39 Essex CHAMBERS

MENTAL CAPACITY REPORT:
HEALTH, WELFARE AND DEPRIVATION OF LIBERTY
September 2022 | Issue 125

Welcome to the September 2022 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: Person-specific contact and sexual relations capacity; treatment plans for disordered eating; and updated DoLS statistics.

(2) In the Property and Affairs Report: Electronic billing pilot rolls out.

(3) In the Practice and Procedure Report: Transparency orders; and the BMA opines on s.49 MCA reports.

(4) In the Wider Context Report: Brain stem death testing; deprivations of liberty of young people in Scotland; the CRPD's application in the Battersbee case; foreign convictions; coercive control; litigation capacity; the Care Act considered in the Court of Appeal.

(5) In the Scotland Report: Further updates on Guardians' remuneration and the PKM litigation; nearest relatives; and the MHTS project concludes.

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.

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

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Contact and sexual relations with an abusive partner

Hull City Council v KF [2022] EWCOP 33 (28 July 2022)(Poole J)

Best interests – contact
Mental capacity – sexual relations
Mental capacity – contact

Summary

KF wanted to spend one last night with her long-term partner, days before he was due to be imprisoned for causing her grievous bodily harm. Given the absence of bail conditions, whether this could happen depended upon her capacity to make the relevant decisions and, if not, whether unsupervised overnight contact was in her best interests.

KF was 34 with a condition of agenesis of the corpus callosum, which caused her to have moderate learning disability, with an IQ of 49. Her life expectancy was limited to 3-18 months as metastatic breast cancer had spread to her liver, lungs and spine and, despite chemotherapy, the prognosis was poor. KF had previously given birth to two children, who were no longer in her care.

Her partner previously encouraged her to have sex with other men. Angered that one of those men had anal sex with her, he 'fisted' her which caused tears to her vagina requiring hospitalisation, two units of blood and suturing without which she could have died. They separated but she returned to live with him and further violence was perpetrated. Social services were also seriously concerned about him exercising coercion and control, including taking her money, and overbearing her decision-making. KF moved to a care home placement. KW pleaded guilty to committing GBH and was soon to be sentenced but was on unconditional bail at the time of the application.

KF met remotely with the Judge, expressing her hope that her "wishes come true" to have some alone time with her partner ('KW') in private in a hotel room. She also stated to the expert:

> *16…"I have had two children. I can have sex with KW. If that's what I want, that's what I will do. No-one can stop me. I'm sick of this. You can tell the judge that too. It's my decision. I'm being treated like a child… I can make my own decisions. I want my freedom. I can make a decision about sex."*

Capacity

The first issue for Poole J was to carefully identify the matter(s) requiring a decision. It was possible to frame the decision to spend unsupervised overnight time with KW as a contact decision or a sexual relations decision and both needed to be considered. At para 24 his Lordship observed that, "*It is difficult to see how*

a person who lacks capacity to decide to have contact with a specific person could have capacity to decide to engage in sexual relations with that person. Sexual intimacy is a form of contact with another or others." And it was clear that KF lacked capacity to decide on contact with her partner.

In any event, the application for unsupervised overnight contact was person-specific and it was quite logical for her to have capacity to engage in sexual relations on a general basis, whilst lacking such capacity specifically in relation to her partner:

> *"24 … KF does not want to make decisions about having sexual relations in general, she wants to have (the opportunity for) sexual relations with KW and for that to occur within the next few days, prior to his likely incarceration. Information relevant to that specific decision includes information about the history and nature of the relationship between KF and KW. KW has been violent to KF in that relationship and has perpetrated sexual violence against her. KF is at specific risk of harm or assault by KW including in a sexual context. That risk is a foreseeable consequence of KF's decision-making about having sexual relations with KW. Dr Mynors-Wallis had already advised that KF cannot retain information about KW's past assaults on her or the risk that KW will assault her again. That is information relevant to the matter for decision, particularly given the nature and circumstances of the most serious assault by KW on KF, which was a sexual assault. Dr Mynors-Wallis also advises, that KF cannot weigh or use the foreseeable consequences of deciding to have sexual relations with KW, which include the risk of assault from him as has happened in the past. Dr Mynors-Wallis' previous report approached the matter for decision as general – the capacity to engage in sexual relations. He has now considered capacity to decide to engage in sexual relations in a person-specific context and, unsurprisingly given his previously expressed opinions, concludes that KF lacks capacity to decide to engage in sexual relations with KW.*

It was important for the Court not to approach questions of capacity in silos: "*I would regard it as incoherent to find that KF did not have capacity to decide to meet KW alone for a meal in a restaurant but did have capacity to decide to have sexual relations with him. Decisions about capacity must be coherent and allow those responsible for caring for and safeguarding KF to make practical arrangements*". [24] Poole J went on to emphasise:

> *24…In cases in which it has been determined that P lacks capacity to make decisions about contact with a past or potential partner because of the risk of harm to P or by P, and it has been determined that P has capacity to decide to engage in sexual relations, consideration should be given to P's capacity to decide to engage in sexual relations with that partner. Failure to do so could result in incoherent capacity decisions. It was right to consider capacity to engage in sexual relations as a person-specific issue in this case."*

Given her inability to retain, weigh and use the additional relevant information specific to engaging in sexual relations with KW in particular – namely, that he sexually assaulted previously which was very harmful, the risk of a further assault and/or harm to her, the degree of that risk, the consequence if it should materialise, and the means by which the risk could be mitigated – it was declared that she lacked capacity to make the decision (para 26).

Best interests

If unsupervised overnight contact did take place in a hotel room, any sexual intercourse would be rape given her inability to consent. On the eve of his possible incarceration for assaulting her, her partner's mood might well be unpredictable, he might again become angry and take that out on her. There was no adequate means of ensuring that she could be kept safe and she could not be relied upon to seek support to prevent sexual relations taking place. Moreover, it would be unreasonable to expect support works to enter the hotel room to intervene. In the circumstances, any such contact was not in her best interests. Instead, it was in her best interests to continue to have supervised contact during the day and in a public place, such as a park, café, or restaurant, where they could kiss and cuddle, with support works supervising nearby.

Comment

The facts and judgment in this case illustrate the more nuanced approach to sexual relations that can be taken following the Supreme Court's decision in *JB*. Whilst KF was *able* to engage in sexual relations on a general basis, she was *unable* to do so in relation to KW. That is because there was much more at stake for her to comprehend, given the reasonably foreseeable risks and consequences that he presented.

The approach taken – to focus on contact first and then a person-specific take on sexual relations – is sensible and focused on 'the matter' about which a decision was needed. It provides a much more individualised perspective, sensitive to the particular risks. To do otherwise risks a greater, unnecessary intrusion upon a person's autonomy. For example, to silo capacity to have contact 'with others' and to engage in sexual relations in general runs the risk of greater interference as compared with the more targeted approach taken here. In a case of this nature, where the reasonably foreseeable consequences did appear to focus on KF and KW's relationship and the risked he posed to her, to focus on capacity to decide on contact with person X, and if sexual relations is a reasonably foreseeable consequence of such contact, to then take a person-specific approach in that latter regard. Whilst proxy consent to sexual relations cannot of course be given on a best interests basis, support scaffolding can be put in place on a best interests basis so as to create where possible a safe environment for contact.

Injunctive Relief

Re TT (Injunctive Relief) [2022] EWHC 2185 (Fam) (04 August 2022) (HHJ Scully sitting as a DHCJ)

COP jurisdiction and powers - Injunctions

The court considered the best interests of TT, a 46-year-old man of Asian heritage with a diagnosis of a mild learning disability. TT lived with his parents until 2019, when he moved into a supported living accommodation. The case considered applications for injunctions to prevent P's mother from interfering in the exercise of his personal autonomy, heard simultaneously in High Court under the Inherent Jurisdiction and in the Court of Protection.

The background to the case concerns the relationship between TT and his mother ST. Within earlier proceedings in 2019, HHJ Moir (sitting in the High Court) found that ST had done her best to care for TT but found: *'she has controlled TT, or sought to coerce TT, throughout his life, as she sees it, for his benefit and she has not made the transition from caring for a child, to supporting an adult to make the best of his life.'* In 2021, TT's social worker began raising concerns about ST exerting pressure and influence on TT to return to the family home.

This judgment concerned the power of the COP '*to grant injunctions to support and ensure compliance with its best interests' decisions and its orders*.' HHJ Scully considered the judgment of Keehan J in SF [2020] EWCOP 19 at para 33

> *I so find for the following reasons:*
>
> *i) s.47(1) of the 2005 [Mental Capacity] Act is drafted in wide and unambiguous terms;*
>
> *ii) it must follow that the Court of Protection has the power which may be exercised by the High Court pursuant to s.37(1) of the 1981 Act to grant injunctive relief;*
>
> *iii) this conclusion is fortified by the terms of s.17(1)(c) of the 2005 Act which permits the court to prohibit contact between a named person and P;*
>
> *iv) it is further fortified by the terms of ss. 16(2) & (5) of the 2005 Act. The provisions of s.16(5) are drafted in wide terms and enable the court to "make such further orders or give such directions….as it thinks necessary or expedient for giving effect to, or otherwise in connection with, an order….made by it under subsection (2)";*
>
> *v) finally, the 2017 Rules, r.21 & PD21A , make provision for the enforcement of orders made by the Court of Protection including committal to prison for proven breaches of court orders.*

HHJ Scully also considered the case of *Re SA* [2005] EWHC 2492 (Fam) in relation to the court's powers under the inherent jurisdiction; and that, following Munby J's judgement at paragraph 79 it '*can be invoked wherever a vulnerable adult is, or is reasonably believed to be, for some reason deprived of the capacity to make the relevant decision, or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent. The cause may be, but is not for this purpose limited to, mental disorder or mental illness.*'

ST's evidence was that '*does not and has not sought to control or exert pressure on her son*' and that '*TT "plays games" with the staff and everyone else about where he wants to stay.*' [23] The judge had a '*clear impression of ST is of a mother who loves her son dearly and who believes that her actions are well founded,*' however '*ST is unable to see that TT has any real autonomy in respect of many decisions around his life or that he deserves the opportunities, as the social worker put it, to be supported and assisted where possible, to exercise that autonomy.*' [paras 31-32]

After reminding herself of the words of Munby J in SA in relation to the influence of a parent or other close and dominating relative that '*is in TT's best interests and as a vulnerable adult, that the court should properly exercise its jurisdiction, both within the Court of Protection so far as it is able and under the inherent jurisdiction, to grant the relief sought*.' [36] The order therefore included injunctions on ST, specifically that:

> *37…ST shall not: (whether by herself or instructing, encouraging or permitting any other person):*
>
> *i. Prevent TT from living at 'the placement', save that and solely subject to his wishes, he is at liberty to spend a maximum of two nights per week at his family's home*
> *ii. Allow TT to live at the family home*
> *iii. Seek to persuade or coerce TT into not returning to 'the placement'*
> *iv. Take any action to prevent TT returning to 'the placement'*
> *v. Seek to persuade or coerce TT once he has returned to 'the placement' into moving back to the family home and/or to reside with ST anywhere, or to move to or reside at any property, premises or otherwise other than 'the placement'*

Within the inherent jurisdiction of the High Court, it was ordered that:

38…'ST' shall not (whether by herself or instructing, encouraging or permitting any other person):

i. Prevent, restrict, or seek to persuade or coerce TT not to have, or to have less, contact with 'Miss Y'.

ii. Contact by any means Miss Y or Miss Y's mother.

iii. Request, demand or take from TT any sum of money by way of 'rent' or contribution to expenses save in circumstances when TT remains overnight at ST's home when his contribution must be limited to a maximum of £5 per night.

Eating disorders and disordered eating: treating in the face of serious risk, and withdrawing treatment

Pennine Care NHS Foundation Trust v Mrs T & Ors (Rev1) [2022] EWHC 515 (Fam) (11 February 2022) (Morgan J)

A Mental Health Trust v BG [2022] EWCOP 26 (24 June 2022)(Sir Jonathan Cohen)

Best interests – medical treatment
COP jurisdiction and powers – Experts
Media – Court reporting

In two recently-reported cases, one in the Court of Protection and one in the Family Division, courts considered applications by trusts to approve treatment plans for two young women who had either entirely or all but entirely ceased eating. One plan was a risky intervention to keep the patient alive so that treatment to continue; the other was a plan to withdraw all but palliative care.

In *Pennine Care NHS Foundation Trust v Mrs T and Others*, Morgan J considered a proposal to sedate and feed 'Amy', a 17-year-old detained under the Mental Health Act 1983 who was in a perilous physical state after refusing to eat for over two years. The proposed intervention was:

- Amy would be transferred to an Intensive Care Unit for a period of sedation under General Anaesthetic
- She would be sedated for 3-7 days to allow physical investigation and treatment, and a period of refeeding
- Amy would then be returned to the psychiatric setting *'to continue intensive mental health treatment and treatment to support her physically in that.'* [12]

The application was brought by Pennine Care NHS Foundation Trust, a mental health trust with responsibility for Amy; Northern Care Alliance NHS Foundation Trust was the acute trust which was to carry out the proposed medical interventions, which did not oppose the application but considered that the court should take the final decision on it.

The judgment records that in September 2019:

4…Amy started to show signs of what was later diagnosed as 'Obsessive Compulsive Disorder' [OCD]. There was, at first success with intervention and treatment but there came a time when her family noticed that she had started to show marked weight loss. She was restricting her calorific intake and increasing her use of those calories she did take in by exercising in an excessive way. She was referred to Community Eating Disorder services by which time her weight and her 'Body Mass Index' [BMI] were at less than 75% of that which would be desired. An intensive community re-feeding regime produced at first some improvement but matters deteriorated such that by April 2021 she was admitted (informally) to Royal Manchester Children's Hospital (RMCH). She refused all oral nutrition and 5 days after her admission tried to abscond. Following detention under s3 of the Mental Health Act 1983, the operation of s 63 of the Act meant she could be, and / or was,

> *fed by means of restraint. Two months later she was moved to a small unit specialising in the care of young people with significant and or enduring mental health difficulties. Over time her refusal of nutrition and of treatment was accompanied by self-harm. Self-harm at a serious level. The refusal of treatment is characterised by those treating her as an 'inability' to accept it and is described as being pitched at 'an extremely high level'. That inability to accept interventions and assistance for herself is one of the manifestations of her mental illness…*
>
> *6. Those who are looking after her mental health are firmly of the view that she wants to live but that her will to accept the interventions she needs to be able to do so is overborne by the mental disorder from which she suffers. That firm view is shared by her parents…*

At the time of the application in 2022, Amy was refusing *'all medication, examinations, treatment, intervention or assessment save and except that there has been one recent instance in which she was compliant with a particular imaging assessment. She is fed involving restraint but has developed a mechanism whereby she is able to expel a significant proportion of the nutrient even when restrained. The result of this is that she is taking in so little of her required nutrition - an estimate of about half her minimum nutritional needs is what I have been given – that she is now on a downward trajectory which is overwhelmingly likely to end in her death. The extent and degree of supervision and restraint required to try to reduce her opportunity to harm herself is such as to markedly diminish her dignity.'* [7]

However, her treating mental health professionals (who had consulted broadly with other specialists nationally) felt that her overall prognosis for recovery was good, and that her OCD was treatable if her health could be stabilised sufficiently to allow for more time for treatment.

The court found that Amy lacked capacity to make decisions as to her treatment; while her parents consented to the treatment, the case had come to court due to the *'unusual…nature of the treatment proposed.'* The court noted precedent which stressed the importance of the views of a child's parents, it note that *'parental right is, however, subordinate to welfare.'* [10]

Amy was appointed a Guardian, though had been selectively mute and refused to speak with the Guardian. In written communications, Amy discussed wanting to recover and come home, and wrote about career ambitions she had. The court considered that these statements were not consistent with a wish to die.

The treatment was considered to be quite risky, and might lead to Amy dying or suffering from organ failure. It also put her at risk *'of delirium once re-awakened from sedation, which risk would be exacerbated by her already troubling mental health history.'* [12] Due to the risks of the procedure and risks to Amy's health due to her continued refusal of food, the procedure had to be carefully timed to commence not sooner than was absolutely required, but also before Amy had become so unwell that the probability of a positive outcome was very poor.

The acute trust did not feel able to predict the likelihood of success of the intervention, and emphasised that it could result in Amy dying or surviving with even worse health than she already had. The doctors also were clear that they had no previous experience with an intervention of this nature. While they were willing to perform the intervention, they did not feel able to affirmatively recommend it.

The court approved the proposed treatment plan in principle, summarising the extremely difficult situation in which Amy found herself:

> *26. Dr Ferris at the end of his evidence in chief said this: I think we all feel uncomfortable but here is a very unfortunate young woman who*

> *desperately needs help and I think the right thing to do is to offer that help at the right time.* I agree. Cross examined by Mr Sachdeva about whether he could see any other option to the proposed plan if Amy continues to deteriorate against a background where the timescales for the psychiatric treatment are measured in terms of months, Dr Ferris's response was *No I don't think there is any other choice.* I agree with that also…

The court gave discretion to the clinicians on the ground as to when it should be implemented.

In *A Mental Health Trust v BG*, the court considered an application for declarations that BG lacked capacity to make decisions about her care and treatment, including nutrition and hydration, and that it was in BG's best interests that no further treatment be provided against her wishes (including any artificial nutrition and hydration, and any life-saving treatment). The application was supported by the independent expert in the case and all parties to the application, including the Official Solicitor and BG's parents. A postscript states that BG died approximately two months after judgment was given and shortly before it was reported.

At the time the application was heard, BG was 19 years old. BG was described as both highly intelligent and much-loved by her family, and she participated actively in the proceedings. The judgment set out the background of the case:

> *6. From a very early age BG has been exceptionally sensitive and has struggled with regulating her emotions and dealing with the ordinary events of everyday life that others take in their stride. She took the weight of the world on her shoulders, and she was exceptionally anguished and distressed by, for example:*
>
> > *i)The recounting of historical events in which people had suffered;*
> > *ii) Accounts of suffering of animals or seeing roadkill;*
> > *iii) World events, whether they show the plight of humans or animals.*
>
> *All these events would lead her to become overwhelmed and inconsolable with distress.*
>
> *7. BG's emotional awareness of the suffering of others completely overwhelmed her. She felt the pain of everyone and everything and was unable to regulate her own emotions.*
> *8. BG first came into contact with mental health services aged 8. Her increased anxiety had led her to have not only the frequent overwhelming experiences to which I have already referred, but she became unable to sleep in her own bed and developed fears of terrorism, burglars and family death, for example, without any personal experience of the same. She had two courses of cognitive behavioural therapy, one when aged 10 and one when aged 13.*
> *9. BG's depression is estimated to have started when she was 14 years old and her suicidal and self-harm behaviours started soon afterwards. At that time she was completely dependent on her mother. In December 2017 self-harm by cutting commenced.*
> *10. In February 2018 BG was formally diagnosed with anorexia nervosa.*
> *11. Since early 2018 BG has been under the continuous care of psychiatric services.*

From 2018 until 2022, treatment for BG's anorexia and self-harming behaviours had continued. Though during some initial periods eating was established, BG remained suicidal and highly distressed. She had only been able to be at home for a few months in late 2020 and

early 2021; by the time of her re-admission to hospital *'BG was very agitated, self-harming including banging her head, punching herself and cutting, culminating in her ingesting bleach.'* [13] BG had had a variety of treatments, none of which had resulted in any significant improvements in her condition.

> *14…BG's medication and treatment regime was summarised as follows:*
>
> > *i) Her nutrition was delivered twice per day via nasogastric (NG) tube and under restraint on all occasions. The nutrition maintained her weight at approximately Body Mass Index (BMI) 15 but her agitation and resistance to feeds worsened progressively during the second half of 2021.*
> > *ii) BG drank sugar free squash or water but declined any oral intake which might contain calories.*
> > *iii) She was prescribed 12 different medications.*
> > *iv) She received weekly psychological support, with little or any effect.*
>
> *15. BG had by then received over 1,000 NG feeds under restraint during her various hospital admissions. This has caused her immense distress. She has to be restrained by no fewer than 4 staff members as she struggled against it so much. I have no doubt that it was also highly distressing for those having to administer the feeds.*

By the time of the application, BG was described as having *'a deep desire to die and to be allowed to die by the withdrawal of her nutrition so that she can slowly die in her mother's arms in her bed.'* [24] Her treating psychiatrist, Dr Z, considered that all treatment options had been exhausted, and did not have any proposal that might alleviate BG's suffering.

BG's wishes and feelings were extremely clear:

> *38. BG has made it completely clear over a prolonged period of time that she would wish to take her own decision and exercise her own autonomy over her body. Her very clear decision is that she wishes to be discharged from hospital, to go home and determine for herself, what if any nutrition or hydration she takes.*
>
> *39.This is not a sudden decision. It has been a long and deeply held wish of hers. I have had the obligation and privilege of reading her diary over many weeks. It is a harrowing read, setting out her suffering and how it should be resolved.*

BG's parents supported her wish for treatment to be withdrawn, writing, *'[s]he is exhausted from being in so much intolerable pain for so long, and she would like to be sure that any palliative care plan guarantees pain relief such that she is not obliged to suffer further than absolutely unavoidable'*. [42]

BG's treating psychiatrist considered that BG lacked capacity to make decisions as to her treatment as *'BG's beliefs and her using and weighing in the balance the relevant information about care and treatment were dominated by her desire not to experience pain and she saw her death as the only escape. All of BG's views and beliefs had an underlying theme of not deserving anything except punishment and that she is bad.'* [28]

The court also summarised a best interests meeting which had been convened to consider BG's situation, which *'concluded that it was in BG's best interests for active treatment to be discontinued. The level of suffering that BG had experienced, her desire to be allowed to die, her family's agreement with her wishes and feelings, and the poor prognosis following the exhaustion of all treatment options led to that conclusion. The negative aspects of treatment appear to outweigh any potential benefits which would ostensibly be*

only to preserve her life which is not something that she wishes for.' [46]

The court concluded with a plainly heavy heart that it was it was in BG's best interests for compulsory treatment to end.

Expert evidence

The court considered that independent expert evidence was needed for a number of reasons, and postponed a final decision in the matter for five weeks to accommodate this evidence. While the court offered no criticism (and indeed, high praise) for the evidence of BG's treating psychiatrist, 'Dr Z', it set out the reasons why it considered independent evidence was required in this case:

> *20…i) The court was being asked to make a decision which would lead inevitably to BG's death on the advice of just one doctor, albeit that she was reflecting a team view;*
> *ii) That doctor was in a therapeutic relationship with her patient which inevitably impacts on her independence;*
> *iii) Only a short time before Dr Z had been seeking the advice of a second opinion doctor but had been unable to obtain that opinion in time for the hearing. It seemed to me that if that second opinion was desirable then, it remained desirable.*
> *iv) Although the matter was plainly urgent, the necessity of making the right decision on the best evidence was paramount and the relatively short period of time, then thought to be about 5 weeks, seemed to me to be justified.*

An expert report was obtained from Dr Tyrone Glover, who had very limited substantive disagreements with Dr Z in relation to either BG's capacity or her best interests. He considered that *'BG is suffering from very severe, unremitting forms of mixed anxiety and depression and anorexia nervosa'* [32] and concurred with BG's views in relation to further treatment.

Transparency

The court also considered the position on reporting restrictions after BG had seen a reference to her case in a published tweet; the judgment described her as being 'deeply distressed', though she was not identifiable from the tweet. Blanket reporting restrictions were in place during preliminary hearing, and all parties to the proceedings sought to convince the court to continue the RRO as any report BG found about herself would likely only cause her further anxiety and distress in what were likely to be the final days and weeks of her life. Brian Farmer on behalf of the Press Association argued against the order, asking how *'could it be justified for the court to take a decision that will almost inevitably lead to someone's death without the public being allowed to know that such a decision had been taken'*? [55]

The court wrote that it had:

> *57…considered the matter anxiously. I was persuaded by Mr Farmer that it would not be proper for a decision of this gravity to be made in secrecy, particularly in circumstances when the duration of BG's life was uncertain. Accordingly, on 23 May when announcing my decision I authorised publication in these terms:*
>
> *"The court today has been dealing with an application by a Mental Health Trust seeking orders permitting the ceasing of artificial nutrition and hydration to a young person suffering from a very complex condition including a severe eating disorder. The inevitable result will be that the young person will die unless he/she chooses otherwise. The application is supported by the young person and the immediate family and the independent expert instructed by the Official Solicitor. I have allowed the application and will, in a reserved judgment, give my reasons in this very difficult case. I will reconsider the issue of further publication after I have handed down my reserved judgment. In the meantime, there is to be no additional reporting or identification of the Mental*

Health Trust, the Acute Trust, the young person, their family or the treating doctors or the geographical location in which any of the above are situated."

Updating DOLS statistics published

The DOLS statistics for England during the period of 1 April 2021 to 31 March 2022 have been published and are available here.

The main headlines are:

- DOLS applications rose slightly: There were 270,650 DoLS applications, up from 256,610 applications for DoLS received during 2020-21. This is a 5.5% increase, following an approximately 3% drop in the previous year. This is in contrast to growth averaging 14% each year between 2014-15 and 2019-20.'

- More than half of DoLS applications are not granted, usually due to changed circumstances: *'The proportion of completed applications in 2021-22 that were not granted was 56%. The main reason was given as change in circumstances, at 65% of all not granted cases.'*

- Applications are taking longer to process: *'The proportion of standard applications completed within the statutory timeframe of 21 days was 20% in 2021-22; this has fallen from 24% in the previous year. The average length of time for all completed applications was 153 days, compared to 148 days in the previous year.'* In in 2015-2016, the average duration was 83 days.

- Regional variation continues: as in previous years, the North East has continued to have the highest number of applications per capita, with 212 per 100,000 individuals (the next highest being the North West with 150 per 100,000 and the lowest being the East of England, with 105 per 100,000).

- Despite this, the East of England had the longest mean time for completing applications with 214 days; the North East had the second shortest average duration of completing applications, at 113 days, and London the lowest at 85 days.

- For some further statistics:

  - 150,740 authorisations granted were urgent authorisations, and 116,340 were standard authorisations

- 88,960 were in nursing homes, 80,225 were in care homes, 74,385 were in acute hospitals, and 5,330 were in mental health hospitals; others were blank, invalid or in other settings. The vast majority of the rise in applications were attributable to people in residential care homes or nursing homes.

- There were 28,015 people who had two standard authorisations, 6,585 who had three standard authorisations, and 2,290 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 7,829 applications made per every 100,000 people over the age of 85, and only 127 per 100,000 people aged 18-64.

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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.

Nyasha Weinberg: Nyasha.Weinberg@39essex.com

Nyasha has a practice across public and private law, has appeared in the Court of Protection and has a particular interest in health and human rights issues. 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 and Seminars

Forthcoming Training Courses

Neil Allen will be running the following series of training courses:

14 September 2022	AMHP Legal Course Update
16 September 2022	BIA/DoLS legal update (full-day)
30 September 2022	Court of Protection training
13 January 2023	Court of Protection training

To book for an organisation or individual, further details are available here or you can email Neil.

The University of Essex is hosting two events in October:

3 October 4.30pm – 7pm: Evaluation of Court of Protection Mediation Scheme Report Launch
Garden Court Chambers,
57-60 Lincoln's Inn Fields, London, WC2A 3LJ, and online by zoom
Register at: *https://www.eventbrite.com/e/evaluation-of-court-of-protection-mediation-scheme-report-launch-tickets-411843032597*

5 October 1pm – 5pm Mental Capacity Law in Contract and Property Matters
Wivenhoe House Hotel, University of Essex, Colchester, and online by zoom
Register at: https://www.eventbrite.co.uk/e/mental-capacity-law-in-contract-and-property-matters-tickets-365658192497
Speakers include: Clíona de Bhailís, Researcher, NUI Galway, Shonaid and Andy, PA and Support Workers, Outside Interventions
Professor Rosie Harding, University of Birmingham, John Howard, Official Solicitor and Public Trustee Property and Affairs Team, Gareth Ledsham, Russell Cooke Solicitors, Her Honour Judge Hilder, Court of Protection

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.

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