Mental Capacity Law Newsletter September 2015: Issue 58

Court of Protection: Health, Welfare and Deprivation of Liberty

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Introduction

Welcome to the September 2015 Newsletters: Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Newsletter: an update on the *Re X* saga, clarification over DoLS and conditional discharges, scrutiny of DoLS scrutinisers, an important decision on withdrawal of treatment, and a guest article by Dr Gareth Owen and capacity and brain injury;

(2) In the Property and Affairs Newsletter: an important decisions on P's use of funds for school fees in the context of mutual dependency, successive deputies, adverse costs orders and interest free loans, bad LPA behaviour, and family members as deputies;

(3) In the Practice and Procedure Newsletter: clarification over the (lack of) funding of s49 court reports, the importance of participation in proceedings, and habitual residence;

(4) In the Capacity outside the COP Newsletter: CRPD Committee's guidelines on article 14, assisted suicide, and litigation capacity in other proceedings;

(5) In the Scotland Newsletter: questionable policies and article 8 ECHR, the Education (Scotland) Bill, new guidance and ordinary residence, and new DOL guidance.

And remember, you can now find all our past issues, our case summaries, and much more on our dedicated sub-site here.

For all our mental capacity resources, click here. Transcripts not available at time of writing are likely to be soon at www.mentalhealthlaw.co.uk.

Judicial deprivation of liberty update

Judicial authorisations – Party status – Litigation friends

The fall out from *Re X* continues. We anticipate judgment being handed down very shortly by Charles J, the Vice-President of the Court of Protection, in *NRA & Ors*, considering the question of the participation of the person concerned in proceedings for the judicial authorisation of the deprivation of liberty. In response to the Court of Appeal's (non)decision in *Re X (Court of Protection Procedure)*, District Judge Marin listed a number of cases before him on 8 July to identify common issues for resolution by the Vice-President (*Re MOD & Ors* [2015] EWCOP 47). The Vice-President identified further issues to be addressed at a hearing which took place on 30 and 31 July; judgment is awaited. The issues raised are urgent and serious, in particular in the light of the apparent absence of IMCAs available to act as litigation friends. As DJ Marin identified in his initial judgment:

> *"55. What results therefore is a complete impasse. The Court of Appeal strongly suggests that P should be a party. If so, he must have a litigation friend before he can become a party. If family members cannot take on this role either because it is legally or procedurally wrong or simply because none exist, then all eyes turn to the Official Solicitor. But he says that he cannot act as he has no resources to do so. The result therefore is that the cases all stand still and cannot proceed as will hundreds and potentially thousands of other cases. The ramifications of this are huge. In fact, I cannot think of a more serious situation to have faced a court in recent legal history."*

A key issue that will be determined by Charles J is whether (and how) the new Rule 3A and the menu of options identified therein may present alternative ways in which to secure the necessary degree of participation. Mostyn J has already opined (in advance of the coming into force of the Rule) on this point – it will be of considerable interest to see whether Charles J agrees with him.

Re X considered (and limited)

HSE Ireland v PD [2015] EWCOP 48 (Baker J)

Foreign Protective Measures – Deprivation of liberty – Party status

Summary

Baker J has had cause to consider *Re X* and Rule 3A on the very first day of the latter's life. In *HSE Ireland v PD* [2015] EWCOP 48, Baker J was asked to consider whether the subject of an application for recognition and enforcement of a foreign protective measure providing for their deprivation of liberty in England and Wales had to be made a party to the English proceedings.

This case, the sequel to *HSE Ireland v PA & Ors* [2015] EWCOP 38, required him to consider both the effect of *Re X* and the scope of the powers available to the court under Rule 3A. In relation to *Re X* Baker J noted that:

> "14. […] *the Court concluded that the President had no jurisdiction to determine the issues upon which the appellants were appealing and, accordingly, the Court of Appeal had no jurisdiction to entertain the appeals. It could then be argued that the observations of the judges of the Court were (at best) obiter dicta or (possibly) merely dicta. It would, however, be extremely unwise for any judge at first instance to ignore what was said by the Court of Appeal. On the contrary, I consider that I must treat the dicta as the strongest possible indication of how the Court of Appeal would rule on the question before it, in the event that the issue returns to that Court as part of a legitimate appellate process."*

Baker J held that:

> "*31. In Re X, the judges of the Court of Appeal were considering proceedings for orders authorising in the deprivation of liberty by the Court of Protection exercising its original jurisdiction under the MCA 2005. They were not asked to consider applications for the recognition and enforcement of foreign orders under Schedule 3. Their clear statements of principle, however, serve as a strong reminder of the importance to be attached to ensuring that P's voice is heard on any application where deprivation of liberty is in issue."*

Hearing P's voice was, though, at the heart of the process of recognition and enforcement. Therefore, when carrying out the limited review of the process before the foreign court mandated by Articles 5 and 6 ECHR, the Court of Protection "*must therefore bear in mind the observation of Black LJ at paragraph 86 that 'it is generally considered indispensable in this country for the person's whose liberty is at stake automatically to be a party to the proceedings in which the issue is to be decided." To my mind, however, where the adult has been a party and represented in the proceedings before the foreign court, it is not 'indispensable' for that adult also to be a party before this court on an application for recognition and enforcement of the foreign order, given the limited scope of the enquiry required of this court when considering an application under Schedule 3.*"

Baker J continued:

> "*[e]ach case will turn on its own facts. In some cases, the court will conclude that the adult needs to be joined as a party immediately. In other cases, the court will adopt one or other of the alternative*

> *methods provided in Rule 3(A)(2). In a third category of case, the court will be satisfied on the information before it that the requirements of Schedule 3 are satisfied without taking any of the measures provided by Rule 3A(2)(a)-(d). In very urgent cases, the court may conclude that an interim order should be made without any representation by or on behalf of the adult, but direct that the question of representation should be reviewed at a later hearing. Such a course seems to me to be consistent with the analysis of Black LJ at paragraph 104 of Re X. In every case, however, when carrying out that analysis, the court must be alive to the danger identified by Black LJ, at paragraph 100 in Re X that the process may depend 'entirely on the reliability and completeness of the information transmitted to the court by those charged with the task' who may 'be the very person/organisation for P to be deprived of his liberty*.'"

Baker J anticipated that in the majority of applications for recognition and enforcement of this nature, joinder of the adult as a party will be considered necessary, but that in the majority of cases it will not. He further noted that the flexibility provided for by Rule 3A was well-suited to Schedule 3 applications, and expressed the hope that a panel of Accredited Legal Representatives would be swiftly established because the appointment of an ALR would in many cases facilitate a quick but focused analysis of the particular requirements of Schedule 3. Pending such appointment, the court would need to consider in each case what other Rule 3A step should be taken.

Baker J emphasised that this decision was taken in an area "*where the principles of comity and co-operation between courts of different countries are of particular importance in the interests of the individual concerned. The court asked to recognise a foreign order should work with the grain of that order, rather than raise procedural hurdles which may delay or impeded the implementation of the order in a way that may cause harm to the interests of the individual. If the court to which the application for recognition is made has concerns as to whether the adult was properly heard before the court of origin, it should as a first step raise those concerns promptly with the court of origin, rather than simply refuse recognition."* Further, *"The purpose of Schedule 3 is to facilitate the recognition and enforcement of protective measures for the benefits of vulnerable adults. The court to whom such an application is made must ensure that the limited review required by Schedule 3 goes not further than the terms of the Schedule require and, in particular, does not trespass into the reconsideration of the merits of the order which are entirely a matter for the court of origin.*"

Comment

Baker J's conclusion as to the status of the dicta in *Re X* is not surprising. Nor, we suggest, is the conclusion that he reached as to how those dicta apply in the narrow (but important) field of recognition and enforcement. It is clearly of the highest importance that the individual concerned is properly heard (or properly enabled to participate) before the court that is taking the decision to deprive him/her of their liberty. It is not immediately obvious why it is that they should then need to be joined as a party to proceedings for recognition and enforcement of that order before the Court of Protection, so long as the COP is both enabled – and indeed required – to assure itself that the individual in question has been so heard.

Conditional discharge and deprivation of liberty – sanity prevails

Secretary of State for Justice v KC and C Partnership NHS Foundation Trust [2015] UKUT 0376 (AAC) (Charles J)

MHA/MCA interface – Conditional discharge of restricted patients

Summary

Ever since the decision in *SSJ v RB* [2011] EWCA Civ 1608 it has been difficult to discharge restricted patients from detention under the Mental Health Act 1983. Often they require robust conditions in the community that amount to a deprivation of liberty. And the Court of Appeal decided that it was unlawful for a tribunal to discharge from MHA detention into what effectively amounted to community detention because that was not a "discharge" from detention. Many have long questioned the validity of that decision. This comprehensive judgment addresses a large number of issues, not all of which are relevant to MCA practitioners. Our focus, therefore, will be on the interface between the MHA and the MCA.

KC was a restricted patient and lacked capacity to make decisions in relation to residence and care regime. The tribunal made a provisional decision to discharge him from hospital on the following conditions:

1. He will reside at the placement and will not leave the premises unless accompanied and supervised at all times by an appropriate member of staff.
2. He will comply with all aspects of the care package which is devised for him by the NF organisation, and accept supervision and support from their staff.
3. He will accept psychiatric and social supervision from his community responsible clinician.
4. He will refrain from taking any alcohol and submit to any routine testing which may be required of him.

All agreed that this amounted to a deprivation of liberty. The placement was not a care home or hospital and so would require the authorisation of the Court of Protection. The main issue was whether it was lawful for a first-tier tribunal ('FTT') to discharge KC in such circumstances.

MHA protective conditions: MCA/DoLS/MHA interface

Having analysed the legislation, Charles J set out an important aspect of the interface insofar as the relationship between the various statutory decision makers was concerned:

> *"62. In my view the points made in the last two paragraphs confirm that:*
>
> *(1) the Court of Protection and the DOLS decision makers are ill equipped to make and should not make decisions on the arrangements and thus the protective conditions required to provide appropriate protection to the public and the patient as and when the patient moves from hospital into the community,*
>
> *(2) the statutory responsibility for making the decision on what the protective conditions should be is placed on the MHA decision maker (and so the Secretary of State or the FTT), and so*
>
> *(3) the decision under the MHA on what the protective conditions should be limits the choices available to the Court of Protection or the DOLS decision makers, with the result that*

(4) the Court of Protection and the DOLS decision makers have to determine whether a regime of care, supervision and control that includes the protective conditions is in the patient's best interests and in doing so they cannot choose a regime that does not include the protective and other conditions decided on by the MHA decision maker (see paragraph 36 hereof).

63. An alternative route to the same result is that it would be a waste of time and money for the Court of Protection and the DOLS decision makers to consider the care arrangements for a conditionally discharged restricted patient without knowing what the protective conditions decided on by the MHA decision maker are because the patient will not be, and indeed should not be, discharged into any care arrangements that do not include them.

64. Conclusion. The FTT (and the Secretary of State) cannot lawfully pass responsibility for deciding what the protective conditions are to be to the Court of Protection or the DOLS decision makers. This is so even though breach of the statutory duty created by s. 73(4)(b) of the MHA does not of itself trigger a recall to hospital.

117. … the Court of Protection or the DOLS decision maker could refuse to authorise any such placement and if that happened the provider would be likely to refuse to continue to provide it.

118. If that was to happen the Secretary of State could vary the conditions or recall the restricted patient or, subject to timing the restricted patient would have the right to make an application to the FTT under s. 75 of the MHA…"

Those lacking capacity to consent to their confinement

Charles J confirmed that "*A restricted patient who is conditionally discharged is not ineligible to be deprived of his liberty by the MCA and so if the implementation of the conditions selected by the MHA decision maker would result in a deprivation of liberty it can be authorised under the MCA by the Court of Protection or under the DOLS (provided of course that the relevant tests and assessments are satisfied)*." (para 113).

Those with capacity who consent

In *RB*, the Upper Tribunal's view was that the patient could not validly consent to his deprivation of liberty because it was not "free and unfettered" and "*consent to alternative conditions of his detention regime is not the same as his consent to the existence of the regime itself*". All parties in the present case agreed that this conclusion was obiter (para 46). This is important because the Court of Appeal's subsequent reasoning assumed that *RB* had capacity but could not give a valid consent.

Charles J provides obiter comments on these obiter comments. He fundamentally disagrees with the approach to consent and provides detailed reasons (para 124-133). His Lordship makes the crucial point "*the existence of only unpleasant choices does not prevent the individual patient having the right to choose or the Court of Protection from choosing on his behalf*" (para 130). At the same time, one must "*be alive to the possibility that an expression of consent may not be "real", but if real consent is given to the relevant protective conditions there will be no deprivation of liberty under or in breach of Article 5. Given that many patients are legally represented before the FTT by panel solicitors, if a represented patient gives consent after discussing the matter with his lawyers then the FTT can usually be reassured that the consent is real*" (para 132). His Lordship also considers the risk of

such a patient withdrawing their consent (para 134-139).

Timing of DoL authorisations

His Lordship held that:

> *"114. A standard authorisation under the DOLS can provide for it to come into force at a time after the time at which it is given (see paragraph 63 of Schedule A1 to the MCA). Also, in my view the Court of Protection can approve a care plan and authorise any deprivation of liberty it would create from a date in the future (i.e. when it comes into effect)."*

Conclusions

The conclusions of this detailed judgment can be found at paragraph 141:

> *"2. The FTT has power to impose (and so direct a conditional discharge on) conditions that when implemented will, on an objective assessment, give rise to a deprivation of liberty that is lawful because it has been authorised by the Court of Protection under the MCA or pursuant to the DOLS contained in the MCA (the MCA authorisations) and so complies with Article 5.*
>
> *3. The FTT should consider and generally should include in the protective conditions it imposes an ability to apply to it for a variation or discharge of them on the basis of a material change in circumstances (a) if a variation or discharge is refused by the Secretary of State or the FTT agrees to consider the application, and (b) if the FTT is invited to consider such an application by the Court of Protection (or a DOLS decision maker).*
>
> *4. The MCA authorisations can only be given if the relevant restricted patient lacks capacity to consent to the relevant conditions and is not ineligible to be deprived of his or her liberty by the MCA. Provided that the terms and conditions that give rise to the deprivation of liberty do not conflict with conditions the FTT have decided are necessary and have identified the restricted patient will not be ineligible and such authorisations can be given under the MCA applying the tests it sets out.*
>
> *5. Both of the MCA authorisations can be given to come into effect at a future date or on a future event but the MCA decision maker needs to know the conditions (including those that when implemented will objectively give rise to a deprivation of liberty) that the FTT considers necessary to satisfy the tests under the MHA, before the MCA decision maker can properly make the relevant MCA decision.*
>
> *6. So, the FTT needs to identify what conditions it considers need to be in place as and when the direction for the conditional discharge of the restricted patient takes effect so that the MCA decision maker knows what they are when applying the MCA tests.*
>
> *7. The FTT will need to be satisfied that the proposed placement on the relevant conditions (and so the relevant care plan) is sufficiently defined and an available option in practice and if it is not when it will be so available (see KD v A Borough Council, the Department of Health and Others [2015] UKUT 0251 (AAC) at paragraph 68).*
>
> *8. The parties will therefore need to provide the necessary evidence on this and any other factors that will need to be taken into account by the FTT*
>
> *9. The FTT should apply the guidance given by Upper Tribunal Judge Jacobs in DC v Nottinghamshire Healthcare NHS Trust and the Secretary of State for Justice [2012]*

> *UKUT 92 (AAC) on when the FTI should adjourn, make a decision under s. 73(7) of the MHA or a provisional decision in reliance on R (H) v SSHD [2003] QB 320 and [2004] 2 AC 253).*
> *10. The Court of Protection and the DOLS decision makers cannot override the conditions identified by the FTT and so can only choose between alternatives that include them.*"

Comment

This is a very important decision as it significantly limits the damage done by the controversial *RB* decision. It is entirely possible for a person lacking capacity as to residence/care to be given a conditional discharge from detention under the MHA 1983 if the conditions amount to an objective deprivation of their liberty, so long as that deprivation of liberty is authorised in advance either by the Court of Protection (for supported living placements etc) or DoLS (care homes or hospitals). The MHA and the MCA can therefore work in parallel, achieving different purposes.

A degree of controversy is likely to continue, however, regarding those with capacity who consent to community confinement. This is because Charles J in *KC* disagrees with Collins J in *R (G) v MHRT* [2004] EWHC 2193. We are convinced by the powerful reasoning of Charles J but inevitably the higher courts will need to resolve the issue on another day. The analysis around the meaning of "consent" in such coercive circumstances as mental health is particularly interesting and is equally relevant to patients' capacitous decisions to "voluntarily" be admitted to psychiatric hospitals. If they withdraw their consent, the holding powers under MHA s 5 are available. If conditionally discharged patients withdraw their consent, paras 137 to 138 of the KC judgment provide further food for thought.

The implications of the decision go beyond conditional discharges, and surely suggest that it is equally possible (as the wording of Sch 1A to the MCA, the DOLS Code of Practice and the 2015 MHA Code of Practice suggest) for section 17 leave to be given for a detained patient for them to receive treatment for a physical disorder in a general hospital in circumstances amounting to a deprivation of their liberty – i.e. that (as we made clear in our note) *A Local Health Board v AB* [2015] EWCOP 31 was wrongly decided.

Avoiding hypotheticals

DW v KW and LCC [2015] EWCOP 53 (DJ Bellamy)

Deprivation of liberty – Interface with public law

Summary

KW had resided in her current placement since 2010. Her sister challenged a standard DoLS authorisation, seeking a declaration that it was in KW's best interests to move from Rotherham to London. The local authority accepted that more appropriate accommodation should be sought for KW but, until an alternative had been identified, a best interests declaration could not be made. The expert social work view was that the placement met her assessed needs and recommended that it was in KW's best interests to remain there. However, the local authority should continue to explore alternative residential and supported living provisions within the Rotherham area.

The court accepted the local authority's submission that, without a geographic area being identified, it was impossible for the court to make

a declaration that, for example, it was in KW's best interests to live in London. This ran the risk of the court straying into making hypothetical decisions:

> *"57 … There is no available option currently before the court (or indeed the likelihood of a further option in the foreseeable future) such as to permit the court to consider such declaration. (Re MN [2015] EWCA, followed)."*

Accordingly, the MCA s21A challenge was dismissed although the court expressed the hope that significant lessons would be learnt by the history of failings by the local authority to fully understand and then act upon their duty under the MCA.

Comment

Although the issue did not arise on the facts of this case, it strikes us that there is a significant issue regarding the relationship between best interests and Article 5. If the State is not able or willing to find a less restrictive option, does the decision in *Re MN (Adult)* [2015] EWCA Civ 411 mean that best interests decision makers (including the Court of Protection) must sanction an overly intensive deprivation of liberty regime in the absence of an alternative? Or can *MN* be distinguished where the right to liberty is at stake? We hope to be able to report further on this soon. In the meantime, *DW* can be contrasted with *P v Surrey CC* where the alternative placement was less hypothetical.

Supervisory bodies: Detached authorisers or proactive investigators?

P v Surrey County Council and Surrey Downs CCG [2015] EWCOP 54

DoLS authorisations

Summary

P was 26 years old with severe learning disability and autistic spectrum disorder. His placement broke down and he was urgently moved into a care home on 5 September 2014. On 24 November 2014 an urgent authorisation was issued and, on 23 December 2014, a standard authorisation was granted by Surrey County Council expiring on 18 October 2015. His mother, acting as relevant person's representative and litigation friend, successfully challenged the authorisation and the court declared that it was in P's best interests to move to a Homes Caring for Autism placement after a period of transition.

The court held that P had been unlawfully deprived of liberty prior to the urgent authorisation and between its expiry and the commencement of the standard authorisation. Although the best interests assessor had recommended a maximum of 12 months' authorisation, HHJ Cushing was very critical of the supervisory body, naming its authoriser, in a number of respects:

With regards to the duration (emphasis added):

> *"19. What was, in my judgment, not open to the supervisory body was to do what it did, namely to receive un contradicted information from three separate sources that the care home was only suitable in the short term or for a short period and then proceed to grant the standard authorisation for a substantial period, i.e. 80% of the maximum permitted duration. Having regard to the period of time that P had been*

deprived of his liberty prior to the urgent authorisation, the ultimate decision on duration is drawn into sharper focus. Furthermore, in my judgment, in deciding on the duration of the standard authorisation, Mr Butler placed too much weight on the desirability of avoiding further assessments. There was no evidence that the assessment by the best interests assessor had caused P any actual distress."

In terms of pursuing a less restrictive alternative:

"27. I cannot speculate how long it would have taken for the alternative proposed by the relevant person's representative and P's other parent and his non-appointed advocate to be fully investigated, but, in my judgment, given it was recognised that BR, the relevant person's representative and his mother, was acting appropriately and in her son's interests, as is clear from the assessment, it was incumbent on the best interests assessor to investigate her proposal to see whether in fact it offered a less restrictive, more suitable environment in which P could be cared for and, to the extent necessary in his best interests, to have his liberty circumscribed. The alternatives had to be considered by the supervisory body as part of its determination independent of the best interests assessor's recommendation of the period for which the authorisation of deprivation of liberty would be granted.

…

29. In my judgment, the best interests assessor and/or the supervisor body failed to analyse the four necessary conditions sufficiently. Had they done so, they would have asked themselves three questions:

i) What harm, if any, may P suffer if his continued detention is authorised? The circumstances were that not less than two-to-one staffing ration was considered appropriate and necessary to limit self-harm.

ii) What placement or type of placement would be a more appropriate response?

iii) How long will it take to investigate the availability and suitability of a more proportionate response? Mr Butler said in his oral evidence that he had had several discussions with Mr Hill, as undoubtedly was necessary to enable him to approach his task correctly, but it was also necessary that he approach his task as a detached supervisor. It was evident that he did engage with the issue and brought his own judgement to the question, but in my judgment he also failed to ask the three questions. His reasons for authorising deprivation of liberty for 10 months did not relate to the qualifying requirements or the least restrictive principle.

…

32. The [supervisory body] had the duty to investigate whether a less restrictive alternative was available. It could not delegate its responsibility in this regard to the relevant person's representative or the non-appointed advocate. It already knew that the care home was not suitable in the medium or longer term because it had been told so by the social worker undertaking the best interests assessment. Being in possession of that knowledge, the obligation was on the first respondent to be proactive, and they failed in that obligation.

33. It was submitted on behalf of the [supervisory body] that it was not unreasonable to authorise P's deprivation of liberty for 10 months on the basis that

> *P's relevant person's representative or his family members could apply to discharge it. That is, in my judgment, the wrong approach. It is for the supervisory body to ascertain the least restrictive alternative, including the question of duration. It is not for the family to apply, although they have the opportunity to do so under the Act."*

Comment

This is an important decision in a number of respects. First, it illustrates the significance of the proactive nature of the supervisory body's role in the DoLS process. The legislation says that if all qualifying requirements are met an authorisation must be given. But determining whether those requirements are, in fact, met can never be a tick-boxing exercise where a vulnerable person's liberty is at stake. In the instant case, the authoriser had discussed the case with the best interests assessor but there was no contemporaneous record of this discussion. Note, therefore, that it would be prudent for authorisers to take such a note of that critical conversation if they do not do already. But even such a conversation would not have satisfied the judge, who went further by saying "*an alternative approach which would have been less restrictive of P's liberty would have been to call for further information before granting the standard authorisation at all or for the duration in question*". (para 18) Some might suggest that the "supervisory" body may in fact need to be more of an "investigatory" body.

What is particularly interesting in this case is that P was entitled to NHS continuing healthcare so the CCG commissioned his care and was responsible for the arrangements that amounted to a deprivation of his liberty. But the court emphasised that it was the local authority in its supervisory body role that had a duty to investigate whether a less restrictive alternative was available. To some extent this may overcome the fact that DoLS conditions only 'bite' on managing authorities when often the fault in finding alternatives lies elsewhere. Note, also, that the Judge emphasised that P's mother and non-appointed advocate were under no duty to investigate the cost or availability of a room at the Homes Caring for Autism facility. They had done all that they need to do by raising the existence of a more suitable alternative.

The second noteworthy feature of this case is its confirmation that deprivation of liberty is not a binary question – i.e. is it, or is it not, in P's best interests? Rather, it involves questions of degree: P may need to be deprived of liberty but not to this intensity. For example, two members of staff were following P wherever he went inside the care home. His opportunities for safe, positive interaction with his fellows were limited by the fact that the home's client group was older than him. The intensity of the deprivation can vary. Moreover, and thirdly:

> *"21 … the deprivation of liberty authorisation relates to the circumstances in which P is deprived of his liberty, not to his condition, i.e. it is situation specific, not person specific. It does not authorise P's detention in any other location, and so, on moving P to a different care facility, a fresh deprivation of liberty authorisation would have had to have been applied for."* (emphasis added)

These notions are not novel: but it does not hurt to be reminded.

What the judgment does not address is the question of which organ of the state was responsible for the unlawful deprivation of

liberty. Of course, as regards P himself, this was irrelevant – the obligation is on the state. The judgment implies that it was the local authority which breached P's rights under Article 5(1), but had a claim for compensation and/or damages in fact been pursued, some interesting arguments would no doubt have ensued as to the relative responsibility of the CCG and the LA.

Balancing best interests and amputations

Surrey and Sussex Healthcare NHS Trust v Ms AB [2015] EWCOP 50 (Keehan J)

Best interests - Amputation

Summary

The NHS Trust applied for the court for a declaration that an above the knee amputation was in a patient's best interests. By the time of the application there was a stark choice between the amputation proceeding quickly or the patient dying. The application was briefly adjourned in order for the Official Solicitor to instruct his own experts to advise on capacity and best interests.

Both The Trust's psychiatrist and the Official Solicitor's psychiatrist agreed that the patient suffered from a predominant persecutory delusional state which meant that she lacked capacity to take a decision about the need for amputation. She did not understand that the alternative to amputation was death. She believed that the doctors and nursing staff were responsible for the problems she had with her leg and that it would get better if she went home.

The judgment sets out a series of considerations in relation to whether amputation was in the patient's best interests (see paragraph 59(a) – (h)). The judge balanced the disadvantages with the advantages and concluded that in this case it was in the patient's best interests for the amputation to take place. He notes that he should only grant permission if he was satisfied that no other course would save the patient's life and avert her imminent death.

Summary

Although developing no new propositions, this is a useful case which sets out the relevant case law and a detailed balance sheet approach.

SMART at end of life

CWM Taf University v M [2015] EWHC 2533 (Fam) (Newton J)

Summary

F was born in 1948. From 1993 onwards, she had significant liver failure caused by chronic abuse of alcohol. She had been admitted to hospital on a number of occasions in 2000, 2001 and 2006. On 11th January 2007 she was found slumped across her bed apparently with concussive symptoms. She had suffered an acute and bilateral subdural haematoma. Over the next two days, whilst in hospital, there was a reduction in her level of consciousness. On 28th February 2007 F was transferred to a different hospital where she remained.

She has been assessed over a long period (8 years) as being in a vegetative state with no perception of her surroundings. She was not communicative, although she made moaning sounds and could blink her eyes (but these were considered to be entirely reflexive movements). In 2010 it was recorded by a nurse that F was in a persistent vegetative state, having had no

communication or interaction with family or care staff.

In 2013 a best interests meeting concluded unanimously that it was not in her best interests to undergo invasive surgery. The application to the court was triggered, by an anxiety about a PEG feeding tube. At the time of the application a temporary solution to the issue had been found.

An application was issued by the Trust on 25th February for a declaration under s.15 of the Mental Capacity Act that F lacked capacity to make decisions about her clinically assisted nutrition and hydration CANH), that it was not in F's best interests for CANH to be continued and that it was lawful and in her best interests for CANH to be withdrawn. The application was supported by F's family. The Official Solicitor was appointed by the court to act as litigation friend of F.

In support of the application the treating clinicians had provided reports that confirmed that in their view F had been in a vegetative state for 8 years with no prospect of recovery. F had been observed routinely and informally by staff and formally using the WHIM procedure. Professor Wade had been asked to provide a report for the Trust and he had agreed with the treating clinicians assessment that F was in a permanent vegetative state (PVS) and was of the view that undertaking further assessments of the level of awareness *'would delay matters and no realistic prospect of identifying awareness.'* His report supported the Trust's application.

During the course of carrying out his enquiries the Official Solicitor appears to have been concerned that there were unusual entries in F's medical records 2007 between April and December that may have been evidence of some signs of awareness - the last unusual entry being 31st January 2010. He instructed Mr Badwan to provide a further report. Mr Badwan concluded that notwithstanding the unusual entries in 2007 between April and December the records were consistent over five years and that, on the balance of probability, F has been in a vegetative for at least five years, and very probably eight. He agreed with Professor Wade that further treatment was futile and would not result in any improvement of the patient' s level of awareness or clinical status.

The judge found that F was in a permanent vegetative state and had been so for five years and probably eight and that F would neither improve nor would she recover awareness. The treating doctors, clinicians, the independent experts, family members and the Official Solicitor acting for F agreed that it was in the best interests of F for CANH to be withdrawn. The judge approved the withdrawal of the CANH from F and made the declarations sought.

During the course of giving judgment Mr Justice Newton expressed concern that the Royal College of Physicians' National Clinical Guidelines on Prolonged Disorders of Consciousness (2013) had not been strictly complied with and that the patient's diagnosis had not been clear before the application was made. In the judge's view structured assessment tools should ordinarily always be used by those applying to the court in such cases and failure to do so would result in summary rejection of the applications:

> *"14…The Court must examine therefore diagnosis with some considerable degree of care. In essence, without setting out the entirety of the guidance which is substantial, it seems to me that the guidelines which are set out in them*

ordinarily should always be followed by applicants in circumstances such as this. Indeed, the guidance itself sets out that it is an area where the tools which are set out extensively within them are ones which should be precursors to applications being made. There are good examples, but I preface it all by the fact that it is evidently of the utmost – indeed the most vital – importance that every step should always be taken to diagnose a patient' s true condition before the application is made. If that does not occur what has happened in this and indeed in other cases in my experience is that there is inevitably delay, uncertainty and anxiety, as well as increased cost."

"16… Those assessments are there for good reason. Authorities must understand that in future without that evidence, it is likely that the application may be subject to summary rejection. The guidance makes it clear that structured assessment tools should ordinarily always be used for assisting the court, and those who apply to it. It refers to three main assessment processes: The first is the Wessex Head Injury Matrix ("WHIM"); second, is the Sensory Modality Assessment and Rehabilitation Recovery Scale as revised ("CRSR"). The guidance recommends that the use of one or more of those three assessments should be used as instruments of formal structured assessment over time in such applications. Though it is not necessarily prescriptive it does recommend, for example, that if there were to be a WHIM assessment that should be carried out on a specific number of occasions (in fact ten) and over an extended period over a number of weeks. In relation to the SMART assessment, it is a detailed assessment. It is developed to detect awareness, functional and communication capacity. The SMART assessments are ones which need to be carried out by suitably qualified persons. They are very sophisticated tools of invaluable insight and assistance. The court expects a high level of certainty with respect to diagnosis, because as earlier cases have shown it is easy to reach a diagnosis which in fact is subsequently shown to be incorrect (some 40% I am told). The court can only reach a safe conclusion once it has regard to the clinical evaluation and having regard to the WHIM or the CRSR or probably better still a SMART if that is necessary in the particular case. If there is any degree of uncertainty or disagreement on the level of responsiveness then the SMART test, as the court's experience shows, is essential to resolve it.'

' 17…Ideally the guidance suggests that at least two of those assessments should be carried out (the WHIM, the CRSR or the SMART) in support of any application made to the Court of Protection. Additionally, where assessments are to be used in support of an application to the court to withdraw treatment as life sustaining therapy or treatment, a SMART assessment should also be used. Here no SMART assessment has been carried out. Here, fortunately from the experts familiar to the court, it is considered that the equivalent of a CRSR assessment "can be properly deduced and inferred" from the length of time. There were WHIM assessments (although they were in fact not carried out in compliance with the guidance as suggested)."

Mr Justice Newton was prepared to make the declarations sought because Mr Badwan had supported the other evidence in the case.

> *"24…The advices of Dr. Bagwan, which are always helpful and to the point, are clear and support the other evidence in this case; the court is therefore prepared to make the declarations as sought. The guidelines are set out for good reason. It is not just that it is good practice and a gold standard that should be adhered to, but because the court is in fact being asked to sanction a course of conduct which, If granted, almost always leads to the death of a patient. The law recognises the overriding importance of the sanctity of life. Therefore the guidance must be complied with in relation to all such applications so that the court can deal with the matter swiftly, humanely and justly."*

Comment

This is an extempore judgment given by Mr Justice Newton. This is the third case which Mr Justice Newton has sat on recently where he has had cause to comment on the failure of the applicant to comply with the RCP Guidelines or to provide adequate evidence and analysis to enable the court to carry out the necessary analysis and balance (see *St George's Healthcare NHS Trust v P &Q* [2015] EWCOP 42(Newton J) and Comment at http://www.39essex.com/content/wp-content/uploads/2015/07/MC-Newsletter-July-2015-HWDOL.pdf).

The RCP Guidelines set out to provide a more consistent approach to diagnosis and management of patients with prolonged disorders of consciousness (PDOC) including the vegetative state and minimally conscious state. The Guidance covers the definitions and criteria for diagnosis of vegetative and minimally conscious state, the assessment, diagnosis and monitoring of patients in PDOC, and care pathways for acute and long term management of patients in PDOC. It attempts to set out for clinicians, service providers and commissioners what members of the working party considered best practice within the existing legal framework. (https://www.rcplondon.ac.uk/sites/default/files/pdoc_web_final_navigable_2014.pdf)

The court quite rightly requires a high level of certainty concerning the diagnosis of the patient's condition because, as Mr Justice Newton says, if the diagnosis is PVS, the court is being asked to sanction a course which will lead to the patient's death. The Court therefore requires a firm diagnosis to have been made in accordance with the RCP Guidance before an application is made to the Court.

It appears from the reported cases that the Court interprets the Guidelines as requiring a SMART assessment to be carried out in almost all cases that come before the court. This has consequences in terms of delay and cost and it is not always appropriate. As Professor Wade comments in his report:

> *"22 (2) 'Although the guidelines had indicated the need for a SMART assessment it was justified in this case stating there must always be an element of clinical judgement, pragmatism and interpreting and in using the guidelines to the specific case in hand. He additionally made the point that the guidance had focused very much on people in early stages of recovery and, without in any way wishing to be glib, effectively the guidance is just that guidance."*

And later

> *"21 (6) As to the suggestion that a SMART assessment should be undertaken now, this assessment has no pre-eminent superiority or position and indeed increasingly uses evidence taken from nursing staff and family as an important part of the assessment. Clinically, there is no justification for the expenditure of considerable resources or time on undertaking this assessment in addition to the existing evidence."*

If there is some doubt or ambiguity in the Guidance as to when a SMART assessment is appropriate, then supplementary Guidance should to be given to clarify when it is appropriate. It is essential that the Guidance is clear on this point and it is equally essential for the RCP to ensure that those carrying out the assessments using the structured assessment tools set out in the Guidance have received sufficient training and are sufficiently experienced in their use.

Beverley Taylor

Guest Article – Dr Gareth Owen

Assessing mental capacity in brain injury – yes it's hard but that's not a reason to avoid it.

The recent House of Lords Select Committee on the MCA had a very large number of submissions relating to brain injury. Many submissions reported major concerns about financial and welfare vulnerabilities in this group. Submissions also spoke to the difficulties of assessing mental capacity. Impulsivity in decision-making and problems with insight were referred to.

With this level of practical concern together with our decade (now decades) of the brain – one might be forgiven for assuming a large research industry on the topic of decision-making capacity and brain injury. Well, in fact, the literature is tiny and provides little to guide practitioners in assessments. If the difficulty of an area is proportional to the research that has not been done on it then it really is no surprise that we are struggling with brain injury in mental capacity policy and practice.

The area is difficult to research. That is true but it was a good reason to persuade the Wellcome Trust to fund an in depth interview study that would allow a return to first principles: to talk carefully to people with experience of the disability itself and try to hear what they are telling us.

I spoke to the most challenging group – the so-called "Frontal Lobe syndrome". Here, it is often said, practitioners can get it wrong by taking what is said at interview at face value. Instead, so the folk knowledge goes, you are better advised to look at what a person does - and does impulsively (or unwisely). The problem of course is section 1(4) of the MCA: "A person is not to be treated as unable to make a decision merely because he makes an unwise decision."

The results of the interview study are here and free to read for all practitioners with brain injury clients (see note). Interview data revealed that people with severe frontal brain injuries, where others have expressed concern about their decisions, can show awareness of disability and can think about their psychological states (hence the difficulty of these mental capacity assessments). But, go a little deeper, and one can see how the awareness of disability may not be

effectively integrated into their decision-making. Without this *online* awareness the ability to appreciate or use and weigh information in the process of deciding financial or welfare matters can be threatened. We give some advice for practically incorporating these considerations within assessments of Mental Capacity.

Practitioners should shout loudly when they are expected to make important assessments with a poor research base upon which to do so. I hope this study helps practitioners who are tasked to perform these assessments but it would be gratifying to see the study stimulate more research investment. The concerns expressed to Parliament require society's *online* awareness.

Note: For those wanting a longer read that also addresses the question of "overlap" between people with brain injury and people who are impulsive (all of us) another paper is upcoming here.

Dr Gareth Owen
Clinical Senior Lecturer in Mental Health, Ethics and Law
Institute of Psychiatry, Psychology and Neuroscience
King's College London

DoH, MCA 2005 – Valuing every voice, respecting every right: One Year On

This document is an update on the progress made by the Department to address the concerns of the last year's House of Lords Select Committee report. It provides a useful summary of what is happening across the country and its hyperlinks to resources you may find particularly useful.

Law Commission's DoLS Impact Assessment

The Law Commission has published its estimate of the costs of the options that exist in light of its proposals:

Option 1 (Fully fund DoLS) - £1,584,971,094 (best estimate), with a present value over ten years of £13,181,579,036 (best estimate) and transitional costs of £2,564,274.

Option 2 (New protective care) - £529,534,670 (best estimate), with a present value over ten years of £4,403,930,855 (best estimate) and transitional costs of £3,886,420.

Option 3 (New protective care without automatic tribunal review) - £209,713,321 (best estimate), with a present value over ten years of £1,744,102,921 (best estimate) and transitional costs of £3,886,420.

We remind people also that the consultation is still open, and will be until 2 November 2015. Do please make sure that you have your say.

DoLS improvement tool

This improvement tool has been has been developed throughout 2014/15 by the sector, with funding from the Department of Health and support from the Local Government Association (LGA) and the Association of Directors of Social Services (ADASS). The key areas of focus have been used in a number of peer challenges and as a means of self-assessment. The characteristics of a well-performing and ambitious organisation are also described.

Putting the MCA principles at the heart of adult social care commissioning: A guide for compliance

Commissioners are likely to be greatly assisted by this guide which has been jointly published by ADASS and the LGA to support the commissioning process to apply the MCA.

Voiceability's 'Guidance to support advocates in challenging decisions or actions with or on behalf of individuals'

This is an essential guide for anyone acting on behalf of an incapacitated or vulnerable person. It is particularly valuable for IMCAs, RPRs, litigation friends and family members seeking to ensure that a person's voice is heard. Written in helpful plain English, the guide offers practical tips and advice to support personal choice, and ensures that issues are raised appropriately and sensitively in a variety of different contexts, both a formal and informal. It covers important topics such as bringing legal challenges under the Mental Capacity Act 2005, Mental Health Act 1983 and the Care Act 2014.

The full guidance can be found here.

Dementia Law Clinic

Neil has set up a clinic to provide **free** legal and nursing advice on all matters relating to dementia. It assists those with dementia, their families, and carers with issues like LPAs, mental capacity or best interests disputes, DoLS, welfare services and NHS continuing healthcare assessments, advance decisions. It is a collaboration between the University of Manchester and the mental health charity, Making Space. One-to-one legal consultations with supervised students via Skype are available and face-to-face consultations with a Consultant Admiral Nurse are available on the Making Space site. The project is starting its life in Warrington but hopes to expand nationwide in due course. So if you or someone you know needs help (whether in Warrington or elsewhere), contact free.legal@manchester.ac.uk or 0161 275 7976 or rachel.yates@makingspace.co.uk.

And, yes, it is entirely free!

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Conferences at which editors/contributors are speaking

The Mental Capacity Act 2005 – Ten Years On

Alex will be delivering his paper, '(Re)presenting P', and Neil will be delivering, 'The (not so?) great confinement' at this major conference hosted by the University of Liverpool on 9 and 10 September 2015. For further details and to book, see here.

Court of Protection Practitioners' Association National Conference

Alex will be speaking at COPPA's national conference on 24 September 2015. For further details, and to book, see here.

Queen Mary University

Jill will be a discussant at the Rethinking Deprivation of Liberty in a Health and Social Care Context Conference at Queen Mary University of London on 30 September 2015.

Bromley Safeguarding Adults Board 2015 Conference

Annabel is speaking at this conference on 6 October 2015 about the role of the Court of Protection.

Jordan's Court of Protection Conference

Alex will be delivering, 'More Presumptions Please? Wishes, feelings and best interests decision-making' at Jordan's Annual Court of Protection Conference on 13 October 2015. For further details, and to book, see here.

Seventh Annual Review of the Mental Capacity Act 2005

Neil and Alex will both be speaking (along with Fenella Morris QC) at this annual fixture in York on 15 October 2015, under the auspices of Switalskis solicitors. For further details, and to book, see here.

Taking Stock

Neil will be speaking on 16 October 2015 at this annual fixture, arranged by Cardiff Law School and the University of Manchester, at the Royal Northern College of Music. For further details, and to book, see here.

Community Care Live

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Victoria Butler-Cole
Neil Allen
Annabel Lee
Anna Bicarregui
Simon Edwards (P&A)

Guest contributor

Beverley Taylor

Scottish contributors

Adrian Ward
Jill Stavert

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 Mind in return for postings for English and Welsh events. For Scottish events, we are inviting donations to Alzheimer Scotland Action on Dementia.

Annabel is presenting a legal masterclass on the Mental Capacity Act 2005 and Alex will be on a panel discussion on deprivation of liberty at Community Care Live 2015 in London on 3-4 November 2015. For further details, and to register for this event, see http://www.communitycare.co.uk/live/

Other conferences and training events of interest

Our friends Empowerment Matters are hosting an IMCA conference on 12 November at the Smart Aston Court Hotel in Derby, entitled 'Interesting Times – developments for IMCAs in practice and law.' For more details and to book, see here.

The charity, Living Well Dying Well, is holding its first annual national conference, 'Doing Death Differently' in London on 7 November 2015. For more details and to book, see here.

Peter Edwards Law have released details of their autumn training courses on matters MCA and Care Act related. The full details of (very well received) courses can be found here.

Chambers Details

Our next Newsletter will be out in early 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 Newsletter in the future please contact marketing@39essex.com.

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THE QUEEN'S AWARDS FOR ENTERPRISE INTERNATIONAL TRADE 2013

Alex Ruck Keene
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Alex been recommended as a leading expert in the field of mental capacity law for several years, appearing in cases involving the MCA 2005 at all levels up to and including the Supreme Court. He also writes extensively about mental capacity law and policy, is an Honorary Research Lecturer at the University of Manchester, and the creator of the website www.mentalcapacitylawandpolicy.org.uk. To view full CV click here.

Victoria Butler-Cole 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 contributing editor to Clayton and Tomlinson 'The Law of Human Rights', a contributor to 'Assessment of Mental Capacity' (Law Society/BMA 2009), and a contributor to Heywood and Massey Court of Protection Practice (Sweet and Maxwell). To view full CV click here.

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Neil has particular interests in human rights, mental health and incapacity law and mainly practises in the Court of Protection. Also a lecturer at Manchester University, he teaches students in these fields, trains health, social care and legal professionals, and regularly publishes in academic books and journals. Neil is the Deputy Director of the University's Legal Advice Centre and a Trustee for a mental health charity. To view full CV click here.

Annabel Lee annabel.lee@39essex.com

Annabel appears frequently in the Court of Protection and is instructed on behalf of the Official Solicitor, individuals, local authorities, care homes and health authorities. Her COP practice covers the full range of issues in health and welfare, property and affairs, and medical treatment cases, with particular expertise in international cross-border matters. Annabel also practices in the related fields of human rights and community care. To view full CV click here.

Anna Bicarregui anna.bicarregui@39essex.com

Anna regularly appears in the Court of Protection in cases concerning welfare issues and property and financial affairs. She acts on behalf of local authorities, family members and the Official Solicitor. Anna also provides training in COP related matters. Anna also practices in the fields of education and employment where she has particular expertise in discrimination/human rights issues. To view 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.

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Adrian is a practising Scottish solicitor, a partner of T C Young LLP, who has specialised in and developed adult incapacity law in Scotland over more than three decades. Described in a court judgment as: "*the acknowledged master of this subject, and the person who has done more than any other practitioner in Scotland to advance this area of law*," he is author of *Adult Incapacity*, *Adults with Incapacity Legislation* and several other books on the subject. To view full CV click here.

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Jill Stavert is Professor of Law within the School of Accounting, Financial Services and Law at Edinburgh Napier University and Director of its Centre for Mental Health and Incapacity Law Rights and Policy. Jill is also a member of the Law Society for Scotland's Mental Health and Disability Sub-Committee, Alzheimer Scotland's Human Rights and Public Policy Committee, the South East Scotland Research Ethics Committee 1, and the Scottish Human Rights Commission Research Advisory Group. She has undertaken work for the Mental Welfare Commission for Scotland (including its 2013 updated guidance on Deprivation of Liberty) and is a voluntary legal officer for the Scottish Association for Mental Health. To view full CV click here.