MENTAL CAPACITY REPORT: THE WIDER CONTEXT

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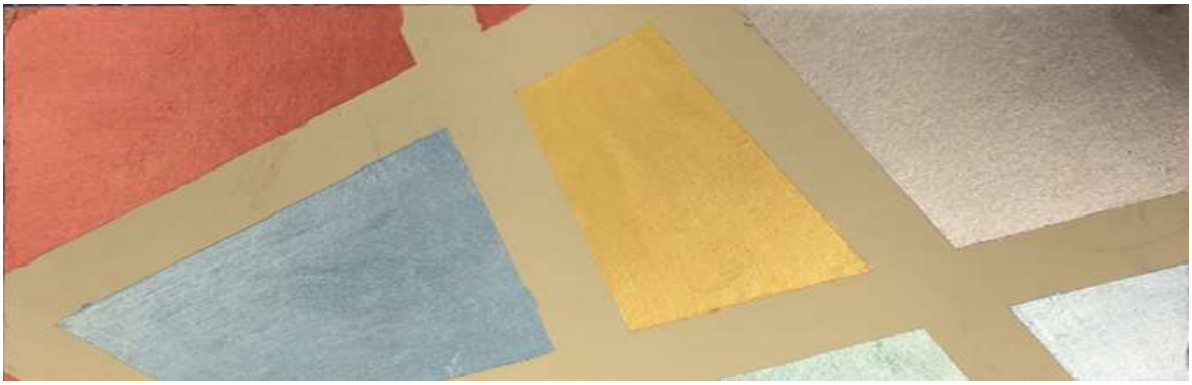

Welcome to the May 2021 Mental Capacity Report. Highlights this month include:

(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.

Contents

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.[1] 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.

[1] 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.

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 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.

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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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