enter into an agreement with someone to receive payments on behalf of the individual where there is medical evidence that person lacks capacity to manage their financial affairs, and where that recipient signed a form stating, inter alia, that they understand their duty to apply the money they receive in the best interests of the person who would otherwise be entitled to it. The payment limit under any agreement could not exceed £5,000, and the proposed statutory provision was time-limited to 2 years.

The debates around the amendment, which was ultimately not pushed to a vote, and the wider issues, are considered in this article written by Alex.

PRACTICE AND PROCEDURE

Discharging a party, special advocates and transparency

Re P (Discharge of Party)[2021] EWCA Civ 512 (Court of Appeal (Jackson, Baker and Warby LJJ)

Practice and procedure – Court of Protection – other – without notice applications

Summary

In this unusual case, the Court of Appeal considered an appeal by a decision of Hayden J to discharge a party from proceedings without notice following concerns that contact with the party and disclosure of information to her might be a risk to P.

P was described as a *'highly vulnerable 19-year-old woman'* who had diagnoses of *'cerebral palsy, atypical anorexia, post-traumatic stress disorder and selective mutism.'* Until April 2019, P had lived with her mother, AA, in the family home. P had been the subject of a child protection plan in 2018 due to concerns that she had been neglected; during assessments, it was discovered that P had been sexually abused by a male visitor to the family home. By April 2019, *'P's condition had deteriorated.'* She was severely underweight with a body mass index of 10.9 and considered to require treatment in a paediatric medical ward. An application was made in April 2019 to the Court of Protection to move P from the family home and to a residential unit; P's direct contact with AA was also supervised and limited to weekly (though with more substantial indirect contact). As proceedings continued, it appeared that the preponderance of the evidence was that P had capacity to make decisions as to her contact with others.

Without notice discharge of AA from proceedings

In November 2020, the local authority and trust were presented with information that P had been sexually abused by AA's partner, and that P feared for her safety. The information also set out that P had informed AA of both her earlier abuse by the male visitor to the family home and the more recent abuse by AA's partner, and AA had either taken no action, or told P not to disclose having been sexually abused.

Following receipt of this information, the local authority, trust and Official Solicitor made a joint application to hold a hearing partially in private, and to prohibit any further contact between P and AA. This application was made without notice to AA until her leading counsel was informed shortly before the hearing that an application to exclude AA and her legal representatives was to be heard.

At the hearing held on 3 November 2020, AA was discharged as a party to the proceedings on the court's own initiative, without an application to do so having been made by any party. All contact between P and AA was ended. Hayden J stated that "*if the question of contact between P and [AA] requires to be reconsidered, then [AA] will be contacted and invited to apply to re-join proceedings and participate in*

them if she so wishes" (in an extract from the judgment given at paragraph 16 of the Court of Appeal's judgment).

Baker LJ, giving the sole reasoned judgment of the Court of Appeal, described the circumstances of AA's discharge, and her attempts to challenge this decision:

> *2. The appellant was given no notice that the order was going to be made, no notice of the evidence on which the Court relied when making the order, and no opportunity to make representations before it was made. No judgment was delivered at the hearing on 3 November and the appellant was given hardly any indication of the reasons why the order was made. At the same time as making the order, the judge directed that, if the appellant wished to make any representations in respect of the order, she should do so within three days, by 6 November. Despite having no copy of the order, nor any notice of the evidence supporting or the reasons for the order, the appellant's lawyers complied with that direction. A fortnight later, having heard nothing from the Court, they sent an email asking when they might expect a decision following the filing of their submissions. In reply to a further email dated 27 November, they received an email from the judge's clerk stating that the judge was unclear what they were inviting him to do and that, if they wished to make an application, he would try to accommodate it. On 8 December, the appellant's solicitors filed a notice of application asking for a judgment relating to or reasons for the order dated 3 November and any further decision made in the light of the submissions filed on 6 November. The second order under appeal, adjourning the application for a judgment, was made in response to that application.*

At paragraph 3m the Court of Appeal set out what it understood to be the reasoning for the discharge of AA as a party:

> *The principal explanation for the judge adopting this highly unusual, if not unique, course was that the other parties to the proceedings had disclosed information to the court without notice to the appellant and the judge concluded that, if the information was disclosed to the appellant, there was a risk that P, who is, as I have already noted, a highly vulnerable young woman, would suffer serious harm.*

AA appealed her discharge as a party. Following the 3 November hearing, she had become aware of some of the information which the court had relied on in making the decision to discharge her as a party, but not all of it. A linked police investigation relating to the same information had commenced, *'and the investigation officers have raised concerns about any further disclosure at this stage.*'

As a result, part of the appeal itself was held in closed session, and AA was represented by a special advocate who had full access to the closed materials. The respondents prepared a summary or 'gist' document of the closed material, which was approved by Hayden J, and was disclosed to AA and her representatives.

Case management powers of the Court of Protection

The Court of Protection Rules give the court broad powers of case management in furtherance of the

overriding objective, and to dispense with the provisions of any other rule. The court may exclude a person from attending a hearing or part of it or determine that a hearing is to be held in private if there is a good reason for it. The court may require a document to be edited prior to service, or dispense with the service of a document. The court also has power to direct a party to proceedings to be removed as a party.

However, notably, COP Rule 3.4(4) states:

> *(4) Where the court proposes*
> *(a) to make an order on its own initiative; and*
> *(b) to hold a hearing to decide whether to make the order*
> *it must give the parties and may give any person it thinks likely to be affected by the order at least 3 days' notice of the hearing.*

Baker LJ accepted that the Court of Protection has "*wide powers to exclude parties from hearings, to withhold information from parties, to discharge parties from the proceedings, and to dispense with the rules altogether*" (paragraph 30) However, these must "*be exercised in accordance with the overriding objective and with wider principles of law and justice which have been developed and recognised both at common law and latterly under the Human Rights Act 1998*" (paragraph 30).

Discussion

After a detailed review of the case law, Baker LJ summarised the issue at paragraph 51 thus:

> *By the time of the hearing on 3 November 2020, there had plainly been a serious development in the case which required the court to take action. The court could have made injunctions or other protective orders. It could have directed that some of the evidence be withheld from the appellant for a period of time, or served in a redacted or gisted form. It could have excluded the appellant from hearings for a period of time. It could have appointed a special advocate to represent her. If satisfied that the circumstances were exceptional, it might conceivably have been appropriate to discharge the appellant as a party after giving her a fair opportunity to make representations. What was unprecedented, however, was to discharge her as a party without notice, without disclosure of any evidence, and without giving any reasons for the decision.*

Baker LJ did not rule out the possibility that, in an extremely urgent and serious matter, there may be a justification for withholding information or excluding a party from a hearing – or even, in some exceptional circumstances, discharging a party. "*It is, however, difficult to think of any circumstances in which a party who has played a material role in the course of proceedings can fairly be discharged without notice, without any opportunity to make representations, and without being informed at all of the reasons for the decision*" (paragraph 52).

Baker LJ noted (at paragraph 53) that the decision to discharge a party was not a decision made "for or on behalf of P" (and thus bound to be made in P's best interests), but nonetheless, the best interests of P were a central consideration in any decision made in relation to withholding evidence from a party.

AA's Article 6 and 8 rights were also engaged:

> *53.* […] *Insofar as her rights conflicted with P's, the law required the conflict to be resolved by reference to P's best interests…But any restriction on the appellant's rights should have gone no further than strictly necessary.*

In light of all of these matters, Baker LJ considered that in November 2020, there was a

> *54.* […] *very strong argument for withholding information from the appellant and suspending her contact with P for a period. But I have reached the clear conclusion that it was not shown to be necessary to discharge her as a party and that there was certainly no basis for discharging her without notice.'*

Baker LJ emphasised that the ordinary principles of judicial requirement are a requirement in the Court of Protection, and *'can only be in an extraordinary class of case that any one of them can be disregarded.'*

> *55. […]* [t]*he same legal principles of fairness and natural justice apply across all jurisdictions, but the way in which they are applied varies depending on the nature of the proceedings and the circumstances of the individual case.*

Baker LJ also noted that the primary reasoning given by the court for its decision to discharge AA as a party was that it was no longer in P's best interests to have contact with her (and at the time of the hearing, P appeared to have stating that she did not wish to do so). However, the information had only come to light a few days prior, and it appeared that P's wishes in relation to her mother had not been consistent:

> *57.* […] *It could not be assumed that the position that had emerged in the days leading up to the hearing was permanent and definitive. Given the complex history of the case, it was not possible for the court to reach a final decision on contact at that stage… [AA] had been an active party in the proceedings for over 18 months. Until shortly before the hearing on 3 November, it had been anticipated that P might return to live with the appellant in due course. Even if contact was to be suspended indefinitely, and evidence withheld from the appellant, it did not follow that she should be instantly discharged as a party.*

Baker LJ also noted some confusion in relation to the status of the court's order, where it appeared to have been the position of the parties that P had capacity to make decisions as to contact with others. It did not appear that the court was invited to reconsider P's capacity, nor did the court make a s.16 order on capacity. The order contained a recital that the Court was "concluding" that "as a vulnerable adult" it was not in P's best interests to have contact with the mother or her partner' and was headed as having been made in both the Court of Protection and in the Inherent Jurisdiction of the High Court. Whilst Baker LJ did not comment expressly upon this confusion, it is clear that he considered that it added to the mix in terms of identifying where things had gone awry.

On the facts of the case before him, Baker LJ considered (at paragraph 60) that, while it was necessary

to withhold information about the police investigation and local authority investigation into the welfare of P's child that did not justify discharging the appellant as a party.

More broadly, Baker LJ considered that, generally, the fact of an ongoing investigation would not necessitate discharge as a party; nor did the convenience of discharging a party to avoid disclosure of material form a proper basis for departing from the ordinary principles of a judicial inquiry (paragraph 60).

Baker LJ endorsed the approach taken:

> *61. […] by Cobb J in KK v Leeds City Council [2020] EWCOP 64 that a judge considering an application to be joined as a party "should always consider whether a step can be taken … to acquaint the aspirant with the essence of sensitive/withheld material, by providing a 'gist' of the material, or disclosing it to the applicant's lawyers". In the M and M case, Hedley J had identified a staged approach to applications to discharge a party, starting with full participation then considering partial participation, for example by redacting documents and then, only as a last resort, excluding the party from the proceedings. In this case, the judge adopted the opposite approach, asking whether there was any reason for the appellant remaining a party, and having concluded that, given the priority of P's rights, there was no reason, discharging her without notice. Had the judge simply decided to suspend contact and withhold information from the appellant for a period of time, he would have been in a better position to determine whether it was necessary or appropriate to discharge her as a party once the picture had become clearer. In all probability it would have been possible at a subsequent hearing to disclose at least part of the information, either redacted or in the form of a gist document.*

The court also considered that Hayden J could have instigated the special advocate procedure, though noted that a closed material hearing will rarely be appropriate in these circumstances. The court noted that in this case, "*there is nothing in the closed material which goes substantially beyond the gist document*" (64):

> *65. To sum up, given the serious concerns about the harm allegedly suffered by P and the risk of future harm, the judge was entitled to consider the matter in the first instance without notice to the appellant and to withhold evidence from her. He would have been fully entitled to make the order which the respondents were asking for, suspending contact between P and the appellant for a limited period, probably measured as a few weeks in the first instance, to allow the parties to reflect. In my judgment, however, he plainly went too far by discharging the appellant as a party without giving her the opportunity to make representations and by failing to consider alternative procedures which might have protected P's best interests whilst limiting the infringement of the appellant's rights. I see no reason to doubt that he considered the written representations subsequently filed on the appellant's behalf, but in my judgment he ought to have provided reasons for his decision, albeit in brief terms, and was wrong to adjourn indefinitely the application for a judgment.*

The court allowed the appeal, which had the effect of restoring AA as a party, though noted that the first instance judge might wish to make an order that she not be served with documents for the next 28 days while the parties took stock what information would be appropriate to serve on her.

Comment

There are a number of notable points in this judgment.

Process for considering withholding information from a party or excluding a party from a hearing

Baker LJ set out a useful road map for how parties and the court should consider steps to take where the court and certain parties need to be aware of material information, but there is a view that it would be contrary to P's welfare for all parties to be informed. While the Court of Appeal did not rule out the potential for discharging a party in extremely grave cases, it gave robust guidance that parties should start from the position of full participation of all parties, and consider any departure from that status incrementally, for example:

- The temporary withholding of information while urgent orders are put in place, followed by disclosure at a later time;
- Long-term withholding of certain information while the party continues to otherwise participate in proceedings on the basis of the 'open' information;
- The partial exclusion of a party from a hearing;
- The use of a 'gist' document to set out the contours of the information considered to put P at risk to allow some participation of the party giving rise to concern;
- The partial exclusion from a hearing (incorporating open and closed portions);
- The use of a special advocate.

Baker LJ noted, in particular, that the use of a 'gist' document in the appeal allowed AA to largely have effective participation, and that there was little discussed in closed session that added materially to that document. The 'gist' document was prepared by the respondents and approved by the court, who appeared to all be satisfied that the material in it could be disclosed to AA without compromising the ongoing investigations.

Special Advocate

At paragraph 5, Baker LJ also noted that the judgment:

> *it provides an opportunity to set out a description of how this Court has proceeded in these unusual circumstances which may be of assistance in any future proceedings of this kind which require a form of closed procedure. It appears that this is the first case in which a special advocate has been instructed in the Civil Division of the Court of Appeal.*

It is noted in the judgment that the use of a special advocate appeared to pose significant logistical

challenges to arrange, which were overcome only after the respondents offered to provide funding for this function. The Court of Appeal did not recommend the regular use of a Special Advocate in circumstances where a party's receipt of full information in proceedings is considered to potentially pose a risk of harm to P:

> *62. If necessary, the judge could have instigated the special advocate procedure. This is undoubtedly a more complex and costly option. But as Mr Cragg submitted to us in the closed session, the special advocate procedure is flexible and can be implemented quickly, as this appeal has demonstrated. On instructions from SASO, Mr Cragg confirmed that it can be used in this rare type of case. As Cobb J observed in KK v Leeds City Council, a closed material hearing will rarely be appropriate in these circumstances but it is an option to be considered wherever important evidence has to be withheld from a party.*

Transparency

The judgment is also notable for mentioning that observers were present at the appeal, and that they sought the parties' skeleton arguments. In obiter dicta, the court offered some guidance as to parties' consideration of drafting skeleton arguments with a view to the presence of observers who may seek them:

> *In preparation for the hearing of the appeal, counsel for all the parties filed open skeleton arguments and the respondents' counsel and Mr Cragg filed closed skeleton arguments. In passing I observe that the manner in which Ms Paterson's documents were drafted was particularly helpful, with the closed skeleton argument highlighting those passages which were excluded from the open skeleton. Regrettably, however, and in breach of the requirements set out in para 33 of PD52C, the parties' open skeletons were not all formulated in a way they considered suitable for disclosure to court reporters. As a result, the court was unable immediately to meet requests by two observers to provide the skeletons, and it was more difficult for those observers to follow the arguments during the hearing. In future, this is a point which should be considered by the parties and the court during preparation of an appeal.*

In search of white leopards: the relationship between subject matter and litigation capacity

Re P (Litigation Capacity) [2021] EWCOP 27 (Mostyn J)

Mental capacity – litigation

Summary

In this case, Mostyn J solely had to consider the issue of P's litigation capacity.

P was 60 years old, and had diagnoses of schizophrenia and HIV. She lived with her daughter, and P was employed as a carer. She had been detained under the Mental Health Act 1983 between 2018 and 2019, and at the time of this application, was being treated under a Community Treatment Order (CTO).

The relevant NHS Trust had brought an application to the court of protection in January 2021 seeking orders that:

> *5.* […] *P lacked capacity to decide whether to take the HIV medication; that it was in P's best interests to take her HIV medication (which takes the form of an oral tablet, taken once daily); and, inferentially, that she should be made to do so.*

P had stopped taken her medication in 2018, due to what was described in the judgment as "*fixed delusional beliefs and ongoing auditory command hallucinations, and hears God telling her not to take her HIV medication, but rather to pray. P has also previously seen snakes emerge from her HIV medication*." The medical evidence presented stated that P had a 50% probability of dying within a year if she refused to take her medication. P took psychotropic medication she was required to take pursuant to the CTO (and she attributed her doing so solely to the existence of the CTO).

Mostyn J noted the history of this application:

> *7. The matter first came before me on 1 February 2021 ("the February hearing"). At that hearing, I made an order that it was in P's best interests to take daily oral HIV medication, and I directed P to take the daily medication. It was hoped that the existence of such an order would result in P taking her HIV medication, even if begrudgingly, given that she takes her antipsychotic medication, albeit reluctantly, because of the existence of the CTO.*
>
> *8. Unfortunately, the order has had no effect and P still refuses to take her HIV medication. I therefore heard the matter again on 28 April 2021 ("the April hearing").*

The issue of P's litigation capacity had also arisen at the earlier hearing. The court had evidence from P's consultant psychiatrist concluding that P had litigation capacity. The psychiatrist noted (in an extract set out at paragraph 9 of the judgment) that:

> *I believe that because P's delusions are encapsulated and because she is coherent and not thought disordered she will, with assistance be able to participate in litigation proceedings and understand the process. She is also fully aware of the fact that her delusional belief system is at odds with her medical and psychiatric team's advice, but nevertheless she remains adamant not to comply with that advice due to her delusions, hence the need for the application to the Court of Protection.*

As a result, the first hearing (in which the relevant substantive orders were made) proceeded with P acting on her own behalf rather than through a litigation friend.

Following that hearing, the same psychiatrist later reversed her conclusion after reviewing an assessment by P's care coordinator. She found (in an extract set out at paragraph 12 of the judgment) that:

> *P did not think the proceedings related to her. Secondly, P's refusal to read the court papers and to communicate with others about the proceedings would be replicated in refusal to engage with*

counsel in my opinion, to instruct and take expert evidence."

Given the conflict in the evidence, before considering the substantive application, the court heard submissions on the preliminary issue of whether P had litigation capacity (with the Trust arguing that she did not, and the Official Solicitor arguing that she did). The court also heard evidence from P's treating psychiatrist.

Mostyn J found that P lacked litigation capacity in these particular proceedings. At paragraphs 26-29 emphasised the following points:

- A person can have capacity in relation to some matters but not in relation to others: *Dunhill v Burgin* [2014] UKSC 18;
- When judging a person's capacity to conduct litigation the question is whether the person can conduct the particular proceeding rather than litigation generally:
- "*Conducting litigation is not simply a question of providing instructions to a lawyer and then sitting back and watching the case unfold. Litigation is a heavy-duty, dynamic transactional process, both prior to and in court, with information to be recalled, instructions to be given, advice to be received and decisions to be taken, on many occasions, on a number of issues, over the span of the proceedings as they develop*": *TB and KB v LH (Capacity to Conduct Proceedings)* [2019] EWCOP 14 at paragraph 29 per MacDonald J;
- "'[L]*itigation capacity required the ability to recognise a problem; to obtain and receive and understand relevant information about it, including advice; the ability to weigh the information (including that derived from advice) in the balance in reaching a decision; and the ability to communicate that decision*": *Masterman-Lister v Brutton & Co (Nos 1 and 2)* [2002] EWCA Civ 1889;
- "[T]*he level of capacity to conduct litigation is set relatively high. Litigation, even so-called simple litigation, is a complex business. For virtually every case the substantive law, to say nothing of the procedural rules, is a daunting challenge, and can be a minefield*" (paragraph 29)

At paragraph 31, Mostyn J noted his disagreement with the conclusions of MacDonald J in *TB and KB v LH (Capacity to Conduct Proceedings)*:

> *that if a person lacks capacity to conduct proceedings as a litigant in person she might, nevertheless, have capacity to instruct lawyers to represent her and that the latter capacity might constitute capacity to conduct the litigation in question. I differ because, as MacDonald J himself eloquently explained, conducting proceedings is a dynamic transactional exercise requiring continuous, shifting, reactive value judgments and strategic forensic decisions. This is the case even if the litigant has instructed the best solicitors and counsel in the business. In a proceeding such as this, a litigant has to be mentally equipped not only to be able to follow what is going on, but also to be able figuratively to tug counsel's gown and to pass her a stream of yellow post-it notes. In my opinion, a litigant needs the same capacity to conduct litigation whether she is represented or not.*

Mostyn J robustly agreed with the conclusions of Munby J (as he then was) in *Sheffield City Council v E* [2004] EWHC 2808 (Fam) that it was unlikely for a person have capacity to litigate about a decision she lacked the capacity to make for herself:

> *33.* […] *I would go further and say that it is virtually impossible to conceive of circumstances where someone lacks capacity to make a decision about medical treatment, but yet has capacity to make decisions about the manifold steps or stances needed to be addressed in litigation about that very same subject matter. It seems to me to be completely illogical to say that someone is incapable of making a decision about medical treatment, but is capable of making a decision about what to submit to a judge who is making that very determination.*

On the facts, Mostyn J concluded that P's opposition to taking her antiretroviral medication was:

> *34.* […] *completely irrational and directly contrary to her best interests. There is no doubt that she suffers from an impairment of, or disturbance in the functioning of, her mind. As a direct consequence it is clear that she cannot understand the information relevant to the administration of the antiretroviral medication, nor can she use or weigh it as part of her decision-making process. The assessment of P's incapacity in this regard was open and shut.*

Mostyn J therefore considered that he had two issues before him:

1. The substantive question of P's best interests with respect to taking medication, which needed to be taken regardless of whether P had litigation capacity; and
2. Whether P had litigation capacity, or required a litigation friend to conduct proceedings for her.

Mostyn J found that the answer to the second question:

> *34.* […] *merely determines how P conducts the proceedings….if a party is assumed to have litigation capacity then she is taken to be capable of understanding, in a real sense, what is being proposed, and why. She is taken to be able to weigh, again in a real sense, the advantage of the medication. This understanding, and this weighing, will be the key drivers of the formation of the forensic decisions that she will make in the litigation process. Thus, she weighs all the information, both written and spoken, to formulate instructions to her lawyers in order to equip them to cross-examine and advocate generally on her behalf.*

Mostyn J queried:

> *37. How P could be assessed as being capable of doing all this when her schizophrenia-induced belief is that God has spoken to her and told her not to take the medication, and where she believes that the medication is infested by snakes, is completely beyond me.*

Mostyn J concluded that P lacked litigation capacity, and had throughout proceedings (despite the his earlier findings to the contrary, accepting that he had "take[n] his eye off the ball" when allowing the case to proceed on the basis that she had had capacity). Mostyn J stressed his view of how unlikely it

was a person would have litigation capacity where they lacked subject matter capacity:

> *39.* […] *I am not saying that differential decisions are impossible, but I am saying, as I have previously said in an admittedly completely different context, that such a case should be as rare as a white leopard. And this is not one of them.*

Comment

Mostyn J's discussion of litigation capacity in the context of COP proceedings is notable for two primary points:

1. His analysis of where the bar should be set for a person to be able to conduct litigation; and notably, that he did not consider that it was relevant whether the person was to conduct proceedings him or herself, or with the assistance of legal representatives; and

2. His more general comments that he found it 'virtually impossible' for a person to conduct proceedings about an issue in which the person did not have subject-matter capacity.

The judgment takes a notably stronger view on the latter point than the leading authority of *Sheffield City Council v E*, and if followed, would result in even fewer people who are the subject of Court of Protection proceedings being able to conduct their own litigation. The logic presented – specifically, that it is not clear what less important a person needs to be able to understand, retain or use and weigh to make a decision about how to argue a case to the judge than is needed to make the decision in one's own right – would seem likely will be the subject of further comment in other applications in which this issue arise.

Mostyn J's conclusions as to the relevance (or otherwise) of lawyers in the context of determining whether a person has litigation capacity are in line with the observations of Lady Hale (in the civil context) in Dunhill v Burgin, in which she had held (at paragraph 21) that "*the test of capacity to conduct proceedings for the purpose of CPR Part 21 is the capacity to conduct the claim or cause of action which the claimant in fact has, rather than to conduct the claim as formulated by her lawyers*" (paragraph 18). However, on one view, and especially within the context of the Court of Protection, they do not not sit easily with either the principle of support within s.1(3) MCA 2005 or the broader requirements of access to justice in Article 13 Convention on the Rights of Persons with Disabilities. After all, it could properly be said that one of the roles of the lawyer is to support their client to be able to make their own decisions as to the litigation by providing them (for instance) with information about the decisions that they need to take in a way that is appropriately tailored to their needs. On this analysis, it would only be if the client is unable – even without that support – unable to make those decisions that they should be said to lack litigation capacity.

E-filing in deprivation of liberty cases

HMCTS have announced that:

> To further support digital working within the Court of Protection we are starting to use electronic filing of documents (aka e-filing) for all Deprivation of Liberty cases. This involves the introduction of an automated system where correspondence and attachments received by email are placed directly onto the court's digital files (e-files).
> As well as providing the many general efficiencies of increased digital working, the use of the e-filing system will enable faster allocation of information to court files to ensure that judiciary and court administrators have immediate access to information within minutes of it being received by email.
>
> *When will the changes happen?*
>
> The e-filing system is being introduced at the Court of Protection to manage Deprivation of Liberty cases submitted to First Avenue House (FAH), London on/around the end of March 2021

For more details, see the update here.

Short note: domestic abuse and fact-finding

Although the decision in *H-N and Others (Children) (Domestic Abuse: Finding of Fact Hearings)* [2021] EWCA Civ 448 is a family law case, it provides useful general guidance from the Court of Appeal to approaching fact-finding when it comes to allegations of domestic abuse which may apply in cases in the Court of Protection or High Court involving vulnerable adults. In particular, the Court of Appeal emphasised the following general points:

- It was now accepted without reservation that it was possible to be a victim of controlling or coercive behaviour or threatening behaviour without ever sustaining a physical injury. Importantly, it was now understood that specific incidents, rather than being seen as free-standing matters, may be part of a wider pattern of abuse or controlling or coercive behaviour (para 27) (see also in the Court of Protection context *Re LW* [2020] EWCOP 50);
- A pattern of coercive and/or controlling behaviour can be as abusive as or more abusive than any particular factual incident that might be written down and included in a Scott Schedule (para 31);
- The value of Scott Schedules in domestic abuse cases had declined to the extent that, in the view of some, they were now a potential barrier to fairness and good process, rather than an aid (para 43);
- Serious thought was needed to develop a different way of summarizing and organising the matters that were to be tried at a fact-finding hearing so that the case was clearly spelled out but the process did not distort the focus of the court from the question of whether there had been a pattern of behaviour or a course of abusive conduct (para 46). There was a need to move away from using Scott schedules (para 49).

Court of Protection statistics October-December 2020

The most recent set of statistics have been published. They show (perhaps unsurprisingly) a decrease in applications in the period October – December 2020, down some 6% on the equivalent quarter in 2019. Of those, 41% related to applications for appointment of a property and affairs deputy. The statistics also show an increase in orders made, up 3% on the equivalent quarter in 2019.

In terms of deprivation of liberty, there were 1,363 applications relating to deprivation of liberty made in the most recent quarter, which is an increase of 16% on the number made in the same quarter in 2019. This comprised 105 applications for orders under s.16, 395 s.21A applications and 863 so-called "Re X" applications (for whatever reason, this last represents a fall from the previous quarter, when 1,299 had been made). However, there was a decrease by 8% in the orders made for deprivation of liberty over the same period from 820 to 757.

There was also a sharp decrease in the number of LPAs received, some 191,414, down 14% compared to the equivalent quarter in 2019.

THE WIDER CONTEXT

EU settlement scheme deadline

EU citizens and their family members (including non-EU citizens) need to apply to the EU Settlement Scheme to continue living in the UK beyond 30 June 2021. Children need to secure an immigration status as well as adults. The guidance for local authorities emphasises their responsibilities in relation to those with impaired decision-making capacity, and discusses their position thus:

> *Where someone who lacks mental capacity has appointed a legal representative with Lasting Power of Attorney, or has a Deputy appointed by the Court of Protection, their legal representative should make an application on their behalf.*
>
> *If someone's mental capacity fluctuates then their consent should be sought, when they are able to give it, for an appropriate third party to make an application on their behalf if they are unable to apply themselves.*
>
> *In each case, the person acting on behalf of the individual will need to be satisfied that they:*
>
> - *have the authority (in the general sense of permission or consent) to do so*
> - *are acting in the best interests of the individual in accordance with the Mental Capacity Act 2005*
>
> *Those signing the declaration on behalf of someone without mental capacity should upload a letter in the evidence section of the application form to inform caseworkers of the individual's circumstances.*

DNACPR decisions during COVID-19

On 18 March 2021, the CQC published its final report, following its review of 'do not attempt cardiopulmonary resuscitation" (DNACPR) decisions during the COVID-19 pandemic. The CQC report makes sobering reading.

CPR is an emergency procedure that aims to restart a person's heart if it stops beating or they stop breathing. It can involve chest compressions, delivery of high voltage electric shocks across the chest, attempts to ventilate the lungs and injection of drugs. A DNACPR decision is a decision taken that CPR should not be attempted, either because it would not work or would not be in the interests of the patient. As it is in reality no more than a recommendation as to what course of action to take, is not binding upon the person faced with the patient who might require it. However, in practice, it is likely to play a significant part in their decision. The Court of Appeal therefore confirmed, in the case of *R (Tracey) v Cambridge University Hospitals NHS Foundation Trust* [2014] EWCA Civ 822, that a patient must be involved in this decision unless do so would cause harm. If an individual lacks capacity to participate in such a discussion, then the decision-making process must involve those interested in their welfare:

Winspear v City Hospitals Sunderland NHS Foundation Trust [2015] EWHC 3250 (QB).

As readers will be aware, there have been concerns since the start of the pandemic that DNACPR decisions were being made without involving individual patients or their families/carers. Instead, the decisions were being applied to groups of people, rather than taking account of individual circumstances. In October 2020, the CQC was commissioned to conduct a review into these concerns.

In their report, the CQC observed that the concerns around DNACPR decisions were not new, but the pressures of the pandemic exposed them. The CQC did not find a national blanket approach to these decisions, but considered that there was confusion and that providers (worryingly) felt under pressure to ensure DNACPR decisions were in place.

The CQC emphasised that DNACPR decisions need to be considered as part of wider conversations about advance care planning and end of life care, and that these decisions must be made in a safe way that protects people's human rights.

The report concluded that the focus should be on three key areas:

1. Information, training and support – There was a need for ensuring that staff had sufficient training and support to ensure that conversations around DNACPR decisions are held in a person centred way. To facilitate those discussions, there is also a need to ensure that patients and their families are given sufficient information and time to understand the decision being taken.

2. A consistent national approach to advance care planning - There are a number of types of advance care planning in use, including ReSPECT plans, local treatment escalation plans and DNACPR decisions. The models use different approaches as well as different documents, which results in a lack of consistency and, in turn, could affect the quality of care an individual receives. There needs to be a consistent approach in the language used and the way DNACPR decisions are talked about, underpinned by patients and carers having a greater awareness of their rights under the Human Rights Act 1998 and Equality Act 2010.

3. Improved oversight and assurance – There must be comprehensive records of conversations with, and decisions agreed with, people, their families and representatives. Regional health and care systems need to improve how they assure themselves that individuals are receiving personalised, compassionate care in relation to DNACPR decisions.

For a reminder of the law around DNACPR decisions and advance care planning, readers are invited to watch Alex's shedinar, available here.

The Care Act 'Easements' are no more

In March 2020, pursuant to s.15 and Schedule 12 Coronavirus Act 2020, a number of 'easements' were made to the statutory duties owed by local authorities to people with needs for care and support. These notably included changing the threshold for Care Act 2014 eligibility to only require care and support

to be provided to avoid a breach of a person's human rights. The easements also allowed needs and financial assessments to be delayed, though guidance issued stated that local authorities:

> *will however still be expected to carry out proportionate, person-centred care planning which provides sufficient information to all concerned, particularly those providing care and support, often at short notice. Where they choose to revise plans, they must also continue to involve users and carers in any such revision…*
>
> *All assessments and reviews that are delayed or not completed will be followed up and completed in full once the easements are terminated.*

A formal process was required to trigger the use of the easements, and they were not widely used – only 8 local authorities triggered the process at all, and DHSC reports that 'the power has not been used since 29 June 2020' by any local authority.

The relevant provisions of the Coronavirus Act expired 29 March 2021, and all Care Act 2014 duties must now be complied with in full.

It should perhaps be noted that the equivalent power to enable easements under the Social Services and Well-Being (Wales) Act 2014 under the Coronavirus Act were not expired, although, at the time of writing, it is not understood that any local authorities in Wales are seeking to make use of them.

Short Note: litigation capacity in the civil context – advancing proper evidence

In *Greetham v Greetham* [2021] EWHC 998 (QB), Soole J considered an unusual contested application that a man should be appointed as litigation friend for his brother in the context of a partnership dispute. Soole J had to consider both whether the brother lacked capacity to conduct the litigation and, if so, whether his brother satisfied the conditions in CPR r.21.4(3) to be appointed as litigation friend.

Soole J noted (at paragraph 75) that:

> *In Masterman-Lister v Brutton & Co [2003] 1 WLR 1511 Chadwick LJ observed in respect of the previous rules (RSC O.80 r.3(2)) that 'The rule making body plainly contemplated, and intended, that the question whether a party was required to act through a next friend or guardian ad litem (as the case might be) should, in the ordinary case, be determined by the party himself or by those caring for him; perhaps with the advice of a solicitor but without the need for enquiry by the court.' : [66]. These observations were reaffirmed in Folks v. Faizey [2006] EWCA Civ 381 at [18] and [24]. However thse observations were qualified by the words 'in the ordinary case'; and in Folks Keene LJ acknowledged that there may be cases where the other party to the litigation may have a legitimate interest in disputing the need for and appropriateness of the appointment of a litigation friend : [25].*

In the instant case, having examined with care, and clearly increasing concern, the evidence advanced in support of the proposition that the brother lacked litigation capacity, Soole J found himself "quite

unpersuaded" (paragraph 91) that the presumption of capacity was displaced. The principal reason for his doing so was the wholesale failure to present the two individuals who provided capacity reports with "*any significant information about this litigation, its issues and the history of its conduct*" (paragraph 93). Soole J continued (at paragraph 94) that:

> *Of course, the fact that successive solicitors and Counsel have been satisfied as to Andrew's litigation capacity is not determinative of that issue. No more is it determinative that detailed letters, applications and appeals have been submitted to the Court over Andrew's name and signature. However these are all matters of obvious relevance which any useful assessment of litigation capacity needs to take into account. Thus if, e.g., it is the case that Richard and/or the unidentified intermediary drafted the various documents submitted and signed by Andrew and have been the source of instructions to Counsel, then the assessment needs to consider the basis on which they felt able to draft and give instructions on his behalf; and if necessary to seek further evidence and explanation for that purpose.*

Soole J also found, on the facts, that he would not have been satisfied that Andrew's brother could fairly and competently conduct proceedings on his behalf had he reached the conclusion that he lacked litigation capacity. In this, he noted, in particular, his failure to provide those who provided the capacity reports with highly relevant information.

This case provides an object lesson in relying upon reports in the context of contested disputes about litigation capacity. Although Falk J confirmed in *Hinduja v Hinduja* [2020] EWHC 1533 (Ch) that CPR Part 21 does not require medical evidence, the reality is that in a difficult and/or contested case the court is likely to wish such evidence as the civil courts clearly retain a preference for medical evidence as to incapacity. . If the decision is taken not to advance or, if not from a medical professional, it would be prudent to explain why the individual instructed is in a position to give a better picture of the capacity question in issue. They should also make clear: (1) their qualifications to speak to litigation capacity; (2) their ability to interpret for the benefit of the court any relevant medical evidence; and (3) clear evidence that they have taken into account all relevant factors.

How long is too long? Extending s.17 MHA leave beyond its appropriate limits

DB v Betsi Cadwaldr [2021] UKUT 53 (AAC) (Upper Tribunal (AAC), UTJ Jacobs)

Mental Health Act 1983 – Interface with MCA

Summary

Upper Tribunal Judge Jacobs considered an appeal from the Welsh Mental Health Review Tribunal (MHRT) against a refusal to discharge a patient from detention under s.3 Mental Health Act (MHA). The UTT was called to answer the question:

> *What decision should a tribunal make if a patient is on leave and not attending a hospital but the clinical team believes that the discipline of recall is necessary to ensure compliance with medication?*

MHRT decision

The patient, DB, was detained under s.3 MHA; he had been on leave under s.17 MHA since October 2019. By September 2020, he had not been physically back in hospital for 11 months; his solicitor referred to his arrangements at the hospital as a 'virtual bed,' which had been at two different sites during his leave. Throughout that time, DB had been living in a care home with supervised leave in the community.

He challenged his detention under s.3 MHA on the basis that it was no longer appropriate for him to be detained, as his care did not involvement 'a significant component of hospital treatment.' His clinical team opposed his application to the MHRT, arguing that he should remain liable to detention due to his continuing symptoms of Bipolar Affective Disorder and his care team's belief that he would discontinue his medication if discharged (as he had done in the past). DB's Responsible Clinician did not believe that a Community Treatment Order was appropriate for him.

The MHRT refused DB's application. It found that DB's "*appropriate treatment is medication, support and continuous review by his Care Team,*" that he was receiving "*appropriate and necessary treatment whilst on Section 17 leave'* and that *'it is probable he would not take his medication or remain at*" the care home if he were discharged from s.3 MHA.

UTT decision

DB appealed the MHRT's decision; the Health Board did not appear before the UTT, and the matter was considered on the papers.

UTJ Jacobs noted the cases of *R(CS) v MHRT and the Managers of Homerton Hospital* [2004] EWHC 2958 (Admin) and *R(DR) v Mersey Care NHS Trust* [2002] EWHC 1810; these cases considered challenges to decisions by first-instance tribunals not to release patients who had been on long-term leave.

In *CS*, the court considered a patient who had been having increasing periods of leave from hospital, eventually attending hospital only once every four weeks for a ward round. The court considered that the tribunal had made a rational decision not to discharge CS from detention under s.3. Noting *DR*, the court considered "*whether a significant component of the plan for the claimant was for treatment in hospital.*" In both cases, the courts accepted that the leave was part of the overall treatment of the patient.

In *CS*, the court found that "*treatment in hospital under section 3 can take place daily without overnight stays in hospital*," and that:

- monthly visits for review at ward round (which included clinical oversight of CS's medication);
- weekly sessions with the ward psychologist; and

- regular review of whether the continued periods of s.17 leave remained appropriate

constituted "*treatment at hospital remain[ing] a significant part of the whole*." The court did not consider "*that the mere existence of the hospital and its capacity to be treated by the patient as a refuge and stability is part of the treatment at that hospital*." The court accepted that "*in the closing stages of the treatment in hospital*" the role of the patient's treating psychiatrist "*may be gossamer thin*," but "*it is not appropriate to abruptly discharge a patient who has been subject to compulsory admission and treatment as an in-patient for a number of months*." An approach involving continuing s.3 detention while phasing out time in hospital did not necessitate immediate discharge by the tribunal.

However, in *DB*, Judge Jacobs distinguished *CS* and considered that the Welsh MHRT had erred at law. In *DB*, the patient had not had any contact with the hospital since going on s.17 leave 11 months prior; "*it followed that he had not received any treatment in a hospital in that time…he had managed without receiving any part or form of his treatment in a hospital for eleven months. The question then arises: why was it necessary for the patient to be detained in hospital at all?*"

While the MHRT had found that DB "*needed the discipline of liability to detention*" in order to remain compliant with his medication and it was a significant part of his care plan, UTJ Jacobs found that there had not been any finding by the MHRT that he required "*a significant component of his treatment to be in hospital.*"

UTJ Jacobs accepted that "*this may appear to create a dilemma,*" as DB may have been complying solely due to his liability to detention. If he were released from his liability to detention, he may then disengage, "*leading to a deterioration and the inevitable new admissions…in an unending cycle of discharge and admission.*" UTJ Jacobs considered that other options may potentially be considered, such as a Community Treatment Order, or potentially using the MCA 2005.

However, even if these other options were not available:

> *liability to detention is not a fallback when the possible options are not suitable or not available. To repeat, if the statutory conditions for detention are not met, the tribunal must direct their discharge. Section 3 is not available just because none of the other options is suitable for the patient. If there are no options under the Act, the proper and only course is to discharge the patient.*

The case was remitted for further consideration.

Comment

This judgment has significant implications for patients on long-term s.17 MHA leave, particularly where such an arrangement is being used to authorise a community deprivation of liberty; it was not clear on the face of this judgment whether DB was detained.

The availability and lawfulness of long-term s.17 leave has been an issue of some controversy since the *MM* and *PJ* decisions by the Supreme Court put beyond question that neither a CTO nor a

conditional discharge may be used to authorise a deprivation of liberty in the community. The *MM* decision appeared to leave an opening to allow a community detention to be effected under s.17(3)'s allowance that a patient on a leave of absence may 'remain in custody':

> *A patient who is granted leave of absence and a conditionally discharged restricted patient remain liable to be detained but are not in fact detained under the MHA (at least unless the responsible clinician has directed that a patient given leave of absence remain in custody, under section 17(3)).*

The current Mental Health Act Code of Practice recommends that s.17 should typically not be of a long duration, stating at 27.11-27.13 that *'Leave should normally be of short duration and not normally more than seven days. When considering whether to grant leave of absence for more than seven consecutive days, or extending leave so that the total period is more than seven consecutive days, responsible clinicians should also consider whether the patient should go onto a community treatment order (CTO) instead and, if required, consult any local agencies concerned with public protection….Leave for more than seven days may be used to assess a patient's suitability for discharge from detention.'*

However, the Code of Practice is at odds with the HM Prisons and Probation Service Mental Health Casework Section Guidance, *'Discharge conditions that amount to a deprivation of liberty,'* published in January 2019. This guidance specifically endorses long-term leave under s.17(3) MHA for patients who would be deprived of their liberty in the community, without the use of any other legal framework to authorise their detention for those lacking capacity. The guidance states, in relation to patients with capacity to determine their residence and care arrangements:

> *Where a patient continues to present such a risk to public protection, linked to his mental disorder, the Secretary of State considers that his treatment is best managed under the provisions of the MHA so that either the Secretary of State or the Tribunal can consider the public protection aspect of detention under the MHA. If further treatment and rehabilitation could be given in a community setting for such a patient, then a section 17(3) long term escorted leave approach would be more appropriate than to conditionally discharge with a care plan that required a DoL authorisation under the inherent jurisdiction of the High Court.*

The *DB* judgment calls this guidance and the practice of authorising long-term community detentions under s.17(3) MHA into serious question. It distinguishes *CS*, noting that there was no 'significant component' of DB's care which was being delivered in hospital. Neither, from the face of the judgment, did there appear to be any indication that the period of leave was being used to test DB's community care arrangements, or 'phase out' his relationship with the hospital with a view to discharging him from s.3. The role of DB's liability to recall to hospital appeared to serve primarily as an enforcement mechanism to insist on his taking medication. He had ended any apparent treatment at the hospital, but it appeared that the long-term plan was to leave him subject to s.3 detention while he lived in the community. The scenario in *DB* was closer to the one considered and rejected in *CS* as presenting no 'significant component' of the treatment being delivered in hospital: *'the mere existence of the hospital and its capacity to be treated by the patient as a refuge'.* Though the UTT did not direct DB's discharge

from s.3, it sent a clear message that some tangible aspect of treatment in hospital must exist to justify continuing detention.

The court acknowledged the potential difficulties DB may face if he is discharged from his s.3 and subsequently suffers a deterioration in his mental health, leading to his readmission to a considerably more restrictive setting than the one in which he currently resides. However, the judgment is robust in its finding that a continuing s.3 detention cannot be a 'fallback' position just because there is no other feasible community option for the patient; the tribunal is obliged to consider it strictly by reference to the statutory criteria for detention.

The same issue of the acceptability of long-term s.17 leave is being looked at in the context of conditional discharge by Lieven J, we will report upon the judgment when it is available following the hearing in early May 2021.

Ordinary residence and s.117 MHA 1983 – back to the statutory guidance

In a perhaps slightly curious development in 2020, the DHSC decided that its own statutory guidance (accompanying the Care Act) was wrong in relation to ordinary residence and s.117 MHA 1983. In judicial review proceedings concluded (at least for now) on 22 March 2021, the Administrative Court has found that the DHSC's approach was wrong, and that set out in the original statutory guidance was correct. The decision in question is that of Linden J in *R(Worcestershire County Council) v Secretary of State for Health and Social Care* [2021] EWHC 682 (Admin).

The SSHC originally determined a dispute about ordinary residence between Swindon and Worcestershire on the basis that the person in question, JG, was ordinarily resident in Swindon as she had been living there immediately before the second period of detention she was subject to under the MHA 1983. This conclusion was also in accordance with the SSHSC's statutory "*Care and support statutory guidance*" issued pursuant to section 78 Care Act 2014, at paragraphs 19.62-19.68 in particular. Swindon then sought a review, and the SSHC reversed the decision and found that JG had in fact been ordinarily resident in Worcestershire. In coming to this conclusion, the SSHSC acknowledged that:

> *The approach which I have taken is clearly at odds with parts of the Secretary of State's Care Act Guidance, and in particular with paragraph 19.64 of that guidance. I have had regard to that guidance, but it cannot override what I regard as the correct interpretation of the relevant primary legislation and the case law. The Secretary of State is in the process of considering how the Care Act Guidance should be amended, on this and other related points, in light of the approach taken to this and a number of other similar cases.*

In a very detailed judgment on the subsequent judicial review proceedings, Linden J concluded, in essence, that paragraph 19.64 of the Statutory Guidance was correct. It provides as follows:

> Although any change in the patient's ordinary residence after discharge will affect the local

> authority responsible for their social care services, it will not affect the local authority responsible for commissioning the patient's section 117 after-care. Under section 117 of the 1983 Act, as amended by the Care Act 2014, if a person is ordinarily resident in local authority area (A) immediately before detention under the 1983 Act, and moves on discharge to local authority area (B) and moves again to local authority area (C), local authority (A) will remain responsible for providing or commissioning their after-care. However, if the patient, having become ordinarily resident after discharge in local authority area (B) or (C), is subsequently detained in hospital for treatment again, the local authority in whose area the person was ordinarily resident immediately before their subsequent admission (local authority (B) or (C)) will be responsible for their after-care when they are discharged from hospital.

Linden J's judgment is also useful for confirming the continuing nature of the s.117 duty and the positive steps that are required by the relevant bodies to determine that it has come to an end:

> *148.* [….] *as a matter of construction, sections 117(2) and (3) contemplate that one clinical commissioning group and one local services authority will owe the person described in section 117(1) the section 117(2) duty, and that they will become subject to that duty when it is triggered under section 117(1). The duty will be triggered by the discharge of the person from section 3 detention and their release from hospital, and there is therefore a need to identify which bodies owe the duty at this stage and on each occasion that this occurs. Absent the intervention of any further detention, the clinical commissioning group and local services authority for the area identified under section 117(3) will then continue to owe the duty until such time as there is a section 117(2) decision.*
>
> *149. In a case where there is then a second period of detention under section 3, the question of after-care services will arise again when the person is due to be released and leave hospital. […] the clinical commissioning group and the local services authority identified by section 117(3) in respect of the second section 3 detention will owe the duty to provide after-care services arising out of that period of detention. If, at that point, the answer to the section 117(3) question has changed, for example because, immediately before the second period of detention, the person was no longer ordinarily resident in the area of the clinical commissioning group and the local services authority which previously provided after-care services, these bodies will not owe the section 117 duty which arises out of the second period of detention.*

In the same vein, Linden J also held that:

> *152.* […] *even where there is a subsequent detention under section 3, a decision as to the discontinuation of after-care services whilst the person is in hospital is needed on the basis required by section 117(2). The decision may well be that the needs of the patient are being met by the hospital in the course of their treatment and that they therefore do not need after-care services, at least for the time being, given that a further decision as to their needs will be taken when they are due to leave hospital. This may well almost invariably be the position, but I have not been shown evidence which would enable me to say what sorts of situations typically arise and so I express no firm view.*
>
> *153. What I do not accept is that Parliament intended that this would automatically be the position as soon as there was a further period of detention given the terms of section 117(2), and given that*

> *it is conceivable that there may be circumstances in which it is necessary to continue certain after-care services whilst the person is detained in hospital or at least for an initial period after admission. I consider that Mr Parkhill's condition precedent argument is wrong as a matter of statutory construction, as I have explained. But it also introduces a lack of flexibility into a situation where the needs of the patient are required to be uppermost in the minds of the decision makers. The Defendant's analysis, on the other hand, ensures that the professionals are in control and make decisions by reference to the person's needs. I also consider that an analysis which maximises flexibility and prioritises the person's needs, as well as continuity of care, is consistent with the pragmatic approach in R(B) v London Borough of Camden* [2005] EWHC 1366 *[57]-[60] which, at the very least, encourages responsible bodies to plan ahead even where the section 117 duty has not yet arisen.*

The DHSC has subsequently (21 April) confirmed that it is seeking to appeal and published a note setting out its position pending that appeal, materially that:

> *Ordinary residence disputes raising similar issues to those in the Worcestershire case will be stayed until we have final clarification as to the correct approach to ordinary residence for the purposes of section 117(3) of the Mental Health Act 1983.*

Short note: puberty blockers and parental responsibility

Following the judgment in *Bell v Tavistock & Portman NHS FT* [2020] EWHC 3274 (Admin), the High Court has returned to the question of when and how *Gillick* competent children may be prescribed puberty blockers.[3] Readers will recall that the question in *Bell* was whether Gillick competent children could themselves consent; in this case – *AB v CD* [2021] EWHC 741 (Fam) – the court had to consider whether parents can consent to the treatment on behalf of the child.

Lieven J held that the right of a parent to consent to treatment on behalf of their child does not cease when the child attains *Gillick* competence. Parental consent cannot trump a refusal of treatment by a competent child: but in this case the parent and child were in one mind. If XY was *Gillick* competent, she had not objected to the consent provided by her parents; if she was not, then her parents could in any event consent on her behalf. The parental right to consent continues even when the child is *Gillick* competent, save where the parents seek to override the decision of the child.

Nor, Lieven J found, was there any obligation to bring a case to court where a parental consent is relied on for the decision to prescribe puberty blockers. There is very limited authority imposing a requirement for court approval where a decision concerning a child is involved: in fact the only time such a requirement has been held to exist is in the context of a decision involving 'non-therapeutic' sterilisation: *Re D* [1976] 1 All ER 326. There is a much wider category of such cases where an adult who lacks capacity is concerned, 'but that merely exposes the critical difference between incapacitated

[3] Note, Tor and Alex having been involved in this case, they have not contributed to this note or comment, which is prepared by Rachel Sullivan.

adults and children' (at [117]).

The factors which in *Bell* were held to mean that a child would be very unlikely to be able to come to an informed decision – 'the poor evidence base for PBs; the lack of full and long term testing; the fact their use is highly controversial, including within the medical community; and the lifelong and life-changing consequences of the treatment, which in some ways are irreversible' – did not justify finding that parental consent did not operate in the normal way. This was because, in the judgment of the court, parents will in general be in a position to weigh up these factors and reach a decision as to what is in the best interests of their child. The gravity of the decision is no greater than that of consenting to a child being allowed to die (at [121])

Lieven J identified a potential need for additional safeguards to be built into clinical decision making, viewing this as a better safeguard for children than removing the ability for parents to give consent. NHSEI has now published interim measures in response, pending the outcome of the Cass Review.

This case raises a number of questions, not least how it fits with the judgment in *Bell*. Although Lieven J (who also sat on the Divisional Court in *Bell*) makes express her view that there is no conflict and that this judgment does not undermine what is said in *Bell*, the reasoning is not altogether easy to reconcile. The fact that parents are presumed to be able to weigh the very factors that in *Bell* were said to undermine the probability of a child being able to make a *Gillick*-competent decision – therefore meaning the court need not be involved – is perhaps troubling. It is not clear why the 'unique ethical problems' the court identified in *Bell* should undermine the likelihood of a child being able to make a competent decision but not of their parents to weigh matters properly. The difference in expectations as to when cases concerning children will need to come to court and the greater protection afforded to incapacitated adults is also a matter of some interest, and perhaps concern. The court's answer – that this is simply reflective of the difference between children and adults – seems rather to beg the question in terms of an analysis of children's rights. The appeal in *Bell* is due to be heard in June, and so it seems unlikely that this is the last that will be heard on these questions.

Deprivation of liberty and prodding into action - what legal route?

CGM v Luton Council [2021] EWHC 709 (Admin) (High Court (Administrative Court) (Mostyn J))

Deprivation of liberty – children and young persons

Summary

A father brought judicial review proceedings in respect of the local authority's alleged failure to seek High Court authorisation to deprive his 12-year-old daughter, NM, of her liberty. Parental responsibility was shared by virtue of a care order and, under the care plan, NM resided in a secure residential school. The two main issues were: (i) whether it was arguable that NM was deprived of liberty, and (ii) the proper procedure by which such challenges ought to be brought, especially where a local authority does not consider an authorisation to be required because the person is not deprived of liberty.

(i) Arguably a DOL?

The local authority strongly denied that NM was deprived of liberty. It argued that she was very young and that the restrictions placed on her were in line with those routinely placed on a child of her age. Whereas her father compared the care arrangements to a Category B prison. The issue was one of fact and children confined in accommodation which is not approved secure accommodation for s.25 Children Act 1989 purposes require authorisation from the High Court and at least annual reviews. According to paragraph 48 of *Re A-F (Children)* [2019] Fam 45:

> *"An application to the court should be made where the circumstances in which the child is, or will be, living constitute, at least arguably (taking a realistic rather than a fanciful view), a deprivation of liberty. (original emphasis)*

NM had autism and ADHD and the residential school was a former stately home within extensive grounds. It was a "completely secure compound" with the following liberty-restricting measures:

1. Access was via a long driveway blocked by gates, which were secured and monitored.
2. A high fence surrounded the estate, and no authorised access was permitted.
3. NM was not permitted to leave the school, save when accompanied by two members of staff.
4. If NM was transported by car, she was taken in a car adapted so that she could not release the seat belt herself.
5. Staff monitored her at all times due to her vulnerabilities, even at night or when she was washing.
6. The local authority had complete control over her finances.
7. The school searched her belongings from time to time; she had restricted access to them, like her iPad, and was not permitted the use of a mobile phone at all. The safety settings on her internet use were set for a child seven years and older rather than 12 years and older. Use of social media was not permitted.
8. Outside mealtimes she did not have free access to food.
9. Restrictive physical intervention was at times used on NM.
10. In the event that she were to leave of her own accord, the police would be called to return her to the school.

Applying Lord Kerr's *dictum* in *Cheshire West,* and Sir James Munby's rules of thumb in *Re A-F,* Mostyn J held that the correct comparator was a child of NM's age and maturity who did not share her diagnoses. On the basis, the placement *arguably* did amount to confinement.

(ii) Procedural issues

Mostyn J observed that judicial review proceedings in the Administrative Court are not well suited to this type of case which involve issues of fact which may require oral evidence. His Lordship set out the procedural requirements of a writ of habeas corpus and its relationship to the respective Civil and Family Procedure Rules. Rather than judicial review, the better procedure was as follows:

> *29. I recapitulate. It is my opinion, in a situation such as that with which I am confronted (where a local authority declines to apply to the High Court to determine if the placement amounts to a deprivation of liberty and if so to authorise it), that the appropriate process is for someone in the position of the claimant to issue habeas corpus proceedings, and for the process be modified by initial directions pursuant to FPR 12.42A(1)(b) to allow the claimant to seek no more than a finding in fact and law from the High Court as to whether there is a deprivation of liberty, and, if so, for an order authorising it and for consequential declaratory relief as to reviews by a judge. This relief would be capable of being granted on a hearing under CPR 87.5 as well as (where an order has been made for the issue of the writ) on the return to the writ.*
>
> *30. In my judgment this flexible arrangement achieves the most convenient and just process for resolution of this particular issue. With great respect to the decision of Charles J in S v Knowsley Borough Council [2004] EWHC 491 (Fam), [2004] 2 FLR 716, this process is, in my judgment, more convenient now, following the procedural changes in 2015, than the commencement of judicial review proceedings in the Administrative Court. The advantages are that the application can be issued directly in the Family Division; its disposal can accommodate oral evidence routinely; and it will be heard more expeditiously (I note that in this case the application was issued on 29 December 2020, and it has taken nearly 3 months even to get to the permission stage).*

Accordingly, the case was treated as an application for a writ of habeas corpus and transferred to the Family Division of the High Court with consequent directions. In the interim, NM's deprivation of liberty was authorised without prejudice to the local authority's contention.

Comment

Although there are plenty of cases which consider the consequences of a public body's failure to seek authorisation for deprivations of liberty, this decision helpfully sets out what should be done if there is a dispute about the potential engagement of Article 5 ECHR in the first place, at least in the context of those below the age of 16.

Above the age of 16, then, if the individual's circumstances could in principle be authorised by the Court of Protection, it would be possible to make an application to the Court of Protection for a declaration that the person is currently unlawfully deprived of their liberty (under s.15(1)(c) MCA 2005), joining the public authority in question – which might be an NHS Trust / CCG / Local Health Board as well as a local authority – on the basis that the public authority would then have either to accept that this was the case or take steps to obtain appropriate authority. It should be noted that it would appear unlikely that the Court of Protection can issue a writ of habeas corpus, as it is a creature of statute, and has not been granted the statutory power to issue such a writ (there is no equivalent under the COPR to

the CPR/FPR provisions in relation to habeas corpus).

The *TTM* case is an example of habeas corpus being used in the Mental Health Act context (not in relation to the question of whether the person was in fact deprived of their liberty, but in relation to the question of whether they were lawfully deprived of their liberty).

Short note: care orders and medical treatment

In *YY (Children: Conduct of the Local Authority)* [2021] EWHC 749 (Fam), Keehan J was extremely critical of the misuses by a local authority of its power under a care order over a wide range of welfare issues but including specifically in respect of withdrawal of life-sustaining treatment, the focus of this note.

This case concerned four siblings who were placed with local authority foster carers and made the subject of care orders. One sibling (known as Child C) tragically died when she was 14 years old.

Child C's health deteriorated and she was diagnosed with anxiety and PANDAS (Paediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infection). She was prescribed various medications but she continued to be very unwell and was unable to return to school. She was admitted to hospital suffering with chest pains, left side paralysis and tics. The following day she was transferred to a different hospital where the serious of her condition rapidly became apparent. She was placed in an induced coma suffering from severe sepsis.

Over the succeeding days, Child C remained in a stable but critical condition. The mother and father were not involved in any meetings with the treating clinicians nor forewarned by the doctors of the potential outcome that Child C may die and/or that a decision may need to be made to withdraw life support.

Child C's condition significantly deteriorated. The local authority team manager was informed that Child C was deteriorating and that the treating clinicians had agreed a plan to remove life-support but this would need consent. The team manager spoke with one of the assistant directors of children's services who said that the hospital would need to set out the position in writing and the local authority would need to seek legal advice. It was agreed that Child C's parents needed to be informed and that they should be given the opportunity to have a goodbye contact.

The team manager telephoned the mother to tell her that the hospital planned to withdraw Child C's life support and that the mother may want to seek legal advice. The mother said that she wanted what was best for Child C and that she was on her way to the hospital to say goodbye to her daughter. The team manager recorded that the mother would be arriving at the hospital about 11.30am to 12.00pm. Before the mother arrived at the hospital, the director of children's services sent an email to the hospital giving the local authority's consent to withdrawing life-support. Child C's life support machine was switched off and she died immediately.

In no uncertain terms, the judge held that the local authority had inappropriately used its powers of

parental responsibility to consent to the withdrawal of life-sustaining treatment before the mother arrived at the hospital to see her child:

> *133. In Child C's case, therefore, the profound life and death decision to consent to the withdrawal of life support ought to have been the subject of an application to the High Court either by* [the hospital*] or by the local authority. It was wrong and an inappropriate use of its powers under s. 33 of the 1989 Act for the local authority to have exercised its powers to consent to the withdrawal of Child C's life support.*

The judge expressed the view that it was "*extremely regrettable that the mother was not able to say goodbye to her daughter before she died*."

It is recorded that the local authority did not have a policy or protocol in place for actions to be taken in response to a child requiring serious medical treatment or requiring the withdrawal of life sustaining treatment and the giving or obtaining of consent. There was now a compliant policy in place. In circumstances where decisions often have to be made quickly and with high stakes, other local authorities would be well-advised to consider their own policies and procedures in place for medical decision-making in light of this judgment.

Lawyers, economic activity and the EU

The decision of the CJEU in Case C-846/19 *EQ v Administration de l'Enregistrement, des Domaines et de la TVA* concerned a lawyer in Luxembourg who acted as a guardian or curator for people lacking legal capacity, and was paid for doing so. He argued that his income from such activity should be exempt from VAT, either because it was not economic activity, or because it fell within an exception covering the supply of services for the benefit of adults lacking legal capacity.

The CJEU held that the lawyer had been engaged in economic activity. While legal advice would not fall within the exemption for supply of services to benefit adults lacking legal capacity, it was possible that acting as a guardian or curator might do. As the court's press release notes: "even if the professional category of lawyers cannot be characterised, as a whole, as being devoted to social wellbeing, the Court does not exclude that a lawyer providing services closely linked to welfare and social security work may show a stable social engagement" such they could be treated in the same way as a public body providing welfare services.

SCOTLAND

Consenting Adults - capacity, rights and sexual relationships

The Mental Welfare Commission for Scotland has published *Consenting Adults - capacity, rights and sexual relationships,* an updated version of its 2012 good practice guide on capacity and sexual relationships with the assistance of Deirdre Hanlon and Karen Kirk, founders and partners of the solicitors firm Kirk Hanlon. The update is comprehensive and this time also includes content on social media and internet use.

It acknowledges that people with mental illness, dementia, learning disability or related conditions have the same human rights as anyone else to sexual expression, sexual relationships marriage and children but that where they lack capacity to make informed decisions this may make them vulnerable and at greater risk of abuse, exploitation or other serious consequences. The guidance therefore seeks to navigate the complicated ethical and legal issues associated with this when balancing rights and risks with a view to respecting the person's autonomy but also identifying where protective intervention is lawful, necessary and proportionate. At the same time, it adopts an applied approach in considering real life potential situations. There are sections identifying guiding principles to make these decisions, setting out the legislative and human rights framework in Scotland, assessing capacity and risk and other factors before going on to specifically consider marriage and civil partnership, social media and internet use, capacity, consent and the criminal law, staff knowledge, values, attitudes and practice, adult protection duties and interventions.

Clearly written and with helpful case studies it is a welcome update to badly needed guidance in this complex area. It draws on English case law,[4] there being only one reported case in Scotland of relevance to date,[5] the principles that underpin the operation of the Adults with Incapacity (Scotland) Act 2000, Mental Health (Care and Treatment) (Scotland) Act 2003 and Adult Support and Protection (Scotland) Act 2007, related ECHR and CRPD requirements and possible actions and interventions under the three Acts and the Criminal Procedure (Scotland) Act 1995.

Jill Stavert

[4] Although note that one case, *Re JB*, relied upon is (as discussed in the Health, Welfare and Deprivation of Liberty Report, on its way to the Supreme Court).

[5] *West Lothian Council v L.Y* (Livingstone Sheriff Court AWI9/13)

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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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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.

Neil is doing a (free) event for Dementia Carers on 11 June 2021 at 3pm. The online session provides an overview of carer rights in the context of dementia. It is part of the University of Manchester's research project which is analysing the changes to local authority support during Covid-19. Neil is particularly keen to understand the impact on carers over 70 looking after partners living with dementia at home. For details, and to book, see here.

Neil is doing a DoLS refresher (by Zoom) on 29 June 2021. For details and to book, see here.

Neil and Alex are doing a joint DoLS masterclass for mental health assessors (by Zoom) on 12 July 2021. 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 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.

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