Essex CHAMBERS

MENTAL CAPACITY REPORT:
HEALTH, WELFARE AND DEPRIVATION OF LIBERTY
November 2021 | Issue 116

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

(1) In the Health, Welfare and Deprivation of Liberty Report: the Sexual Offences Act, care workers, and paying for sex; and obligations that cannot be avoided in the context of decisions about serious medical treatment;

(2) In the Property and Affairs Report: an important consultation on a scheme to enable access to funds held by financial institutions; and guidance about disclosure of medical records to attorneys and deputies;

(3) In the Practice and Procedure Report: a new training video on communication and participation, the use of the inherent jurisdiction overseas, and a systemic approach to unblocking entrenched relationships;

(4) In the Wider Context Report: the CQC's State of Care report, vaccination and children, and a new research report on accessible legal information;

(5) In the Scotland Report: an important reversal of course by the OPG for Scotland in relation to remuneration of professional guardians.

We also say a – temporary – farewell to Annabel Lee as she goes on maternity leave, and welcome to Nyasha Weinberg as the newest member of the team.

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.

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

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

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The Sexual Offences Act, care workers, and paying for sex – the Court of Appeal pronounces

Secretary of State for Justice v A Local Authority & Ors [2021] EWCA Civ 1527 (Court of Appeal (Lord Burnett of Maldon, King and Baker LJJ))

COP jurisdiction and powers – interaction with criminal proceedings

Summary[1]

The Court of Appeal has overturned the decision of Hayden J that care workers would not commit a criminal offence under s.39 Sexual Offences Act 2003 were they to make the practical arrangements for a 27 year old man ("C") to visit a sex worker in circumstances where he has capacity (within the meaning of the MCA 2005) to consent to sexual relations and decide to have contact with a sex worker but not to make the arrangements himself. Section 39 SOA 2003 provides (in essence) that it is a criminal offence for a care worker to cause or incite sexual activity by a person with a mental disorder.

As Lord Burnett identified:

> *23. The proceedings in the Court of Protection were unusual. Hayden J was not invited to make a best interests decision but was invited to express a view on the application of section 39 of the 2003 Act to a hypothetical set of facts. That view depended upon assumed facts of which there was detailed evidence. After giving judgment, the judge was invited to make a declaration but declined to do so. In the result, there is no "order" which is the subject of an appeal. The proceedings below were seen by all as a steppingstone. A further hearing considering a fully worked up care plan was envisaged. The judge himself recognised at more than one point in the judgment that the whole debate had a further hypothetical air. The characteristics of C raised a serious question about whether it would be appropriate to expose a sex worker to the risks of spending time alone with him.*

Whilst Lord Burnett noted that s.15 MCA appeared to give the Court of Protection the

[1] Tor and Neil having been involved in the case, they have not contributed to this note.

power to make declarations about the lawfulness of specific provisions in a care plan, he noted that the use of that power to declare lawful conduct which has the potential to be criminal should be confined to cases where the circumstances are exceptional and the reasons cogent (paragraph 30). Although such a declaration was not made, Lord Burnett considered that it applied with equal force in circumstances where the court made a decision reflected in its judgment that certain hypothetical conduct would not amount to a criminal offence. Lord Burnett was therefore "*doubtful that it was appropriate to entertain this application and determine it*." However, he considered that it was necessary to deal with the substance of the matter not least because in coming to his decision, Hayden J had taken a different view of the law from Keehan J in Lincolnshire County Council v AB [2019] EWCOP 43.

For Lord Burnett, Hayden J had erred in seeking to give a definition of "causes or incites" for purposes of s.39 SOA 2003 that he had in order to enable him to find that the potential arrangements for C would not necessarily result in criminal liability. Rather, Lord Burnett considered (at paragraph 49) that:

> *the words "causes or incites" found in section 39 of the 2003 Act carry their ordinary meaning* [...] *The litmus test for causation is that identified in the authorities. Do the acts in question create the circumstances in which something might happen, or do they cause it in a legal sense? Applying the approach of the Supreme Court in Hughes the care workers would clearly be at risk of committing a criminal offence contrary to section 39 of the 2003. By contrast care workers who arrange contact between a mentally disordered person and spouse or partner aware that sexual activity may take place would more naturally be creating the circumstances for that activity rather than causing it in a legal sense.*

A second question was whether a different reading of s.39 SOA 2003 was compelled by the European Convention on Human Rights. Lord Burnett observed that:

> *53.* [...] *The argument advanced under article 8 with reference to section 39 entails the underlying proposition that there is a positive obligation on the state to allow care workers to make arrangements for sexual contact with prostitutes for those in its care over the age of consent (or at least over 18) who are unable to make the arrangements themselves, at least in circumstances where contact with prostitutes is not generally prohibited. There is no sign of such a positive obligation having been recognised by the Strasbourg Court, nor of that court having recognised that article 8 entails a positive obligation on the state to allow the purchase of sex without fear of criminal sanction.*

Noting that the Supreme Court had recently restated the correct approach where arguments under the Convention invited the domestic courts to march ahead of the European Court of Human Rights, Lord Burnett continued:

> *58. It is far from surprising that no case of the Strasbourg Court has been cited to us that recognises a human right to purchase the services of the prostitute or to be provided with such services by the state. The approach to prostitution*

across the Council of Europe states varies considerably. It ranges from closely regulated prostitution with neither prostitute nor client committing a criminal offence to outright illegality. Almost all Council of Europe states criminalise some aspects of the sex trade. The approach of both Sweden and Norway is notable. Prostitution is not an offence. An individual selling sexual services commits no offence but a person who purchases such services does. Similarly, since 2017 in Ireland it has been an offence to purchase sex: see part 4 of the Criminal Law (Sexual Offences) Act 2017 amending earlier legislation.

59. The regulation, including criminalisation, of various aspects of the sex trade is a paradigm example of a sphere of activity redolent with complex and controversial moral judgments. It calls for generic risk assessments with the need for legislatures to strike difficult balances. The Strasbourg Court would allow a wide margin of appreciation to the parties to the Convention in this area. There is no sign in the Strasbourg case law of a recognition of positive obligations of the sort which underpin the argument that section 39, interpreted according to ordinary canons of statutory construction, would give rise to a violation of C's rights under article 8. That is sufficient to support the conclusion that article 8 of the Convention does not require these sections to be interpreted differently if that were possible using section 3 of the 1998 Act. Nonetheless the context of this argument is such that it must be regarded as unlikely in the highest degree that the Strasbourg Court would recognise a positive obligation of the type contended for in these proceedings.

Lord Burnett was therefore clear that s.39 SOA 2003 did not even entail an interference with Article 8(1) rights, but that even if it did, it would be a legitimate interference. He was equally dismissive of the arguments based upon discrimination:

> *64. Section 39 of the 2003 Act is concerned with sensitive moral and ethical issues in the field of penal policy. One of its purposes is to throw a general cloak of protection around a large number of vulnerable people in society with a view to reducing the risk of harm to them. To the extent that the provision discriminates against people in C's position by comparison with others in the care of the state (or more broadly) it represents the considered view of Parliament striking balances in these difficult areas. Such a view should ordinarily be respected. In my judgment, the discriminatory effect of section 39 cannot be stigmatised as being manifestly without reasonable foundation. The statutory provision is clearly justified.*

The Secretary of State had raised a wider argument, namely that any involvement by care workers in facilitating C's use of a prostitute would be contrary to public policy and on that basis should never be sanctioned by a court. However, in light of the conclusions that he had reached as to the interpretation of s.39 SOA 2003, Lord Burnett did not need to consider this wider argument – not fully argued before Hayden J – and therefore refused permission to the Secretary of State to amend his grounds of appeal to argue it.

Baker LJ gave a concurring judgment. He was equally troubled by the procedural approach adopted:

> *72. […] The powers invested in the Court of Protection under the Mental Capacity Act 2005 do not include the power to "decide" whether or not a proposed course of action is criminal and a declaration under s.15 of that Act that the course of action proposed in this case was lawful would be contrary to established authority and wrong in law. As the cases cited by my Lord demonstrate, the circumstances in which such a declaration would be justified must be exceptional and the reasons for making the declaration cogent. In this case I see no cogent reasons for making such a declaration and indeed every reason to refrain from doing so. The course of action proposed in this case would not only place the care workers at jeopardy of prosecution under s.39 of the Sexual Offences Act 2003 but would also expose C to the risk of prosecution under s.53A.*

Baker LJ considered that the same principles as he had identified in Re JB applied in the instant case:

> *74. The Court of Protection strives to promote the autonomy of incapacitated adults to enable them as far as possible to live with the same degree of freedom enjoyed by those who have capacity whilst having regard to their need for safety and protection. I agree with Hayden J that understanding about the importance of respecting the autonomy of adults with learning disabilities has evolved and is still evolving. But as part of the wider system for the administration of justice, the Court has to adhere to general principles of law. Alongside the growing awareness of the autonomy of people with learning disabilities there has been an evolution of thinking about the treatment of people who sell sexual services. Where Parliament has expressly decided that certain conduct should be a criminal offence, it is no part of the Court of Protection's role to declare that it is lawful.*

Baker LJ was, however, at pains to emphasise that the court was only concerned with Hayden J's decision in the case before him. At paragraph 75, he recognised that:

> *There are other situations where care workers are asked to assist people who have the capacity to consent to or engage in sexual relations but lack capacity in other respects, for example to make decisions about their care, treatment or contact with other people. One example is where a person with dementia living in a care home wishes to spend time with his or her partner at the family home. Another example is where a young person wishes to meet people of their own age and make friends. In both cases, one consequence may be that the incapacitated adult engages in sexual relations. I envisage that it might be appropriate in those circumstances for the Court of Protection to endorse a care plan under which care workers facilitate or support such contact and to make a declaration under s.15 of the Mental Capacity Act that the care plan is both lawful and in P's best interests. But in making these observations I emphasise three important points. First, the merits of making such a declaration will turn on a thorough analysis of the specific facts of the individual case. Secondly, in making such a declaration, the court may*

have to consider carefully whether the steps proposed under the care plan have the potential to amount to a criminal offence under s.39. Thirdly, as set out in the cases cited above, any declaration would not be binding on the prosecuting authorities, although no doubt it would be taken into consideration in the event of any subsequent criminal investigation.

King LJ agreed with Lord Burnett, and also with the observations of Baker LJ: [2]

70. As Baker LJ explains, achieving autonomy for an incapacitated adult lies at the heart of the Mental Capacity Act 2005. It is not however the role of the Court of Protection to endorse an act which would be unlawful. Under the 2003 Act, the motive of the care worker, no matter how laudable, and the consent of the person with a mental disorder who wishes to engage in sexual activity are each irrelevant. In those circumstances, I cannot see how on any plain reading of the statute, the extensive arrangements necessary in order for C to engage in sexual relations with a sex worker, and without which sexual activity with a third party would be impossible for him, can be held to be outside the terms of section 39(1) of the 2003 Act.

71. There are, however, many less extreme and benign situations which day in and day out touch on the lives of people up and down the country; Baker LJ gives the example of a care worker arranging private time for a long married couple which she knows is likely to include sexual activity in those circumstances. Such a case is wholly different from that of C and the question of whether it is appropriate to make a declaration under s15 of the 2005 Act in such cases is something to be left open for argument in the appropriate case.

Comment

Hayden J's judgment had been the subject of much (often ill-informed) comment, and it is perhaps forlornly to be hoped that this judgment will not be the subject of comments divorced from the issues actually considered. This is particularly so because, in many ways, the judgment of the Court of Appeal in this case bears much resemblance to that of the Court of Appeal in the *Tavistock* case (another case raising equally strong feelings): perhaps not surprisingly as both Lord Burnett and King LJ sat on both appeals. In both cases, a first instance court had, in effect, been lured onto procedurally dangerous ground by wider concerns. In the *Tavistock* case, it was a concern about the implications of the administration of puberty blockers; in this case, it might be seen as a concern as to how best to secure the ability of those with cognitive impairments to express themselves sexually. In both cases, however the Court of Appeal made clear that the courts had over-extended themselves, and took matters back to first principles: in the *Tavistock* case the concept of *Gillick* competence, in this case first principles of criminal law. Those first principles – and in particular the reading of the language of causation/incitement – made the answer clear for the Court of Appeal.

[2] As a judge senior to Baker LJ, her judgment comes before his in the formal record, but as she agrees with Baker LJ's observations, it makes clearer reading to address her judgment second: no disrespect to her is intended.

It is of note that Baker and King LJJ, both of whom had direct experience at first instance of having to navigate the troubled waters of sex and mental capacity, were both at pains to seek to find a way in which to limit the consequences of their conclusions so as not necessarily to implicate care workers in the situation where money is not going to change hands.[3] The boundaries between the MCA 2005 and the criminal law in relation to sex are, however, difficult, complex, and reflect difficult tensions which were highlighted very clearly in the early 2000s as requiring statutory resolution. They have not been so resolved, leaving complexities both for the Court of Appeal in this case, and – even more broadly – the Supreme Court in *JB* to address.

The practical implications of the judgment are going to require considerable resolution on the ground, and the team are working hard on a webinar to help people think them through.

Fighting ever increasing odds against a draconian intervention – and when is a without notice hearing acceptable?

Hull City Council v A & Ors [2021] EWCOP 60 (Poole J)

Best interests – contact – residence

Summary

In this case, Poole J was concerned with – in effect – what was less bad: allowing a woman with dementia to remain at home in the care of a son about whom there were significant concerns, or authorising steps to remove her, even if temporarily, to enable assessment of her health and wellbeing. The case concerned a 76 year old woman, Mrs A, living in her own home. She was a widow with four living sons, one of whom, B, lived with her.

When the local authority with responsibility for her initially approached the Court of Protection, contending that it was in her best interests to be transferred to a residential care home, it was initially rebuffed, it appears in large part on the basis of her consistent wish to remain at home, the court instead approving B's proposal that he should be her primary carer at home, and assuring the court that he would seek professional support as needed. This position held for several months. However, consideration of whether Mrs A should be vaccinated against COVID-19 triggered a significant change in B's approach to engagement with carers, professionals and the court. He unilaterally and immediately cancelled all care and support for her within the home and he stopped his mother visiting the day centre. He stopped visitors coming into the house. He had become increasingly hostile to visits from social workers such that no professional was permitted by him to cross the threshold of Mrs A's home for at least a month. He had become abusive and agitated when social workers attempted to visit Mrs A, shouting at them from an upstairs window, threatening to call the police, and ordering them to leave. B also refused to meet with social workers outside the house. B's

[3] Where money will change hands then, as both Lord Burnett (at paragraph 34) and Baker LJ (at paragraph 72) identified, C – and potentially also his carers – would be at risk of prosecution for the strict liability offence under s.53A of paying for sexual services of a prostitute who had been exploited.

decisions also made it impossible for other members of the family to visit Mrs A at home.

The local authority's concerns were also heightened by evidence (not previously known to the court) showing that B had a long history of criminal activity including multiple convictions related to cannabis, including supply. He had multiple convictions for assault. Most seriously, he had received a ten year sentence of imprisonment in late 1994 for an offence of causing grievous bodily harm with intent. His most recent offence was for battery in 2010. In light of this, and its escalating concerns as to Mrs A's welfare, it came to court to seek orders bringing about her transfer to a care home – which was not at that point immediately available but would be so within a matter of weeks.

When the matter first came before Poole J it did so without notice to B, as he explained at paragraph 21:

> *The reason for applying without notice was the perceived danger that he would react to notice by putting A at risk of harm. That is not an unreasonable supposition given his recent behaviour, but the court should only proceed in exceptional circumstances to make orders of the kind sought without notice to those affected. Given B's history and conduct, given his stated rejection of the authority and his frank disengagement from the court process, it was my judgment on 29 October 2021 that it was likely that he would take steps to frustrate the order of the court if notice were given to him. Giving notice to B would increase the risk of harm to A. Balancing his Art 6 rights with his, and A's, Art 8 rights, the risk of B acting in a way that would be harmful to A if notice were given, and the risk that he would take action to frustrate the court's orders, I was satisfied the exceptional course of proceeding without notice to B was justified.*

At that point, however, Poole J was not satisfied that the matters had yet reached the point where immediate intervention, with the authorisation of restraint if necessary, was imperative. As an intermediate step, he made orders in Mrs A's best interests that B should allow a health and welfare check to be conducted at his mother's home for up to one hour on reasonable notice without B present in the same room, and that he was prohibited from obstructing or interfering with that meeting. A penal notice was attached to the injunctive orders made. Poole J adjourned the without application to remove and gave permission to the local authority not to inform B of the fact of the application. Poole J listed a closed and then an open hearing for the day after it was intended that the order requiring B to grant access was to be served.

The order was served by social workers on behalf of the local authority, but did not produce the desired effect. B did, however, attend the open hearing, at least for part of it.

> *33. He told the court that A is well and that he ensures that she takes her daily medication. He told me that she was less paranoid and so was improving. Indeed, A has appeared well when seen briefly by others at the threshold to her home. He told me that he wants a second opinion on A's mental capacity, indicating that he does not accept that she lacks capacity to make decisions about her residence and care. The evidence from Dr Adebayo was, however, very clear and relatively recent. He is opposed to any visitors*

> *(including presumably someone who was instructed to assess capacity) entering the house because of the risk that they might spread the Covid-19 virus to him and A. He expressed the view that it was nobody else's business how he and A lived and that she was not isolated because he is with her 24 hours a day. I asked what protective measures could be taken by way of negative testing for Covid-19, mask wearing or otherwise for him to allow visitors into the home to see A for themselves in a proper manner. He became more agitated. He did not answer the question but referred to "things I have seen". I asked him the question again and he left the hearing.*

It appeared that B might have left the hearing because of an internet problem, but he declined to rejoin. Poole J reached the view that:

> *36. From his participation at the hearing today and what he told Ms Bradley as reported to me, as well as all the previous evidence in the case that was before me on 29 October 2021, I conclude that B has become implacably antagonistic to the Local Authority, social workers, the Court, and the legal representatives for A. His avowed reason for not allowing visitors into the house appears to be a fig leaf – his real reason is distrust of all those involved in this case, apparently initially triggered by consideration of A being vaccinated, not protection from Covid-19. If, as he says, he would allow an independent person to enter the house, that shows that his objection to social workers from the Local Authority entering is not due to the risk of Covid-19 transmission.*

Poole J therefore had to grasp the nettle of what to do:

> *39. Firstly, I revisit the question of proceeding without notice to B. Although he knows that the court made orders on 29 October 2021 without notice to him, he still does not have notice of the application to remove A from the home and to convey her to Y. That application has continued to be heard in closed proceedings. I am satisfied following the hearing on 2 November 2021 that if he were to have notice there would be a substantial risk that he would use the time afforded to him to obstruct A's planned removal and conveyance. He would be likely to take steps to frustrate the purpose of the order. Those steps could put A at risk of harm. I am satisfied that the exceptional course of proceeding without notice to him is required in this case.*
>
> *40. As to the substantive question of whether it is necessary now to take steps to remove A from B's care and to accommodate her at Y, I have to weigh all the circumstances when determining A's best interests, following the statutory provisions set out above. I have already referred to A's wishes and feelings and the views of others about her best interests. They have not changed since 29 October 2021. It is however now clear to me in the light of events since 29 October 2021, that it cannot be in A's interests to continue to be looked after by her son, given his current state of mind and his history, with no means of checking adequately on her safety, health and welfare, or her use of medication. It is also necessary to seek to ascertain her wishes and feelings which is not possible so long as B controls her contact with others in the way he has done. It is possible that B is keeping A safe and well. But it is also possible that his relationship with her and care for her is harmful to her.*

The court cannot know, because he has obstructed all reasonable attempts to check on A and for her Litigation Friend and legal representatives to be able to assess her wishes and feelings and interests.

41. It would not now be realistic to force entry to carry out checks on A with a view to her remaining in the home immediately afterwards. The circumstances would not be conducive to an effective assessment of her health and welfare within the home in the immediate aftermath of removing B for the purpose of checks being carried out. After assessment there would be no carers available to provide her with care within her own home. The earliest that carers might be available to provide 24 hour care in the home is 12 November and that is subject to risk assessments. In any event B has shown himself unwilling to allow any carers to have entry to the home, so he would have to be kept out of the home. Previously he has stayed next door to A's home. He could do so again and cause difficulties for A's care in her own home. The alternative of allowing B to continue to care for A in her own home after an assessment would be fraught with risk. He would be likely to be in a very agitated state. He might well be even more likely to take steps to obstruct future access to A. The health and welfare check might confirm that A is safe and well, but it might equally reveal that she has not been well looked after by B, has come to harm, and ought to be protected from him. B's conduct on 1 November 2021 and his appearance at the hearing today have confirmed that attempting to remove B from the house in order to assess A and then to leave her in the home afterwards to be cared for by B is not now a realistic option.

42. B has been given every opportunity to work with others and the court. He stubbornly refuses to do so. The only viable option that remains for checking on A's health and welfare is to remove her from her home for an interim period to be cared for at the Y residential care home.

43. The alternative is to leave A in the care of B in her own home. I have already referred to the risks of so doing. In addition I have to take into account the risk that the process of removing A and transferring her to the care home could well be harmful to her.

Poole J was clearly troubled by the position:

44. The situation is precarious and every option is laden with risk. The decision, balancing all the competing factors, is a difficult one, but it has to be made. My concern in leaving A in the sole care of B with his history of violence and drug use, his easily triggered agitation, his hostility to social workers and other visitors to the house, his intransigent determination to isolate A and to be the only one who has contact with her, his obstruction of attempts to assess her health and wellbeing, mean that the removal of her from the home for a short period is now necessary in her best interests. Taking into account all the matters which the court must balance when considering A's best interests, I am sure that it is now in her best interests to be moved from her home to the Y residential care home for an interim period. I shall list the case before me for a review hearing approximately one week after A's transfer to the Y care home which will now take place on 3 November 2021. I shall authorise the use of restraint to ensure

> *that A is safely conveyed to the care home, in accordance with the measures set out in the Transition plan. I shall make injunctive orders against B to seek to ensure that the transfer is carried out as peaceably and safely as possible. I shall make provision for A to have contact with B and other family members in safe circumstances, in her best interests once she is at the care home.*

In an addendum to the judgment (rare in welfare judgments, even if relatively common in medical treatment cases), Poole J recorded that Mrs A was safely transferred to the care home without the need for physical intervention or restraint.

Comment

Having just had the chance to have a first look at Beverley Clough's new, and very stimulating, work *The Spaces of Mental Capacity Law: Beyond the Binaries* (review forthcoming when he has a moment), what came to Alex's mind when reading this judgment was how to hold a (not literal – thankfully) inquest into what other possible courses of action, and by whom, could have led away from the point where Poole J found that he was constrained to require Mrs A's – temporary – removal from her own home. We would suggest that this would be a very useful exercise for anyone wanting to think – for instance – about the application of Articles 16 and 19 CRPD (the duty upon States to protect those with disabilities from violence and abuse and to secure their right to independent living respectively).

Into that 'inquest' would go the fact that – as happens more often than might appear from reported cases – the court was seeking in the face of considerable odds to secure Mrs A's continued residence at home. Those odds do, from the judgment, appear to have become increasingly insurmountable in light of the position adopted by B – but, notwithstanding the tantalising addendum, it would be fascinating (and important) to understand whether Poole J's clear intention that the transfer to the care home be on an interim basis ultimately leads to a permanent situation, or whether a solution enabling her return home can be crafted and/or tolerated by the local authority and the court. It will equally be fascinating, and important, to identify insofar as possible what Mrs A wants as part of that exercise.

Best interests decision-making, dignity and delay – obligations that cannot be avoided

North West London Clinical Commissioning Group v GU [2021] EWCOP 59 (Hayden J)

Best interests – contact – residence

Summary

In this case Hayden J made a series of very powerful observations about the obligations imposed upon treating bodies to ensure proper consideration of whether continuing treatment is in a person's best interests, and to take proper steps to secure timely resolution of any dispute. The case concerned a man in a prolonged disorder of consciousness who had been cared for at the Royal Hospital for Neuro-disability (RHND) since 2014. By August 2018, and at the request of the man's brother, a best interests meeting was held, at which point it was clear his treating clinicians had come to the clear conclusion that there was no prospect of any change in his condition and that continued

treatment was both futile and potentially burdensome. There was, however, a dispute between family members in relation to whether treatment should be withdrawn. What did not happen were appropriate steps to resolve that dispute, or to make an application to the Court of Protection, for a very prolonged period. When the application was finally made, Hayden J had little hesitation in concluding – not least on the basis of clear evidence as to GU's likely wishes and feelings that – that it was not in his best interests to continue to receive CANH. At the hearing at which this decision was reached, the Official Solicitor had contended strongly that there had been "inordinate and inexcusable delay" on the part of RHND, in giving consideration to the issue of whether continued treatment was in GU's best interests, and in taking steps to enable the Court to determine that issue in the absence of family agreement. This was compounded by further delay on the part of the CCG. Hayden J gave the opportunity to the RNHD to explain the position, and in the judgment now delivered Hayden J made clear in no uncertain terms the extent to which he found the situation problematic.

In formal terms, it is an unusual judgment, because Hayden J did not, in fact, decide anything. He could have undertaken an exercise to enable him to make a declaration under s.15(1)(c) that the actions of the RHND in treating GU had been unlawful. However, he declined to do so on the basis that this was neither necessary nor appropriate (paragraph 40). Rather, he considered it necessary:

> *to evaluate whether GU's dignity was properly protected and, if not, why not. The hearing on 15th July 2021, was specifically convened to afford the RHND an opportunity carefully to review their approach to GU's treatment and to assist this court in understanding what the Official Solicitor rightly, in my judgement, identifies as the 'inordinate and inexcusable delay' in determining GU's best interests.*

A striking feature of the judgment was the extensive review of passages from domestic and international cases and legal instruments, "*to signal and analyse the emphasis given to human dignity, in order to evaluate its application to this case and more widely to the many challenging decisions that the Court of Protection is required to take.*" During the course of this, he set out his clear view that:

> *64. Thus, whilst there is and can be no defining characteristic of human dignity, it is clear that respect for personal autonomy is afforded pre-eminence. Each case will be both situational and person specific. In this respect there is a striking resonance both with the framework of the Mental Capacity Act 2005 and the jurisprudence which underpins it. The forensic approach is 'subjective', in the sense that it requires all involved, family members, treating clinicians, the Courts to conduct an intense focus on the individual at the centre of the process. Frequently, it will involve drilling down into the person's life, considering what he or she may have said or written and a more general evaluation of the code and values by which they have lived their life.*
>
> *65. The case law of the Court of Protection reveals this exercise, in my judgement, to be receptive to a structured, investigative, non-adversarial enquiry which, as here, frequently*

establishes a secure evidential base, illuminating P's wishes and feelings. This investigation requires sensitivity, intellectual integrity and compassion on the part of all those involved. The beliefs and/or prejudices of others are entirely extraneous to the question of what P would want in the circumstances which he or she finds themselves in. Sometimes, where P has become isolated and alone the investigation may be inconclusive but experience shows and the case law reveals, that many of us leave a mark on those around us and closest to us which is clearer, stronger and more enduring than perhaps we might anticipate (See: ***N, Re*** [***2015] EWCOP 76***; ***Sheffield Teaching Hospitals NHS Foundation Trust v TH & Anor*** [***2014] EWCOP 4****). The outcome of this investigation will, of course, never achieve the same evidential weight as a strong, clearly expressed wish by a capacitous individual. But, the evidence of the code by which P has lived his life and the views he has expressed (which cast light on the decision to be taken) frequently provide powerful evidence when evaluated against the broad canvas of the other forensic material.*

66. Although it is not an issue in this instant case, evaluating the codes and values by which an individual has lived his life will, in many cases, involve taking account of both religious and cultural beliefs. This is not to be equated with a superficial assumption that because a person is a member of an identified faith, he will inevitably have wanted a particular medical decision to be taken. It must be recognised that within any faith or culture there will exist a diversity of interpretation and practices, some of which will be extra-doctrinal and not easily reconcilable with the theological strictures of the faith. Thus, for example, some Roman Catholics whilst having a clear religious identity may nonetheless choose to practice birth control; some Jews may not adhere to prescribed dietary requirements; some Muslims may not observe Ramadan. Even those who do not regard themselves as having a faith may have grown up in countries or families where faith-based beliefs have migrated into more general cultural values. All this is in sharp focus when considering what is often referred to as the 'sanctity of life', a phrase which is rooted in religious lexicon, though it has developed a broader meaning in the law (e.g. sanctity of contract). When considering what P would want, it is his own religious views and practices that need to be focused upon and not the received doctrine of the faith to which he subscribes. The latter approach risks unintentionally subverting rather than promoting the autonomy that is integral to human dignity.

Further, and in a helpful reminder of contextual factors, Hayden J observed that:

87. When considering the likely wishes of an incapacitated adult, the religious codes and community values within which he or she has lived will be an important facet of the subjective evaluation of best interests. These are however, for the reasons considered at para 59 [this may be a typographical error for 66] *above, essentially extraneous and contextual factors which can never be permitted to occlude the far more rigorous exercise of identifying what P most likely believed and what he or she would have wanted in circumstances where medical treatment had become burdensome and futile.*

Bringing his attention to bear upon the obligations imposed upon treating organisations, Hayden J emphasised that:

> 98. […] *The judgment in the Supreme Court in* re: Y […] *and the available guidance make it pellucidly clear that the person responsible for making decisions in this sphere, where P lacks capacity, is the individual with overall responsibility for the patient's care, as part of their clinical responsibility to ensure that treatment provided is in the patient's best interests. This will usually be a consultant or general practitioner. This is reflected, almost verbatim within the Royal College's guidance* [i.e. the RCP guidelines on prolonged disorders of consciousness] *and it does not permit of any ambiguity.*

In relation to the RHND itself, Hayden J observed that:

> *99. After what I strongly suspect were years of real distress and concern, the pressure to convene a best interests meeting was, ultimately, generated by E (GU's brother). Even a moment's reflection will reveal that this puts a family member in a highly invidious position. The RHND's failure to act led to a situation in which E had to press for the discontinuance of treatment in order that his own brother (GU) might be permitted to die with dignity. Many in E's situation might have found themselves unable or unwilling to take this course. They should not have to do so.*
>
> *100. The* [RCP] *guidance emphasises that the central point to keep in mind is that the decision-making process is about the best interests of the individual patient not what is best for those who are close to, or around them. I was told by the CEO of RHND that the discontinuance of life sustaining treatment in the kind of circumstances arising here causes distress to staff, other patients and their families. It was clearly intended to signal that this was, in some way, a reason to delay the best interests decision-making process. I have no doubt that these cases cause deep distress to others in the hospital. Indeed, it would be concerning if they did not. I have equally no doubt that these considerations have no place at all in evaluating GU's best interests. Factoring these matters into the decision process is both poor practice and ethically misconceived.*

Hayden J was not attracted to the proposition that the guidance might need to be updated, tartly observing that he was not persuaded that there was a need for any further guidance:

> *102. I am not persuaded that there is a need for further guidance, beyond that which is folded into the analysis of this judgment. Indeed, I have come to the conclusion that the existing guidance must be restated and emphatically so. This Court's guidance* [Serious Medical Treatment [2020] EWCOP 2] *was released as recently as 17th January 2020 and is condensed into five pages. It is intended to be an easily accessible document. I am aware that it is widely consulted. It is, I hope, a convenient gateway to the wider case law and to the other available professional guidance.*
>
> *103. What does require to be spelt out, though it ought to be regarded as obvious, is that where the treating hospital is, for whatever reason, unable to bring an application to the court itself, it should recognise a clear and compelling*

> *duty to take timely and effective measures to bring the issue to the attention of the NHS commissioning body with overall responsibility for the patient.*

Finally, he observed that:

> *105.* [...] *The Royal College has issued guidelines, they are to be treated as such and not regarded as set in stone. Consideration of a patient's best interests arises in response to clinically identified need. The need for an assessment is driven by what the patient requires and not confined to the structure of annual review* [as recommended as the minimum in the RCP Guidance]*. In simple terms, it requires to be kept in constant and unswerving focus. (see e.g.;* ***Cambridge University Hospitals NHS Foundation Trust v AH & Ors (Serious Medical Treatment)*** *[2021] EWCOP 51). Regular, sensitive consideration of P's ongoing needs, across the spectrum, is required and a recognition that treatment which may have enhanced the patient's quality of life or provided some relief from pain may gradually or indeed quite suddenly reach a pivoting point where it becomes futile, burdensome and inconsistent with human dignity. The obligation is to be vigilant to such an alteration in the balance.*

Comment

It is likely that advocates and others will regularly have recourse to Hayden J's review of the approach to dignity in the case-law.[4] For Alex's part, and having fought 'dignity wars' in different contexts, he does still require some persuasion that it is necessarily the answer to really difficult questions.[5] He would, however, entirely agree that the way in which the dignity of the individual in question is spoken about will be very revealing of the person doing the talking.

The judgment also stands as a clear restatement of both the procedural and substantive requirements in relation to decision-making. For my part, the four critical points to draw out are that:

1. Proper best interests decision-making is a matter of good governance, requiring identification of who is responsible for coordinating the process and (if different) who is responsible for implementing any decision that is taken;
2. Best interests decision-making is an ongoing process, requiring review both on a regular basis and whenever a material factor emerges which might change the calculus;
3. Even if implementing a decision may challenge the conscience of those involved, they are still obliged to undertake the process of consideration of what course of action is in the best interests of the person (see also in this regard this case).
4. Where there is no consensus, action has to be taken by the public body responsible to obtain a timely resolution from the Court of Protection.

[4] Professor David Feldman's articles: "*Human dignity as a legal value - Parts I and II*" [1999] Public Law 682-702 and [2000] Public Law 61-71 make a good introduction to the – very extensive – academic literature about the concept.

[5] Similarly, 'autonomy' is also a term which can sometimes obscure more than it reveals. Some may find this podcast discussion between Dr Camillia Kong, Jane Richards and I of interest here.

It is understandable, at one level, why Hayden J did not wish to engage in an analysis of whether the actions of the RHND were unlawful. Had he done so, a number of very difficult questions would have arisen. If and when they arise again, it may be that assistance can be gained from a German Federal Court of Justice decision in 2019 in a very similar situation.

Winter is coming

The DHSC has published its Adult Social Care Winter Plan for 2021-22 (together with a review of its previous plan). For present purposes, of most relevance, given that this continues to be a source of real concern, is what it says about visiting in care homes:

> *Visiting in care homes*
>
> *It is critical to support all people who receive care to safely meet with their loved ones, even in the most high-risk settings. Residents should have visiting opportunities throughout the winter, in line with current government and local guidance, as outlined below.*
>
> *National support*
>
> *We regularly update our guidance on care home visiting to outline how providers can take a dynamic risk-based approach to support safe visiting in and out of care settings, with the support of their local director of public health (DPH) where required.*
>
> *We have strengthened the recognition of the role of essential care givers to ensure residents can have visitors in most circumstances, including during an outbreak.*
>
> *Actions for local authorities*
>
> *Directors of public health (DPHs) and directors of adult social services (DASSs) have an important role to play in supporting visiting, and in supporting the care home to deliver safe visits into care homes. This may be through a dedicated care home outbreak management team or group, often in partnership with local social care commissioners. The DPH should work with the local DASS in developing and communicating their advice to care homes.*
>
> *Local authorities should support visiting, recognising its importance for resident welfare – any decision to take a more restrictive approach should be proportionate, targeted and time limited. In all cases, exemptions to any local restrictions should be made for visits to residents at the end of their lives.*
>
> *Local restrictions should also respect the role of essential caregivers, including allowing them to visit in most circumstances.*
>
> *Actions for providers*
>
> *Care home providers should:*
>
> - *develop and update visiting policies that enable visiting, where it is possible to do so, while keeping residents safe – this should be done in line with published guidance on care home visiting (which covers testing, PPE and individual risk assessments)*
> - *ensure that all residents can nominate an essential caregiver*

- *encourage visitors to get the COVID-19 vaccine and flu vaccine before visiting, if eligible*
- *advise visitors to stay away from care settings if they have any flu symptoms*
- *in the case of an outbreak, stop visits in and out of the care home, unless from an essential caregiver or for an end-of-life visit*

The Winter Plan also reiterates the importance of DNACPR decisions being applied in a blanket fashion to any group of people. The DHSC has established a Ministerial Oversight Group on DNACPR decisions that is responsible for the delivery and required changes of the recommendations in the CQC report: Protect, respect, connect – decisions about living and dying well during COVID-19 report. Public-facing information has now been published by NHSEI, which sets out what a DNACPR decision is, how it should be applied, who should be involved and what to do if an individual or their loved ones have concerns. This information can be found on the NHS England website. Alex has also done a shedinar on DNACPR recommendations and advance care planning.

Finally, and in a commitment which will be welcome, DHSC notes that (in response to a recommendation in the review of the last plan) that:

> *We are conducting a full review of all adult social care guidance to ensure that it is clear and consistent. The department is engaging with stakeholders as part of this review process to ensure that our guidance is tested with the end user before publishing and to ensure that the messaging is accessible for the sector. The department will also ensure that guidance is accompanied by a summary of changes table for each guidance update.*

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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.

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 December. 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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