



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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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

Summary¹

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.

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.

*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 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 (2016) 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 Lilia'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 Lillia 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 Rageeb. 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 Rageeb,

"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 MacDonal J's decision in Razeed. 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 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:

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

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 his 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 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 are 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 his 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](#).

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

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

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



Conferences

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](#).

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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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[For all our mental capacity resources, click here](#)