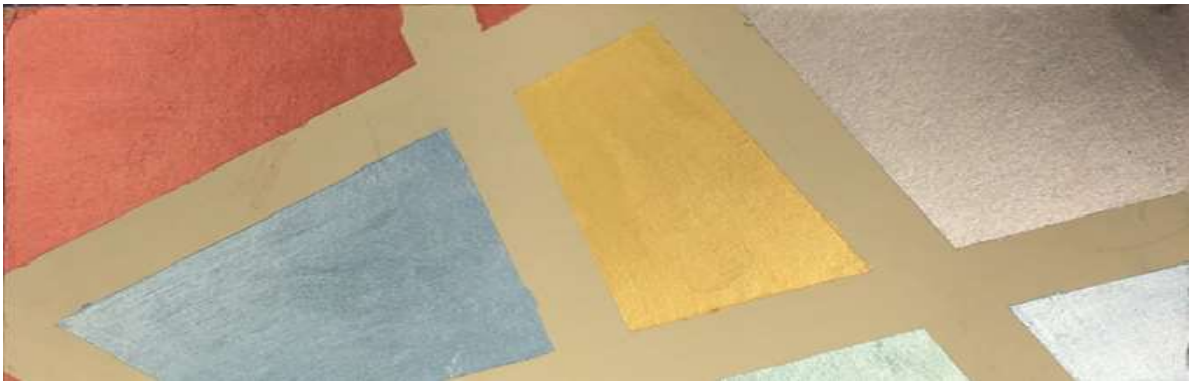
Essex CHAMBERS

MENTAL CAPACITY REPORT:
HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

September 2021 | Issue 115



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

(1) In the Health, Welfare and Deprivation of Liberty Report: capacity, silos and pigeon-holes, medical treatment dilemmas, and the limits of support;

(2) In the Property and Affairs Report: LPA modernisation and help with COP1 and COP1A forms;

(3) In the Practice and Procedure Report: the Court of Protection is, in fact, a court, costs updates, and insights in the future of remote hearings;

(4) In the Wider Context Report: a policy round-up, the inherent jurisdiction and children, advocacy in restricted settings, and the limits on the duty to secure life;

(5) In the Scotland Report: Mental Welfare Commission reports on the use of the Mental Health Act during COVID-19 and advance statements, and thoughts about SIDMA.

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

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

Scottish Contributors
Adrian Ward
Jill Stavert

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

Contents

LPS – no news is… no news (but it is already being amended)

We had hoped to bring you news of the draft Code of Practice to the MCA by now, which is supposed to have been published for consultation. We will provide an update as soon as we can, and share the deep and growing frustration of our readers at its absence (and, almost more materially, the absence of even draft regulations setting out who can carry out material tasks).

In the interim, The Health and Care Bill published on 6 July 2021 makes clear that, even before coming into force, the Government anticipates that the LPS will have to be amended to reflect the proposed abolition of CCGs in England and their replacement with Integrated Care Boards. Paragraph 82 of Schedule 4 to the Health and Care Bill provides that:

> *(1) Schedule AA1 to the Mental Capacity Act 2005 (deprivation of liberty: authorisation of arrangements enabling care and treatment) is amended as follows.*
>
> *(2) In paragraph 3— (a) omit the definition of "clinical commissioning group"; (b) at the appropriate place insert— ""integrated care board" means a body established under section 14Z25 of the National Health Service Act 2006;".*
>
> *(3) In paragraph 6(1)(d)— (a) in sub-paragraph (i), for "a clinical commissioning group" substitute "an integrated care board"; (b) in the words after sub-paragraph (ii), for "clinical commissioning group"*

substitute "integrated care board".

(4) In paragraph 11, for sub-paragraph (b) substitute— "(b) an integrated care board;".

(5) In paragraph 14(1), for paragraph (b) substitute— "(b) each integrated care board;".

The proposed amendment makes clear that the concept of NHS continuing healthcare will remain a reality. Responsibility will therefore continue to lie with the NHS (through Integrated Care Boards rather than CCGs) for arrangements giving rise to a deprivation of liberty which are carried out mainly through the provision of NHS continuing healthcare in England.

For more on the passage of the Bill, see this page on the Parliament website.

MCA/DOLS emergency guidance withdrawn

With effect from 10 August 2021, the DHSC's emergency guidance on the MCA and DOLS has been withdrawn. Whilst it still appears on the website, the message on the page now reads:

> ***This publication was withdrawn on 10 August 2021***
>
> *This emergency guidance will no longer be updated.*
>
> *The care and treatment of people who may lack the relevant mental capacity must always be guided by important principles of the Mental Capacity Act 2005 (MCA) and may in some cases include the safeguards provided by the Deprivation of Liberty Safeguards (DoLS). This was and is the case, before, during and after the pandemic.*
> *Some emergency coronavirus public health powers, including the Coronavirus Act 2020 and the Health Protection Regulations 2020 covering restrictions and self-isolation, are still in force and in certain circumstances these may be relevant to decision making in respect of those lacking the relevant capacity. Where decisions may need to be made in relation to COVID-19 care or treatment, for someone who may lack the relevant mental capacity, practitioners should follow their usual processes, including the best interest decision making process.*

The withdrawal of the guidance means that the urgent authorisation form (form 1B) in Annex B to it should now no longer be used and instead form 1 should be used for all requests. All the relevant forms can be found here.

Alex has also updated the COVID-19/MCA resources page on his website to take account of other recent updates to guidance. It is slimmed down from the form it took previously, but rest assured it can be bulked up again if and when (hopefully only if) it is required.

Compulsory vaccination and care homes

As of 11 November, the Health and Social Care Act 2008 (Regulated Activities) (Amendment) (Coronavirus) Regulations 2021 come into force. These regulations require registered persons of all CQC registered care homes (which provide accommodation together with nursing or personal care) to ensure that a person does not enter the indoor premises unless they have been vaccinated. This is subject to certain exemptions. The Regulations apply not just to

care home staff, but also to those visiting care homes in a professional capacity, such as Best Interests Assessors, IMCAs and lawyers.

The operational guidance accompanying the regulations, which apply only in England, can be found here, and the impact statement here, which as at 19 July suggested that that roughly 7% (40,000) workers in CQC-registered care homes are likely to be unvaccinated by November 11.

The Government is consulting on whether to mandate vaccination for frontline health and social care staff. The consultation, to be found here, runs until 22 October 2021.

Capacity and the limits of decision-specificity

Liverpool City Council v CMW [2021] EWCOP 50 (Sir Mark Hedley)

Mental capacity – assessing capacity

Summary

In this case, Sir Mark Hedley had to consider whether a woman, CMW, who had recently turned 18 had capacity to make certain decisions in seven specific areas: the conduct of proceedings, the management of her affairs, her residence, her care, her contact with others, the use of social media and the internet and whether she could engage in sexual relations. CMW's childhood was identified as having been "very troubled" by Sir Mark Hedley, although the judgment was (deliberately) cagey about the details, save to identify that she had been the subject of a care order which had put in place restrictions around her contact, rolled forward upon her majority by interim orders within the Court of Protection pending the resolution of the question of her decision-making capacity in the domains identified above. She had given birth to a baby boy shortly after turning 18, the birth being identified by Sir Mark Hedley as "probably the most important event" in her life – although the baby was the subject of Children Act proceedings and at that point in foster care. The relationship with the father had been very important to her, although many had questioned whether it had been in her best interests; however, since the father had been arrested in connection with sexual offences (it not being clear whether CMW was the victim), there had been no contact between them and at the point that the case was before Sir Mark Hedley it appeared that neither desired contact with each other.

CMW had been diagnosed as having ADHD, foetal alcohol spectrum disorder as well as specific difficulties with cognition and speech and language. Her expressive language was identified as being quite good but her receptive and processing skills were said to be only those of a child aged 7 to 9. She did not, however, have a learning disability.

Taking each aspect of capacity in turn, Sir Mark's conclusions were as follows.

Litigation capacity

Although there was no argument advanced that CMW had capacity to litigate the Court of Protection proceedings, Sir Mark Hedley did note that she had been found to have capacity to conduct the family proceedings. He accepted the view of the expert, Dr Rippon that these two conclusions were consistent:

> *The issues in the family proceedings are clear and can be shortly stated. The issues in the Court of Protection are potentially much more complex and much longer lasting. I am quite satisfied that she lacks capacity to conduct these proceedings not only in terms of being unable to weigh the relevant issues but also of being unable to understand some of the key ingredients that would require to be weighed. Given the position of the parties, more than that does not require to be said.*

Capacity to manage affairs

There was no argument about this, but Sir Mark Hedley noted that he considered "*whether for example her use of money is merely illustrative of making unwise decisions but I am satisfied that viewed generally, she is unable to grasp all the key ingredients that will have to be weighed in order to make decisions as to her own affairs*."

Residence and care

This was identified as being "much more controversial." Sir Mark Hedley noted that he had considered with care the decision of Theis J in *LBX v K and L* [2013] EWHC 3230 (Fam), in which Theis J set out the categories of information likely to be relevant to care and residence. At paragraph 13, he observed that:

> *Generally speaking questions of care and residence are considered separately but there are cases in which they would be intimately related. If one took the example of a person with serious physical disabilities for whom the issue of residence would be inseparable from that of care, and one heard that the protected person was rejecting of care because they were unwilling or unable to recognise the necessity for it, that would inevitably impact on the question of capacity to make decisions about residence where care would be a key ingredient.*

On the facts of the case before him, he found that to be the case, Sir Mark Hedley considering that CMW was "*unable to understand that she needs the care that she has because she seriously overestimates her own ability to keep herself safe and to control her life and seriously underestimates the consequences for her welfare of independence*." Returning to his theme, he continued at paragraph 15:

> *When dealing particularly with severe emotional difficulties and deficits, it can be very artificial to assign the relevant questions to individual pigeonholes. They are deeply interrelated and have to be considered in the round. It would be artificial, and indeed wrong, in the case of CMW not consider residence and care together. It is her fundamental inability to grasp why she needs support and what would happen if she did not have it that underpins my finding that she lacks capacity in both these areas. She could not choose between packages of care because she seriously overestimates her ability to protect herself and seriously underestimates her own vulnerability.*

Contact

Sir Mark Hedley found that, on the evidence before him, CMW lacked the capacity to make decisions as to contact. But he sought to respond to three broader points raised on CMW's behalf by the Official Solicitor.

> *17.* […] *The first related to fluctuating capacity. Now, of course, CMW's*

> *potential capacity will fluctuate depending on the extent to which she is either calm or distressed and this may indeed be something which has to be considered in future years, as there are grounds to anticipate improvement. At present, however, I am persuaded by Dr. Rippon's view that, although potential capacity does fluctuate, even at her calmest, CMW does not achieve a level of functioning that would amount to having capacity in relation particularly to residence, care and contact.*
>
> *18. The second matter is Miss Hirst's apt reminder that CMW is only 18 and decisions about her capacity should take that into account. Of course teenagers are prone to make unwise decisions; it is often the most effective way to learn. However, in this case I am satisfied that CMW's functioning is affected by matters far more profound than teenage angst. The driving forces are the consequences of ADHD and foetal alcohol spectrum disorder all compounded by complex trauma and language processing difficulties. In coming to that conclusion I have borne in mind the third factor namely the importance and relevance of support. That is certainly currently available to her and even with the advantage of that she remains unable to understand issues of risk and danger to herself.*

Social media and the internet

Directing himself by reference to *Re B* [2019] EWCOP 3, Sir Mark Hedley identified that there was only one matter in the list of relevant information identified in that case which exercised him, namely "the question of understanding risk and danger to self." Here, Sir Mark Hedley made clear that he did:

> *20.* […] *not think it right simply to infer from her difficulties in appreciating safety and risk in relation to care, residence and contact that it automatically deprives her of capacity in this area. This is a much more precise and restricted area and indeed with less call on abstract thought. Whilst I appreciate Dr. Rippon's concerns, my conclusion on reflecting on this particular issue and the evidence around it is that I am not satisfied that it is been established that she lacks capacity in this area. It follows that I must conclude that she has capacity.*

Sexual relations

This was in effect a non-issue as no argument was advanced to the effect that she lacked capacity to decide to engage in sexual relations.

Final observations

Sir Mark identified that:

> *25. This case has been for me far from easy. It evokes my deepest sympathy for CMW who is essentially the victim of the doings of others over 18 years and more. I have reminded myself that I have to decide issues of capacity without regard to the welfare consequences, as required by the decision of the Court Appeal in the York case (supra). Hard though I have found that, having reminded myself of the words of Baker J (as he then was) in PH v A Local Authority* [2011] EWHC 1704 (COP) *(at paragraph 16), that is what I have sought to do.*

Comment

This judgment is a very good example of the difference between:

1. A judgment serving, in effect, as an operational document setting out for the benefit of the parties the basis upon which the local authority should work with CMW; and
2. A judgment serving as a record for wider society as to the basis upon which those conclusions had been reached.

As an operational document, the judgment is crisp and clear, cutting out extraneous background detail with which the local authority and the Official Solicitor on CMW's behalf could be expected to be familiar, and which does not necessarily need to be more widely known. As a record for wider society, it is more challenging, lacking many of the contextual background details that might give light and shade to the contours of the picture. Some may find it useful in teasing out their thinking here to ask themselves what they consider the function of a judgment, and (if feeling particularly enthusiastic) perhaps also to have a read of this article.

Of perhaps wider interest than the facts of this case is the observation of Sir Mark Hedley about the dangers of seeking to break down interrelated decisions into pigeonholes. The Court of Appeal in *Re B* identified the danger with putting decisions into 'silos' of reaching mutually incompatible conclusions – Sir Mark goes one stage further here in identifying that there will be times when striving to achieve decision-specificity simply becomes both artificial and wrong. Of course, as so often in the field of mental capacity, it is a question of striking a balance, because being insufficiently sensitive to the nature of the decision(s) in question risks turning any analysis of capacity into a status test.

The Court of Protection and the "most complex COVID patient in the world"

Cambridge University Hospitals NHS Foundation Trust v AH & Ors (Serious Medical Treatment) [2021] EWCOP 51 (Hayden J)

Best interests – medical treatment

Summary

The Court of Protection braced itself when COVID-19 hit for decisions to be placed before it about the withdrawal of medical treatment, including potentially agonising decisions in the context of triage. Although an early decision (albeit not from the Court of Protection) looked like it might herald a wave of situations being put before the courts to choose who could benefit from the last bed, this did not come to pass. There will, no doubt, continue to be examination as to why (one early stab relating to experiences at a large London hospital can be found here), but in the reported cases before the Court of Protection, the explicit focus has always been upon the individual in question. Hayden J, who has decided the two previous cases relating to treatment withdrawal in the context of COVID-19 (*Re TW* and *Re NZ*), has now decided a third, *Cambridge University Hospitals NHS Foundation Trust v AH & Ors (Serious Medical Treatment)* [2021] EWCOP 51. The case is a stark reminder of the apparently random cruelty of COVID-19, as well as a further illustration of the extent to which judgments about best interests are just that – i.e. the exercise of evaluative judgment, rather than the determination of an objective state of affairs.

The case concerned a 56 year old woman, AH,

who had been an inpatient at Addenbrooke's Hospital, Cambridge, since the end of December 2020, where she was admitted, on an emergency basis, suffering with severe symptoms of Covid-19, and where she remained at the time of the judgment, September 2021. AH was currently being cared for in a critical care unit and was dependent on mechanical ventilation, continuous nursing care, nutrition and hydration delivered via a nasogastric tube, and receiving various medications.

Hayden J noted at the outset that he had been told that "in terms of the neurological impact and complications AH is *'the most complex Covid patient in the world'."* The medical evidence was detailed, complex and set out in very considerable detail in the judgment, but in very headline terms, the COVID-19 virus, whilst no longer infecting AH, had caused substantial neurological damage. Whilst how the virus had come to cause the damage might not yet be understood, Hayden J was at pains to emphasise that the consequence of the damage and likely prognosis was. Her situation was described by the lead consultant, Dr A, as follows:

> *She has* […] *significantly diminished life expectancy, which is now certainly less than 12 months and, though it is difficult to be prescriptive, perhaps somewhere around six or possibly nine months. There is no guarantee that her death might not come unexpectedly, in consequence of untreatable infection (e.g. respiratory tract infection or infected pressure sore). AH is dying. The ventilatory support here is not keeping AH alive, in order to equip her to respond to an underlying illness (for which it is designed), it is simply keeping her breathing. In a very real sense, it is not prolonging her life, it is protracting her death. Moreover, it is extending her pain at a time when her ability to feel it has increased and, sadly, whilst her enjoyment of life has remained tightly circumscribed.*

In the proceedings before him, Hayden J identified at paragraph 3, the

> *The central issue is whether AH's ventilatory support should continue. There is agreement between all the parties that AH lacks the capacity to give or withhold consent for medical treatment. AH's family members have exhibited a wide spectrum of views whilst endeavouring to advance a collective and unified response. In truth, each family member has, both knowingly and otherwise, vacillated as to the best way forward. This, I consider, is because there is no solution which is in any way comforting. Equally, it is imperative that a decision be taken as to where AH's best interests lie. The family recognise this.*

Whilst Hayden J identified agreement about AH's lack of capacity to decide in relation to treatment, and must be taken to have endorsed that agreement by his lack of detailed reasoning on this point, her cognitive impairments were rather more subtle than this might suggest. As Hayden J noted:

> *72. To my mind, the identified 'delicacy' of the issues in this case arise from two important aspects of it. Both are facets of AH's core humanity. AH is able to feel and show some degree of emotion. Predominately, she now reveals pain and real distress. However, she plainly sustains comfort from the presence of*

her children who have been the focus of her life. I have been told that AH has also been able to derive peace from prayers from the Koran and has demonstrated some enjoyment of films shown to her on her iPad. Both M and A [two of her adult children] *consider that she has a level of awareness of and interest in her favourite soap opera which they regularly watch with her. This is doubted but not actively contested by the medical team. In many ways I do not consider that matters, what is more important is that she enjoys the comfort of her children being with her on these occasions.*

73. [AH's son, A] *recently recorded a Koranic call to prayer, he did so in a large warehouse which enabled his strong and clear voice to resonate and echo. He asked me to listen to it and I did, once in the court room but also, on a number of occasions, privately, out of court. I found it powerful, beautiful and an extraordinary expression of filial love. A had plainly thought about this very carefully and planned it. His sincerity was evident both from his reaction when he listened to the recording in the court room, as well as in his voice as he sang the call. I was told, and entirely accept, that his mother manifestly enjoyed listening to it. Having heard all I have about AH I can think of nothing that was more likely to penetrate through her pain than this act of love.*

74. All this signals to me that however depleted and compromised her life may have become, AH retains the capacity to feel and receive love. This is an important facet of human autonomy and dignity.

75. Secondly, whilst AH cannot communicate her own self-generated thoughts she can, with some level of consistency (though not completely), respond to short and focused questions. Of necessity many of these questions are what lawyers would call "leading", in the sense that they permit only of a yes or no answer. I add that I have been repeatedly advised by the medical experts that such questions are frequently accompanied by body language and expression which communicates the desired response. Invariably, this is not deliberate, it is simply human instinct. A desperately wants his mother to live. Though he has the intelligence to absorb the impact of the medical evidence, his love for his mother causes him to retreat from the force of it. He devises questions to put to his mother in which he hopes to find evidence to support his own desire that she may continue to be ventilated.

Hayden J, however, was clear that on the basis of the medical evidence before him that

76. AH's treatment is futile; she is dying slowly in both physical and emotional pain; her treatment is burdensome and exhausting; her rest is of necessity frequently interrupted and she is on a small noisy mixed-gender ward which affords her minimal privacy and fails satisfactorily to respect her cultural norms (this is unavoidable at present), her dignity is preserved by the tireless efforts of her doctors, the rigorously attentive care of the nurses, the sensitive and intimate care given by her daughter M, which is focused not only on her mother's comfort but on her presentation to the world and more generally, the love of her children and family, which is fiercely strong and entirely unconditional. AH's dignity, however, hangs by a thread. The challenge for all the professionals in this case, the family and the Court is as to how it can best be protected in these

last months of her life.

Hayden J was equally clear that the option explored by the Official Solicitor of ventilation away from the ICU simply could not be regarded as medically safe, and hence that it would be a "misleading premise to identify it as an option which preserves life, even to a vestigial degree. The reality is that it runs the real risk of an avoidable, painful unexpected death, with no family in attendance" (paragraph 77). It was against this that Hayden J therefore sought to identify AH's wishes and feelings, and conducted a detailed analysis of the evidence adduced in this regard by her adult children. Having done so, Hayden J set out his decision in simple terms so that it was free from any ambiguity:

> *I do not consider that AH's best interests are presently met by ventilatory treatment in the ICU; ventilation is now both burdensome and medically futile; it is protracting avoidable physical and emotional pain. It is not in AH's best interests that ventilation be continued indefinitely. It is however in her interests that ventilation remains in place until such point as all her four children and family members can be with her. This, I am satisfied, is what she would want and be prepared to endure further pain to achieve. I am also clear that it is in her best interests to be moved to a place which protects her privacy and affords her greater rest. The details of these arrangements can be worked out between the family and the treating team. One of the children is presently outside the United Kingdom and will have to make arrangements to travel. I hope this is possible, but I make it clear that ventilation should be discontinued by the end of October 2021. Though there is an inevitable artificiality to this, it reflects the delicate balance that has been identified. It provides an important opportunity for this close and loving family to be together at the end. The treating clinicians feel able to work with and perfect this plan and recognise that it is consistent with their own professional conclusions and reflective of the central importance of family in AH's hierarchy of values and beliefs.*

It should be noted that Hayden J had been very alive to the fact that keeping AH ventilated to allow her daughter to travel would involve "some continuation of burdensome and futile" treatment, and to the risk that that this would be putting her family before her. However, at paragraph 106, he considered that

> [t]*he preponderant evidence establishes that it is what AH would want. Dr A was inclined to agree. None of the options in this case is free from risk or without ethical challenge. Ultimately, they have to be confronted as best we can, it is impossible to avoid them.*

Comment

Hayden J recorded that the Official Solicitor, Sarah Castle, identified this case as the most troubling and tragic of the cases of this kind with which she had been involved. She did not explain via her Counsel why this was so, although it might legitimately be speculated that this is because of the evidence relating to AH's ability both to experience pleasure (going – it appears – beyond merely instinctual) and to express some level of consistent communication.

Further, and although against a very different

factual matrix to that of the case of MSP or Mr Briggs, this case raises similarly stark questions about the construction of best interests decisions. In this context, it is perhaps particularly striking that despite the fact that Hayden J identified at paragraph 79 that "*it is AH's best interests and her wishes and feelings, in so far as they can be elicited, that are in unwavering focus here*," it does not appear that he was able to reach firm conclusions as to what her wishes and feelings would have been as to the maintenance of life-sustaining treatment per se, as opposed to the maintenance of life-sustaining treatment until such point as her family could be with her. The highest he could put it was to say that he was not prepared to infer from the fact that she was Muslim that it would follow that her religious and cultural views that they would cause her to oppose withdrawal of ventilation in these circumstances:

> *93.* […] *On these difficult end of life issues there are differing views within each of the major faiths, including within Islam. There is recognition that intervention which may have a powerful effect on the body may be antagonistic to the integral well-being of the patient. Once treatment is identified as both burdensome and futile and where death becomes inevitable, the prolongation of death is recognised as disproportionate. Some faiths perceive man as having been created in 'the image of God', from which human dignity is perceived to be established. It is therefore reasoned that the protraction of death is inimical to respect for God and thus, inconsistent with belief. The assumption that AH would have taken a particular theological position on her treatment plan solely because she is a Muslim, even an observant one, is not an assumption I am prepared to make. To do so risks subverting rather than protecting AH's autonomy. I also note that there is a range of opinion, within this Muslim family, as to what is the right course to take.*

Although Hayden J reminded himself of the presumption in favour of life, it is perhaps of some interest (and consistent with his approach in other cases) that he is a judge who is willing to override that presumption even absent "sufficient[ly] certain" evidence as to what the person would have wished (the test applied by Charles J in *Briggs* at paragraph 62). Indeed, on one view, his approach in this case to the macro-question of whether ventilation should be continued on a time-unlimited basis, was not, in fact, so much a best interests decision as opposed to an acceptance of the medical evidence that this was clinically inappropriate. Dr A appears clearly to have been of the view that continued ventilatory support was clinically inappropriate, Hayden J recording his evidence as being that:

> *71.* […] *The ventilatory support here is not keeping AH alive, in order to equip her to respond to an underlying illness (for which it is designed), it is simply keeping her breathing. In a very real sense, it is not prolonging her life, it is protracting her death.*

It was no doubt with a careful eye to the fact that he was asking doctors to continue to provide treatment which was clinically inappropriate (and which he could not, in consequence, demand on AH's behalf, as Lady Hale made clear at paragraph 18 of *Aintree*) that Hayden J was at such pains to say that his decision on AH's behalf as to what should happen in the short-

term was guided by his view about what she would have wanted.

Three observations within the judgment are of note. The first is that Hayden J has now reached the clear conclusion that balance sheets do not assist in serious medical treatment case, noting at paragraph 66 that:

> *Though the attraction of such an exercise is beguiling, it is rarely, in my experience, productive. An assessment of 'best interests' must, ultimately, survey the whole landscape of a patient's medical, welfare and emotional needs. The importance of 'sanctity of life' cannot be weighed effectively, for example, against the frustration of being unable to generate communication or the unrelenting distress of an infected bed sore. They are conceptually different and therefore, to my mind, logically resistant to a balance sheet exercise.*

For those who wish to read more about the extent to which balance sheets not be the answer (even if they may sometimes provide a useful checklist to ensure that important points have not been forgotten), this article may be of interest.

The second observation is that Hayden J was at pains to detail, and praise, the thoroughness of the decision-making by the clinicians involved. It is possible, in part, that this was because of observations which had been made to the contrary at some stages by AH's family, but it also reflects the fact that he clearly took the view that this was a situation which – unlike many he has addressed – where the dilemmas were grappled with early, and the assistance of the Court of Protection sought in a timely fashion.

The third observation was in relation to the evidence of M's daughter, S, who lived in Australia, Hayden J observing that "[p]*aradoxically, I formed the impression that S's geographical distance facilitated a more objective assessment of her mother's best interests*." This observation, deep in the heart of the judgment (at paragraph 83) is perhaps telling in terms of the exercise that is required by the MCA (and would, indeed, be by any CRPD informed approach of "best interpretation" of will and preferences – even if that is framed by reference to what, objectively, constitutes the best interpretation of the person's will and preferences). When and how should evidence from those who are closest to the person be discounted because they are too close?

Short note: medical treatment round-up

By way of round-up of other medical treatment decisions determined recently, we highlight the following:

- *Re KM* [2021] EWCOP 42 (Keehan J). This case concerned a 52 year old man who had suffered a deep vein thrombosis, pulmonary embolism and cardiac arrest following a flight, and had then caught Covid. He was desperately unwell and had been on ECMO – a heart/lung bypass system which in lay terms could be thought of as ultra-intensive care. ECMO is a relatively new treatment which has only been recommended by NICE as a short term measure. The NICE guidance on ECMO (2014) notes that "*ECMO may need to be withdrawn for patients whose heart failure either will not recover or is not suitable for further treatment*." KM had been on ECMO for 15 weeks and was suffering from severe pressure sores and was

thought by the treating clinicians to be in pain. There was no prospect of KM ever being weaned from ECMO, there having been numerous failed attempts. KM was said to hold religious beliefs which included the possibility of divine healing and rejected any withdrawal of life-sustaining treatment, whatever the circumstances. Such beliefs had not been sufficient to outweigh the medical evidence in relation to a child in *Birmingham Women's and Children's NHS Foundation Trust v JB & Anor* [2020] EWHC 2595 (Fam), and were similarly insufficient here in the case of an adult, Keehan J holding that the continued provision of treatment was futile and not in KM's best interests;

- *Re TS (Pacemaker)* [2021] EWCOP 41 (Peel J). This case concerned an 81 year old man who was detained under the MHA 1983 for treatment for a delusional disorder, and required a pacemaker. The man had previously agreed to the surgery but then withdrawn consent. If the pacemaker was fitted, he would be able to receive medication for his mental disorder, and might regain capacity. The court ordered the pacemaker to be inserted, with the use of sedation and restraint if required, noting that the medical benefits to TS were significant, and that he would likely have consented to the operation if he had capacity, since his present wishes and feelings were based on delusional beliefs and he had previously accepted medical advice and intervention.

- *Re* ZA *(Mental Capacity Act 2005)* [2021] EWCOP 39 (Cohen J), which concerned a 53 year old woman with long-standing schizophrenia who was treated in the community. She had type 2 diabetes which had led to leg ulcers and ultimately to a point where amputation of her right leg was recommended to avoid death in 6-12 months from sepsis. She had refused amputation for a long period of time – including having refused consent in 2016, when she was judged to have capacity to make that decision. Ultimately, the clarity of her choice when she had capacity persuaded the court that amputation was not in her best interests;

- *University Hospitals Dorset NHS Foundation Trust & Anor v Miss K* [2021] EWCOP 40 (Lieven J), another urgent application to authorise a caesarean section for a pregnant woman detained under the MHA 1983. The application was made the day before the operation was proposed, as there had been variation in Miss K's agreement to the proposal. The court was, unsurprisingly, unimpressed with being required to make a decision at very short notice and without the Official Solicitor having had time to carry out meaningful enquiries. Nevertheless, the operation was authorised, the judge noting that "I have no reason to believe her wishes would be anything other than to have the safest birth possible."

Mental capacity, the internet, and when is it better to be honest about the limits of support?

C (Capacity to Access the Internet and Social Media) [2020] EWCOP 73 (HHJ Mark George)

Mental capacity – assessing capacity

Summary

In a short judgment delivered in April 2020, but only appearing on Bailii in September 2021, HHJ Mark Rogers made two striking observations about capacity. The first was specific to the decision in question – whether the subject of the proceedings had capacity to make decisions about accessing social media and the internet. The second was of much broader application.

The case, *C (Capacity to Access the Internet and Social Media)* [2020] EWCOP 73, concerned a 28 year old woman, C, with a diagnosis of moderate intellectual disability. She lived in residential care and:

> *5. As a young woman, understandably, she has sexual needs and desires. Similarly, she is no different from the majority of her peers in gaining pleasure and fulfilment from the use of the Internet and social media. This is the context for the current issue.*
>
> *6. In 2017 a significant number of graphic sexual images were discovered on C's electronic devices. Some content was extreme and worrying. The local authority was authorised to place restrictions upon her use of electronic media. A Police investigation was launched, given the suspicion that some of the content crossed into the realm of the criminal law and C was subject to bail conditions for a protracted period. Ultimately, the Police investigation concluded that there was insufficient evidence to justify a prosecution and, in any event, that such would not be in the public interest. The Police acted entirely independently of the Court but, in my view, the decision taken was both fair and humane.*

The question of her capacity to access the internet and social media was now before the court. HHJ Rogers directed himself by reference both to the first principles derived from the statutory framework but also to the decision of Cobb J in *Re A (Capacity: Social Media and Internet Use: Best Interests)* [2019] EWCOP 2. That case, read alongside *Re B (Capacity: Social Media: Care and Contact*) [2019] EWCOP 3, was, in HHJ Rogers' view "*a very useful practical guide to the approach to cases in this category. Whilst facts vary from case to case, Cobb J provides a helpful route map through the issues likely to be in play. Although a decision at first instance, it carries the authority of a hugely experienced Tier 3 Judge*." There was an expert report from a Dr Lilley which made clear her view that C lacked capacity in this regard. As HHJ Mark Rogers continued:

> *29. Were it simply a question of evaluating the evidence as a whole and forming a view based upon Dr Lilley's report, then this would be a relatively straightforward exercise. However, Mr Bellamy takes two separate points on behalf of the Official Solicitor which he submits go to the decision on capacity, even if I am inclined to accept the clinical findings and methodology of Dr Lilley.*
>
> *30. Put shortly, Mr Bellamy submits that there is the danger of an over complicated or sophisticated application of Re A, which will have the tendency to be restrictive of the autonomy of people like C because of such an overly paternalistic application of it. Linked to that he also submits that an unduly analytical approach to what might in general terms be characterised as "understanding" and the other aspects of the functionality aspect of the statutory test will lead to an undesirably restrictive*

> *approach.*

In particular, it was argued on C's behalf:

> *it is dangerous to set the bars of understanding and weighing too high as the result is likely to entail unnecessary findings of incapacity when compared to the often superficial or casual approaches of a large cohort of otherwise capacitous individuals who may not have a severe intellectual deficit but nevertheless are, comparatively speaking in the population, unsophisticated. They, he argues, frequently and without consequence make risky and poorly reasoned decisions.*

HHJ Rogers, however, whilst noting that this "*attractively presented*" argument obviously raised "*difficult legal and philosophical questions*," was not persuaded that the approach set out in the report of Dr Lilley involved "*an elaborate and unnecessarily cerebral approach which runs counter to the statutory language or the helpful route map of Re A*". He continued:

> *34. Cobb J in Re A, specifically in paragraph 27, addressed the question of the correct approach to the "relevant information" issue and set out in broad terms, in succeeding paragraphs, the key factors. The language he uses is practical and clear and directs the reader (or assessor) to the real day to day issues likely to be in play. Further, the qualifications in paragraph 29 are, in my judgment, specifically designed to ensure that an unnecessarily narrow approach is avoided.*
>
> *35. Re A was a decision on its facts and too close a comparison is dangerous. However, I am struck by the terms of paragraph 31 where Cobb J summarises the evidence of the expert in his case. That expert, rather like Dr Lilley, had explored not only the superficial engagement with the criteria but the reality for A in that case. The assessment was described by Cobb J as appropriate, revealing the "deficits" in understanding and weighing ability. It is an example of a carefully refined test without descending into the purely academic. Whilst the particular factors in Re A are irrelevant to my decision, I am quite satisfied that there is an equivalence of appropriateness in the methodology of Dr Lilley.*

On the facts of the case, therefore, HHJ Rogers found that C lacked capacity in this domain. The local authority had been careful to place the decision in its timely context, on the basis that there may come a point where, as a result of the reinforcement and education, she may have a durable ability to retain and understand the relevant information. HHJ Rogers hoped that may be so, but confessed to reservations.

HHJ Rogers, in an observation which has wider resonance, also noted that:

> *40.* […] *whilst the local authority welcomes and encourages practical strategies to assist C and recognises the benefit of support in the area of technology and its use, Mr Johnson's realistic submission was that there comes a point where support and encouragement becomes so integral to the decision making process that, in reality, the individual concerned is little more than an automaton who is simply carrying out the instruction of others rather than responding to prompts and making capacitous personal decisions.*

> *His submission was that for C, at this point in her personal development, that would be the reality as there would have to be continuous one to one supervision and support of her use of technology.*

HHJ Rogers accepted the force of this submission. Having found that C could not understand, retain and weigh the relevant information independently, he continued:

> *41.* […] *if the process could only really occur with the degree of supervision and prompting suggested then that would, in truth, be a fiction rather than a genuine exercise in autonomy. It would probably also be impractical in the care setting.*

Comment

HHJ Rogers' ringing endorsement of the "route map" laid down by Cobb J in *Re A* should, perhaps, be read in its context. This was an avowedly brief judgment, delivered under the exigencies of the first wave of the COVID-19 pandemic. It means that we do not get a clear sense of the precise reason why the local authority was seeking to control C's access to the internet and social media, but it appears that it may well have been in order to ensure that she was not exposed again to the risk of criminal prosecution. If this were the case, the case therefore raises somewhat similar issues to that of JB, in which the Supreme Court is grappling at the time of writing (September 2021) with the fact that the MCA does not exist in isolation but rather has a very complex relationship with the criminal law with its similar, but distinct, considerations of capacity in the context of criminal responsibility. The Supreme Court in *JB* is also grappling with an underlying issue in C's case, namely that there is, in truth, an inescapable normative element to capacity. In other words, asking what information is relevant to the decision in question is, in truth, asking what information should be relevant to the decision. Cobb J had been alive to this in *Re A* in the context of social media and the internet, HHJ Rogers was alive to it in this case, and the issue in *JB*, in turn, can arguably be reduced to the question of whether society expects that people should understand that a sexual partner needs to be consenting to the sexual act in question.

As noted above, it appears that HHJ Rogers was being asked to consider questions of internet use in the context of potential criminal acts (albeit with lurking questions of whether any such acts would attract criminal responsibility on the part of C). It should be remembered that accessing the internet and/or social media may also be something that the person in question is seeking to do for quite different purposes, and it is suggested that alongside Cobb J's route map should also be read the decision (subsequent to that in *C*) of Williams J in *Re EOA*, in which the latter sought carefully to distinguish between general access to the internet, and access for purposes of seeking to make contact with specific people.

The second observation of HHJ Rogers, about the point at which support stops and substitute decision-making takes over, is one that is pithily framed. Put in domestic MCA 2005 terms, it reminds us of an important limit to the crucial requirement in s.1(3) MA 2005 that it is legally impermissible to reach a conclusion that a person lacks capacity to take a decision unless all practicable steps have been taken to support them. Beyond a certain point, and as HHJ Rogers made clear, the provision of support runs

the risk of setting up a fiction which may be superficially comforting, but in fact means that hard-edged questions about who is doing the supporting and on what basis may be dodged. His observation, in turn, then gets to the heart of debates about which much ink has been spilled in the context of the UN Convention on the Rights of Persons with Disabilities (a very helpful summary of the issues can be found in this report from the Essex Autonomy Project, especially at section 6.5): i.e. whether in pursuit of the goal of securing legal capacity for those with disabilities on an equal basis with others it is better to proceed on the basis that some people, at some points, may need "100% supported decision-making," or to proceed on the basis that some people, at some points, may need decisions to be taken by others.

Capacity and (booster) vaccination

Re A (Covid-19 vaccination) [2021] EWCOP 47 (HHJ Brown)

Best interests – medical treatment

Summary

In this case, HHJ Brown considered an application by a CCG to administer two doses of the Astra-Zeneca Covid-19 vaccination, and a booster in a few months' time, to a man in his thirties, AD. This application was opposed by his mother, AC. The court granted the application to administer the two doses of vaccine, but refused to grant a general authorisation to administer a booster dose without either agreement of the parties or a further application to the court.

AD had diagnoses of a moderate learning disability, Down Syndrome and autism. He was overweight, and was considered to be 'clinically extremely vulnerable' by his GP. AD also *"experience*[d] *significant health anxiety and finds health interventions distressing: he consistently refuses to engage with them."* His learning disability nurse considered that if AD became significantly unwell with Covid-19, he was likely to refuse necessary healthcare.

AD was unable to comply with social distancing measures or wear a mask. He was described as a very sociable person who enjoyed physical contact with people he was close to, and going to social settings of interest to him. The case was heard in May 2021, and it was submitted by the CCG that as lockdown ended, the risk to AD of contracting Covid-19 was likely to increase.

Health and social care professionals involved in AD's care and AD's father supported his being vaccinated; his mother (who had previously held AD's lasting powers of attorney in respect of both health and welfare and property and affairs, before these were revoked by the Court of Protection in 2020) opposed it. All parties involved agreed that AD lacked capacity to make a decision about being vaccinated, so the sole dispute was whether it was in his best interests to receive the vaccine (and supportive medication, such as pain relief).

In weighing up AD's best interests, the court considered:

1. AD's wishes and feelings: it was agreed that AD has always been resistant to medical intervention, and would likely find the experience of being vaccinated distressing. When staff attempted to put information about the vaccine to him, he clearly objected to it. The parties were in agreement that AD should not be informed of the proceedings,

as that information was likely to cause him distress and unlikely to provide any further information about his wishes and feelings.

2. AC's objections: AC presented a number of objections to the proposal to vaccinate AD, some of which were specific to AD and some of which were more general concerns about vaccination. She argued that (inter alia):

    a. The use of force or restraint to administer the vaccine would be traumatic and cause physical or psychological damage;

    b. The trauma might cause AD to exhibit uncontrollable behaviours;

    c. The use of force would cause AD to lose trust in care staff;

    d. AD may have previously had Covid-19 with mild symptoms;

    e. AD was quite healthy despite the argument of health professionals that he was extremely clinically vulnerable;

    f. AD might have an allergic reaction to the vaccine given some of his other allergies;

    g. The risk of contracting Covid-19 is very low;

    h. The administration of the vaccine does not guarantee he would not contract the disease;

    i. The vaccination has not been proven safe and adverse side effects were very high;

    j. Alternative treatments (such as vitamins C or D) were preferable;

    k. Nearly all people recover from Covid-19.

AC clearly had grave concerns regarding the vaccine, which she supported with a mixture of materials obtained from the internet. The judgment recorded:

> *Mrs. C has made further points against the vaccine; "It is in the long term (or even as short as 5 months) that we started (sic) to see all the people who have taken the vaccine to fall very sick and have organ failure and will die", and "many specialists expect even more people to experience deadly side effects after the next 'quack' dose and when they come into contact with natural virus similar to SARSCoV2, weeks or months later"*

In describing the documents produced, the judgment states:

> *This set of documents, the origin of which is unclear, include statements to the effect that the vaccine contains "nanoparticles which allow definitive control of people vaccination, thanks to 5G" and "4 fragments of HIV which give to vaccinated people: AIDs syndrome and immunodeficiency" [E24]. The diagram at [E34], duplicated at [E76], appears to demonstrate that "sensor nanoparticles" will be injected into vaccine recipients which will then interact with mobile phones in order to send information via mobile 5G networks to the "cryptocurrency system". The diagram features Bill Gates. At [E36] is a narrative concerning the intention of the "New World Order" to "fully control and enslave the world's population by monitoring and weakening it" through the Covid-19 vaccine..*

Relying on the judgment of Hayden J in *SD v Royal Borough of Kensington and Chelsea* [2021]

EWCOP 14, the CCG argued that such material should be given no weight and the court must make its decision based on the credible professional evidence before it.

The court did consider AC's concerns that force would be used, and the administration of the vaccine might cause AD to distrust people working with him. The CCG confirmed that the application did not include any plan for using force to administer the vaccine. AD was to receive a mild sedative (given covertly in a drink) in advance of the medication, which would also have the effect of preventing memory formation. If the sedative did not appear to be working, the vaccination would be cancelled and rearranged. AD would receive the Astra Zeneca vaccine, which could be administered in his home and would not require him to travel to a medical setting. The person administering the vaccine would not be part of AD's care team, and would leave immediately after administering the vaccine. AD would wear a short-sleeved shirt so his arm could be easily accessed. AD could also be given paracetamol to address side effects. His care provider did not think that this plan would cause any difficulties in the relationship between AD and his care staff.

Professionals involved in AD's care considered it was strongly in his best interests to be vaccinated. His GP noted that serious side effects were very rare, and the vaccination would greatly reduce his risk from illness from Covid-19. The CCG's Deputy Director of Quality considered it would be contrary to AD's best interests to wait for further forms of treatments to be developed.

The Official Solicitor had raised a number of queries about the plan in proceedings, and by the final hearing, considered that these had been appropriately answered. The Official Solicitor also sought explicit orders that physical restraint was not authorised.

The court accepted the arguments of the CCG and Official Solicitor and approved the application, noting that if the plan was unsuccessful and a more restrictive plan was proposed, the matter should be returned to the court. HHJ Brown explained:

> *I entirely understand why there is genuine and legitimate concern from some, about the administering of a new vaccine to combat a new virus. People legitimately and in good faith, raise questions about its efficacy and possible side effects. I approach Mrs. C's concerns with profound respect and deep compassion. I accept that she genuinely holds these concerns and is acting out of what she considers, to be the best interests of her child….*
>
> *...AD's opposition to healthcare interventions must be taken into account, in that the administration of the vaccine will be against his wishes and feelings: but his wishes and feelings are not determinative. These factors must be weighed in the balance, with all the other evidence about the risks to AD of contracting Covid-19 versus the risks to him of carrying out the vaccination in accordance with the proposed Care Plan.*
>
> *I have to look at the professional evidence and the best guidance available to the court at the current time, in the best interests of AD. I have been very impressed with the care that the professional team working with AD has taken to consider his particular case and*

> *his need for the vaccination. When the balance of evidence from all those interested in AD's welfare is considered, in my judgment it is overwhelmingly in favour of him receiving the vaccine.*

Booster: The CCG sought authorisation to administer a booster vaccination in the event that the first two vaccine doses went well and there were no serious adverse reactions. The Official Solicitor resisted the application, on the basis that AD's response to the first doses was not known, and the national position regarding booster jabs had not been determined. AC also opposed the booster.

HHJ Brown declined to give authorisation to the booster. She noted that:

> *The guidance and medical advice may have changed by the time any booster may be required. Any individual would wish to consider whether to have the booster at the time that it is available and those representing AD should be afforded the same opportunity. I respectfully accept the submission of the Official Solicitor that it would represent "overreach" to sanction administration of the booster at this time.*

Comment

The judgment sets out a dispute which has been repeatedly seen in the Court of Protection at all levels this year: a family member, in good faith, strongly believes that receiving a Covid-19 vaccination will harm a loved one based on evidence which is not considered credible by health professionals working the person lacking capacity. In our experience, the approach taken by HHJ Brown (and in line with the *SD* case) to deal briefly with putatively medical evidence relating to vaccines which lacking in credibility or support from mainstream medical establishment has been one consistently taken by judges hearing these applications. The court did not struggle to conclude that, particularly given AD's inability to understand the risks of Covid-19 or practice social distancing, it was in his best interests to be vaccinated even if there was some risk of distress to him.

In this case, AC also raised a number of issues specific to AD that both the court and Official Solicitor found credible (specifically, those relating to the distress he may feel and the impact on his relationships with carers), and the judgment sets out that these were put to the CCG in advance of the hearing, and the plan crafted to take account of them. The court and Official Solicitor appeared to find the plan impressive in accommodating AD's particular needs, and to represent the least restrictive option in the circumstances.

Short note: twin-tracking Court of Protection and MHA matters

In an interesting 'twin-track' case, Lieven J both determined questions of residence, care and contact as a Court of Protection judge, and an application for discharge of P's father as nearest relative under the MHA 1983: *A Local Authority v SE & Ors* [2021] EWCOP 44. As regards capacity, the issues were identified as complex, the 18 year old woman in question only engaging "very variabl[y]" with the expert, Dr O'Donovan. Dr O'Donovan's evidence was that:

> *16.* […] *SE has emerging Emotional Unstable Personality Disorders (EUPD) as opposed to a mixed personality disorder. The effect of this is that when*

> *SE is in a state of arousal and dysregulation, she lacks capacity to make decisions about her residence. It is not possible to make a clear diagnosis of EUPD, or any other Personality Disorder, because SE is only 18 and her personality is still developing.*
>
> *17. She considers that SE lacks capacity to make decisions regarding her care arrangements. She does have some insight into her need for support, but SE is unable to understand her current care needs or the risks to her if care were not available.*
>
> *18. It is her opinion that SE is able to make capacitous decisions about her general use of social media. However, SE lacks capacity to have contact with her family via social media or in person. SE has a significant degree of internal conflict between feeling angry with her family but wanting their acceptance and affection.*

Dr O'Donovan recommended that the court used the inherent jurisdiction to authorise restrictions of SE's general use of social media and the internet "because this would be in SE's best interests."

Lieven J accepted Dr O'Donovan's evidence on capacity, noting that "[a]*lthough SE has some insight into her condition, it is apparent that she finds it very difficult to weigh up the information she is given, particularly when she is stressed*." Whilst she then proceeded to make best interests determinations as a judge of the Court of Protection in relation to residence, care and contact, she did not do so in relation to the internet and social media, nor did she comment further upon whether she should use the inherent jurisdiction to do so.

As regards the nearest relative application, it should be noted that, although the judgment is silent on this, the application for discharge was heard by Lieven J in her capacity as a judge of the Queen's Bench Division, a Court of Protection judge not being able to discharge functions under the MHA 1983. In discharging P's father, Lieven J observed (at paragraph 49) that:

> *ME is, in my view, unsuitable to act as SE's nearest relative. SE does not want to see or speak to her father, she has said that she wants contact with him to cease, she has made allegations of sexual, physical and emotional abuse against him and, as set out above, I have made a number of findings against ME in relation to his abusive and controlling behaviour towards SE. It necessarily follows that ME is not suitable to act as SE's nearest relative.*

Capacity and trauma

A Local Authority v P [2021] EWCOP 48 (HHJ Williscroft)

Mental capacity – assessing capacity

Summary[1]

A 24-year-old with learning disability, autistic traits and mood disorder was sharing a flat with two residents and at significant risks arising from contact with others. Having been sexually abused as a child, he was being sexually exploited, being drugged to have sex with

[1] Note, Arianna having been involved in the case, she has not contributed to this note.

random men. Despite sex and drug education, he continued to abscond so 2:1 support 24 hours a day was put in place which he opposed.

On application to the Court, he was considered to have capacity to make decisions as to sexual relations, internet and social media, but was found to lack capacity as to care, residence and contact with others. In particular, he could not understand the risks he faced when meeting people to engage in sex or drug use. He was not able to put into action even fairly minimal basics that would keep him safe. He was able to describe what dreadful things might happen, but unable to relate them to himself and so could not weigh those risks in the balance. As HHJ Williscroft identified:

> *68. P is unable in my assessment to make decisions about such contacts as he is often in a state it seems to me led by compulsion or obsessive behaviour, by the complex combination of age, sexual drive and diagnoses, driven too by trauma, when he is driven to meet people for sex. Their motivation and engagement with him he cannot understand or process and their communications he cannot interpret so that not just on a rare occasion but very regularly he is so uncomfortable that he calls police or carers to get him home. Then it can appear in discussion later that in fact he has been exploited, pressured and drugged for the advantage solely of other people's pleasure and he is unable to understand that to such an extent that he continues some relationships even when people have behaved in this way to him as it is apparent his understanding of social interactions is so limited.*
>
> *69. Social workers have obviously considered with care whether wanting and engaging in risky multiple sexual relationships might be at least not uncommon for a young gay man like P and they have wanted to enable him to have as much autonomy as possible. It is I accept rather odd that he can understand the basics of sex but not have the capacity to engage in a relationship that is based almost exclusively on the need for sexual activity but this is as a result of looking at domains of understanding separately and part of ensuring autonomy is only restricted where an analysis of lack of capacity is clear.*

Helpfully, the Judge prepared a letter to the young man to explain her decision.

Comment

The silo-ing of sex and contact decisions continues to be of interest and will, hopefully, be considered by the Supreme Court in *JB* in due course. Providing the decision by letter to the young man was also an important step, enabling him to understand the reasons behind the significant measures that were in place.

DoLS statistics

The DOLS statistics for England during the period of 1 April 2020 to 31 March 2021 have been published and are available here. Here are the main headlines, which should be read against the backdrop of the pandemic and thus – on one reading – show what lengths those involved went to seek to maintain 'DoLS business as usual' in the face of extraordinary challenges:

- DOLS applications plateaued: 'There were an

estimated 256,610 applications for DoLS received during 2020-21. This is a small drop of approximately 3% compared to the previous year, following an average growth rate of 14% each year between 2014-15 and 2019-20.' Of these:

- 137,515 were urgent authorisation, and 117,220 were standard authorisations
- 79,880 were in nursing homes, 71,885 were in care homes, 66,375 were in acute hospitals, and 5,685 were in mental health hospitals. 26,685 did not contain information on the detaining authority.
- There were 28,460 people who had more than one standard authorisation, 6,050 who had three standard authorisations, and 2,160 who had four or more standard authorisations.
- Older people were far more likely to find themselves the subject of standard or urgent authorisations than younger ones, with 7,415 applications made per every 100,000 people over the age of 85, and only 125 per 100,000 people aged 18-64.
- Of applications which were not granted, approximately 60% were due to the person's having had a change in circumstances.

- Roughly as many applications were completed in the year as were made: *'The number of applications completed in 2020-21 was estimated to be 246,025. The number of completed applications has increased over the last five years by an average of 19% each year.'*
- Whilst there were significant delays in considering DOLS authorisations, *'[t]he reported number of cases that were not completed as at year end was an estimated 119,740, approximately 10,000 fewer cases (8%) than the end of the previous year. This is the second consecutive year since reporting began in 2015-16 that the number of cases not completed at year end has fallen.'*
- The average length of time for completed application was 148 days. We would note that in 2015-2016, the average duration was 83 days. *'The proportion of standard applications completed within the statutory timeframe of 21 days was 24% in 2020-21, the same as the previous year.'*
- Regional variation: as in previous years, the North East has continued to have the highest number of applications per capita; despite this, the North East also had the shortest average duration of completing applications, at 73 days (with the Southwest the longest at 216 days).

Editors and contributors

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

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

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

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

Neil Allen: **neil.allen@39essex.com**

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

Annabel Lee: **annabel.lee@39essex.com**

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

Nicola Kohn: **nicola.kohn@39essex.com**

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

Katie Scott: **katie.scott@39essex.com**

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

Rachel Sullivan: **rachel.sullivan@39essex.com**

Rachel has a broad public law and Court of Protection practice, with a particular interest in the fields of health and human rights law. She appears regularly in the Court of Protection and is instructed by the Official Solicitor, NHS bodies, local authorities and families. To view full CV click here.

Stephanie David: stephanie.david@39essex.com

Steph regularly appears in the Court of Protection in health and welfare matters. She has acted for individual family members, the Official Solicitor, Clinical Commissioning Groups and local authorities. She has a broad practice in public and private law, with a particular interest in health and human rights issues. She appeared in the Supreme Court in *PJ v Welsh Ministers* [2019] 2 WLR 82 as to whether the power to impose conditions on a CTO can include a deprivation of liberty. To view full CV click here.

Arianna Kelly: arianna.kelly@39essex.com

Arianna has a specialist practice in mental capacity, community care, mental health law and inquests. Arianna acts in a range of Court of Protection matters including welfare, property and affairs, serious medical treatment and in matters relating to the inherent jurisdiction of the High Court. Arianna works extensively in the field of community care. To view a full CV, click here.

Simon Edwards: simon.edwards@39essex.com

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

Scotland editors

Adrian Ward: adw@tcyoung.co.uk

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

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

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

Conferences

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 October. 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.

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

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

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

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

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

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

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

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

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