MENTAL CAPACITY REPORT: HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

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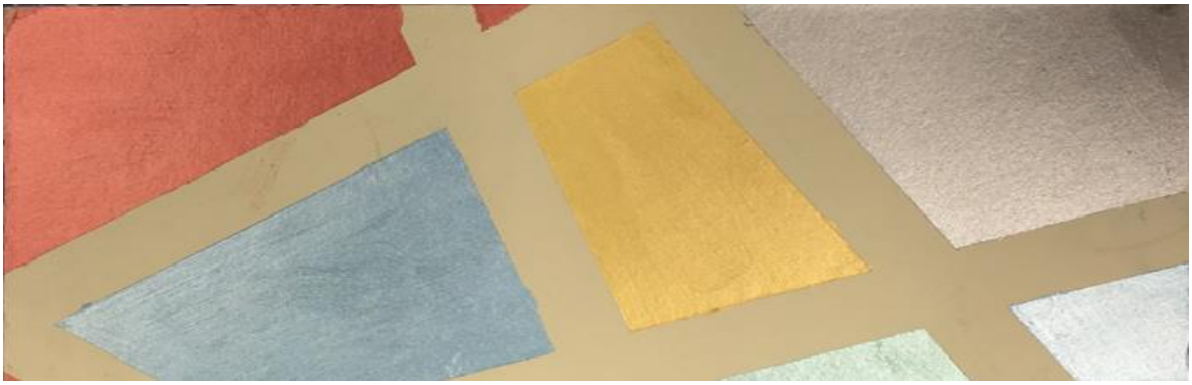

Welcome to the December 2022 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: Collection of sperm where a person is on the edge of brain death; public protection and deprivations of liberty; and many newly-reported 'part 2' judgments tell us what happened next.

(2) In the Property and Affairs Report: Lasting Powers of Attorney bill is published; and deprivations of assets.

(3) In the Practice and Procedure Report: Cross-border placements; and amendments to the Court of Protection Rules.

(4) In the Wider Context Report: 'A gloriously ordinary life'; Crowter in the Court of Appeal; consent to adoption and capacity; prolonged disorders of consciousness; and a Strasbourg update.

(5) In the Scotland Report: A new checklist for cross-border placements; a decision to close day centres is reduced; and model laws for advance choices.

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.

Contents

Collection and storage of sperm from a person on the edge of a brain death diagnosis

Re X (Catastrophic Injury: Collection and Storage of Sperm) [2022] EWCOP 48 (16 November 2022)(Poole J)[1]

Best interests – medical treatment

Summary

This judgment related to a matter heard on an urgent basis on 3 November, with a full judgment reported on 16 November. It related to X, a 22-year-old university student, who had been fit and healthy before tragically suffering a catastrophic stroke of unknown cause on 24 October 2022. He was treated first near his home in South West England, and was then transferred to Kings College Hospital. He underwent surgery to help decompress his brain, but sadly was unresponsive from 27 October 2022 onwards. With the consent of his parents, he removed from life support on 8 November 2022 after doctors concluded that he was brain stem dead.

The application was brought by X's parents on an urgent basis on 3 November. By that time, the medical evidence was that there was *'virtually no prospect he will recover. He may be assessed as being brain stem dead within the next 24 hours.'* [2] X's parents sought an order from the court that *'it would be lawful for a doctor to retrieve X's gametes and lawful for those gametes to be stored both before and after his death on the signing of relevant consents.'* [2] His parents also sought authority to give consent on behalf of X. It was clear from the application that X's parents hoped to be able to use X's sperm at some point in the future so that his biological children could be conceived. The likelihood of the pending brain stem death diagnosis led to the urgency in the case, as there was no application to collect sperm posthumously.

The application was opposed by the Official Solicitor on behalf of X; the treating Trust assisted the court, but took a neutral position on the application. The Human Fertilisation and Embryology Authority did not appear, but made written submissions opposing the application. There was no dispute as to X's lack of capacity in the case.

X's parents argued that he had a clear wish to have his own children; he had spoken about it many times with his family, friends and girlfriend, and had thought about keeping possessions from childhood to pass along to his children. X's parents stated that his girlfriend wished to carry his child. His parents were cognisant of the

[1] Stephanie having been involved in this case, she has not contributed to the report.

urgent nature of the application, and sought a stepwise approach in which an order would be made solely for the extraction and storage of sperm, and the court could further consider on a less pressured basis how that might be used in the future.

The court expressed some hesitation at how much could be read into X's expressed wishes and feelings:

> *11. There is no advance decision in this case nor is there any evidence as to X's views and beliefs as they might have been relevant to a decision such as this. It is one thing to have a consistent and heartfelt desire to be a living, caring father. It is quite another thing to wish to have one's sperm collected and stored when unconscious and dying, with a view to the possibility of the sperm being used for conception after one's death, and without having expressed any view when living about how the sperm should be used…*
>
> *25… The application before me is brought by X's parents not his life partner. X has a girlfriend, but I have no evidence of any discussions he has had with her or others about whether he would want his sperm to be collected and stored in the event of his becoming unconscious with a very limited life expectancy. There is no evidence that X and his girlfriend were in the process of trying to conceive nor that they have tried in the past. There is no evidence of the nature of their relationship. X may have wanted one day to have children, but that is not the same as wishing for his sperm to be collected and stored when unconscious and dying. I cannot know what his wishes and feelings about that decision would be…*

The court considered Schedule 3 of the Human Fertilisation and Embryology Act 1990, which *'deals with consent to the use or storage of gametes.'* [14] The court noted that none of the conditions of the consent which are required to the storage of gametes (which require consent to be given in writing by either the person, or a person signing 'at the direction of' a person physically unable to sign, in the presence of the person unable to sign and witness; consents should also be given after a suitable opportunity for counselling and the provision of information to the person giving consent) could be met in this case.

The court was aware that if the application was not granted out of hours, it may be overtaken by events (where it was considered possible that X could pass away at any time). However, the court was cautious that the urgency of the case should not dictate the outcome:

> *28. If I declared in this case that it was lawful to collect and store X's sperm without any evidence that that is what he would have chosen for himself, then it would follow that the same declarations might be made in many other cases where parents or other relatives wanted their loved one's gametes to be collected and stored with a view to decisions about their use being made at a later stage. I have no evidence as to the practice in hospitals in England and Wales in such circumstances but it would be unlawful under the 1990 Act to store collected sperm without the consents referred to earlier in this judgment. Here, the Trust has not agreed to the procedure and is concerned that without X's actual consent it would be acting unlawfully to collect and store his sperm. If the Court of Protection were routinely to authorise the collection and storage of gametes in cases where there is no or little evidence that the incapacitous, dying person would have consented, then it would undermine the regulatory provisions within the 1990 Act which require actual consent.*

It was held that the Court of Protection did have

the power to grant the consent for the retrieval and storage of gametes. However, in this case, there was no strong evidence that this is what X would have actually wanted. The process of collecting sperm would have involved the surgical removal of X's testicle, and would have been an extremely invasive procedure. The court concluded:

> *33… There is no evidence before the court to persuade me that X would have wished for his sperm to be collected and stored in his present circumstances. I cannot accept that there should be a default position that sperm should be collected and stored in such circumstances as being generally in a person's best interests. I cannot conclude that making the declarations as sought would be in accordance with X's wishes, values or beliefs. The process of collecting X's sperm is physically invasive and there is no evidence that X would have consented to it or would have agreed to its purpose…*

Comment

The court's decision in this case was careful and well-reasoned, particularly in its nuanced analysis of what should be read into X's stated wishes and feelings. The decision is also interest in the court's general finding as a matter of principle that a court could give the relevant consents required under Schedule 3, though the consent may only be given where a person has been given information and counselling in relation to the relevant decision. As we identified in relation to *Y v A Healthcare Trust* [2018] EWCOP 18, this does give rise to two difficulties.

The first is that it is difficult to understand from the judgment itself how the court came to the view that the s.16 MCA 2005 order would comply with the terms of paragraph 1(2) of Schedule 3 insofar as that paragraph requires the consent given on behalf of Z to be at his "direction." There is no doubt that the court was of the view that Z himself would have consented to the storage of the sperm had he been able to. Paragraph 1(2) however seems to demand more than simply identifying what the incapacitated person would have chosen to do. It requires the incapacitated person (here, Z) to direct that the third party gives the consent on his behalf. Given the circumstances of Z's loss of capacity (sudden and unpredicted) there would have been no opportunity for such direction.

The second – linked – problem is that s.27(2)(i) MCA 2005 specifically prohibits anyone, including the court, from "giving a consent under the Human Fertilisation and Embryology Act 2008." It may have been that the court considered that it would not be consenting on X's behalf within the terms of the HFEA 1990, but directing (on X's behalf) another person to execute that consent. That undoubtedly represents a purposive (some might say strained) reading of the wording 'consent' in s.27(2)(i) MCA 2005, which on its face and in its context is addressed to the material giving of consent (i.e. the fact of consenting to storage) rather than the technical execution of the written consent document.

George Orwell and best interests – DoLS and public protection under the spotlight

DY v A City Council & An NHS Trust [2022] EWCOP 51 (6 December 2022)(Judd J)

Article 5 ECHR – DOLS Authorisations

Summary

In *DY v A City Council & An NHS Trust* [2022] EWCOP 51, Judd J has tackled head on the perennially difficult question of whether and how DoLS can provide for public protection. The case concerned DY, a young man in his 20s, who had previously been detained under the MHA 1983.

In 2017 he had pleaded guilty to two offences of sexual assault of a girl aged under 13, and received a 26 month Youth Rehabilitation Order. He was placed on the sex offender's Register for 5 years with a concurrent Sexual Harm Prevention Order with a residence requirement and curfew. He was prohibited from having contact with children under 16 save as was inadvertent and not reasonably avoidable in the course of daily life. He was referred to MAPPA and has been assessed as a category 1 offender requiring level 2 management. He was still considered a high risk to children and known adults. To his mother he was considered to pose a risk of violence and sexual assault. To children he was considered to pose a risk of sexual assault. DY was diagnosed with Autistic Spectrum Disorder in 2011, and also with Generalised Anxiety Disorder and Paedophilia. He moved to a care home in 2019, assessed as lacking capacity to make decisions about accommodation and care. He was subject to a DoLS authorisation, always accompanied by male staff when he went into the community, was checked four times a night due to his sexualised behaviour and self harm, and was not allowed to enter bedrooms other than his own in his placement.

DY challenged the DoLS authorisation both on the basis that he did not lack capacity for purposes of Schedule A1, and also that the best interests requirement was not met.

Judd J considered the best interests challenge first, reminding herself that the requirement in paragraph 16 of Schedule A1 is (in our words) "best interests plus" – i.e. that is in the person's best interests, and necessary and proportionate to the risk of harm they would suffer. At paragraph 20, and in response to DY's challenge that the purpose of the DoLS authorisation was public protection, she made clear that:

> *Having heard and read the evidence and submissions on this point, I have come to the conclusion that the primary purpose of the care plan is to avoid harm to DY. There is no doubt that he poses a risk to the public, but it is also clear that it would be very harmful to DY himself were he to commit further offences. DY is a young person who is vulnerable and has engaged in self harming behaviour (albeit not recently). The social worker stated in her evidence that when DY becomes stressed and anxious that this leads to him ruminating and in turn puts him at risk of self harm. If he were to reoffend he would be very distressed, and engage in self loathing. There would also be the risk of retribution from the public. I agree with Lieven J in Birmingham City Council v SR; Lancashire County Council v JTA [2019] EWCOP 28 that it is a false dichotomy to conclude that the protection of P cannot also include protecting him from harming members of the public. As in that case, it is strongly in DY's best interests not to commit further offences, or place himself at risk of further criminal sanctions. In my judgment this falls squarely within the meaning of the qualifying requirement in paragraph 16 schedule A1, 'to prevent harm to the relevant person'. That this harm would come about by his harming others does not detract from this.*

However, she found that the capacity challenge succeeded, basing herself on the "clear, cogent and firm" evidence of the expert, Dr Ince:

> *34: When interviewed by Dr. Ince DY was honest about the risks he posed, and was able to express his fear of what would happen to him if he committed another offence. I agree with his conclusions that DY was not merely repeating what he had been told or saying what the interviewer wished to hear. I do not accept the respondents'*

> *submissions that Dr. Ince asked himself the wrong questions or relied too heavily on DY being able to describe the risk factors rather than being able to show what benefit his care and support offers him. It is very difficult for DY to demonstrate the benefit to him in circumstances where he has not experienced being without it (a situation he himself recognises). I reject the submission that Dr. Ince did not appear to consider the impact of the interplay between DY's paedophilic or paraphilic disorder, his anxiety and his autism, for he discussed and explained this at length in his evidence. DY has an impairment/disturbance of the mind or brain by reason of his ASD and accompanying anxiety, but Dr Ince does not accept the additional diagnosis of paraphilia is relevant in this context or that the fact that DY can make impulsive decisions regarding further offending is due to lack of capacity.*

Judd J made clear that she could:

> *35.* […] *entirely appreciate why the respondents in this case are so concerned, because there is a high risk that DY will reoffend if he is given the opportunity to do so. If he is allowed to make decisions for himself he could go out alone, and in doing so he could put others and himself at risk by acting impulsively and committing a sexual assault. Those responsible for his care are undoubtedly very worried about the effect upon him (and of course others too) were he to do this. Anyone responsible would be concerned about this, as I am myself. But Dr. Ince is right that any further offending is a matter for the Criminal Justice System. The current SHPO is an example of such risk management. The truth is that most sexual offenders and risky adults have capacity, and, like DY are not to be managed by a Deprivation of Liberty within the provisions of the Mental Capacity Act 2005.*

Comment

Putting aside the capacity challenge in this case, which was fact-specific (but illustrates the power of a good expert report), this case might be thought to illustrate the sometimes Orwellian mental gymnastics that are now required to hold two competing thoughts about best interests in one head. In the majority of cases, following *Aintree v James*, we are told to seek to put ourselves in the shoes of P, and to seek to place a very considerable weight upon their wishes and feelings. In cases such as the present, however, we are told to adopt a very different construction to enable public protection to be levered into the constraints of Schedule A1 (or the lesser implicit constraints upon the Court of Protection, which is only statutorily required to consider the standard best interests test, rather than "best interests plus," and could compatibly with Article 5 ECHR find that deprivation of liberty was necessary and proportionate to the risk of harm to others).

Some may think, as did the Law Commission did in its Mental Capacity and Deprivation of Liberty project, that requiring consideration of best interests means that assessors have to reach the "*somewhat artificial*[…]" conclusion that "*the person's own interests include not harming someone else and thereby, for instance, themselves becoming subject to some form of 'harm,' such as civil or criminal proceedings*" (Final Report, para 9.29). Responding to this, the Law Commission's draft Bill included an approach based upon the likelihood of either harm to the person or to others.

The Bill introduced to Parliament adopted the Law Commission's approach in that it did not include an express best interests element; it did not expressly refer to the potential for deprivation

of liberty to the authorised on the basis of risk of harm to others. However its provisions were drafted broadly enough to enable this to take place, as paragraph 16 of Sch.AA1 simply provided that arrangements had to be necessary and proportionate. This paragraph was the subject of considerable debate and criticism during the passage of the Bill and at Report Stage in the House of Lords, Baroness Barker tabled an amendment specifically tying necessity to prevent harm to the person, so as "*to make it clear that it is harm to the person, and that the proportionality relates to the potential harm to that person if they are not deprived of their liberty*" *Hansard* (House of Lords), 21 November 2018, Vol.794 (Col.284). The Government resisted the amendment but was defeated in a vote (202-188). It did not seek to reverse this position subsequently.

In light of the fact that the position was expressly debated in Parliament, it is therefore even clearer than was the case under DoLS that LPS cannot be used in the situation where the primary purpose is to protect others from the risk of harm caused by the person. This means that the mental gymnastics – or Orwellian – approach identified in *DY* will be even more necessary: as per the draft Code of Practice published for consultation in March 2022:

> *16.72 If the person presents a risk of harm to others, it may still be possible to determine that the arrangements are necessary and proportionate to authorise the arrangements to prevent harm to the cared-for person. Such a determination would only ever be appropriate if, as a result of being a risk to others, the person is also themselves at risk of harm. For example, if a person in a care home is likely to harm another resident, who then may retaliate and harm the person, it may be necessary and proportionate to deprive the person of their liberty. However, the greater the risk to another person – as opposed to the person themselves – the greater the need to consider other alternative legal frameworks such as the MHA.*

More broadly, and in line with the decision of the Supreme Court in *JB*, this decision reinforces the point that the MCA is undoubtedly not a straightforwardly empowering piece of legislation. Rather it is, or should be, seen as the framework for the proper determination of capacity and best interests in circumstances where there is legitimate reason to require such an exercise to be carried out.

And 'fusion' enthusiasts[2] might want to reflect on whether the interpretation of 'blowback' harm in this line of caselaw does not lead to a position where, in fact, DoLS (and in future) the LPS provides the groundwork for fused mental health and capacity legislation. In other words, if the MHA was simply repealed, would not the MCA in fact provide a complete capacity-based framework for detention and treatment, taking into account both risk of harm to self, and risk of harm to others?

Care orders and deprivations of liberty

Re E (A Child) [2022] EWHC 2650 (Fam) (19 October 2022)(Richard Todd KC sitting as a DHCJ)

Article 5 ECHR - "Deprivation of liberty"

Article 5 ECHR – Children and young persons

E was an autistic 17-year-old with additional diagnoses of ADHD and learning difficulties. He had previously been accommodated by the local authority with the consent of his parents, due to

[2] Thinking here, in particular, of the work of Professor George Szmukler.

his challenging behaviour, and was later made the subject of a care order on the basis that, in the words of the Children Act 1989, he was '*beyond the parents' control*'. He was placed in a residential placement. Unfortunately, there were disagreements between the professionals and the parents about E's needs and the causes of his behaviour. The parents were concerned about E's treatment at the placement including alleged harm caused to him by restraint. The court had been authorising E's deprivation of liberty at the placement, and during proceedings E had moved to a new placement. E was reported to have said he wanted to go home and live with his parents.

As the case was being dealt with as a family law case, there was a parenting assessment, which concluded that it was too soon for E to return to his parents. The assessor noted that neither parent believed that E needed 2:1 supervision, and that the working relationship with the local authority was poor. There were other disputes about E's care – his parents did not think that it was ethical to increase E's medication as a means to control him, and did not think he should have his mobile phone withheld from him. The court found that E's parents had undermined his placements, and that no placement would be good enough for them, because of the fundamental disagreement about E's needs and how best to meet them.

The court rejected the parents' application to discharge the care order, and continued the deprivation of liberty authorisation until E's 18th birthday. The court held that the civil standard of proof applied, such that the local authority had to prove on the balance of probabilities that the orders they sought should be made.

In the course of the judgment, the court expressed its concern that E's parents had been deemed ineligible for legal aid, saying

> *51. Once care proceedings are issued, a respondent with parental responsibility (which would include these parents) are automatically entitled to non-means assessed legal aid. They receive this regardless of their income. In such a serious matter as the taking of someone's children and the child's corresponding loss of a parent, this is plainly right. It is wholly inexplicable why this is not applied to DOLs proceedings.*
> *52. Moreover, the denial of legal aid is a false economy. The evidence in this case proceeded over 4 days. This was primarily due to the parents' labouring over difficult legal constructs and asking very wordy questions. Had they been represented, then I have no doubt this case would have concluded within 2 days. That would have been a huge saving to the public purse; 2 days' paid time saved of the High Court, senior counsel, solicitor, all the officials from the Local Authority and the Guardian – every single one of whom was paid from the public purse.*
> *53. […] Legal aid was originally one of the pillars of the welfare state. But for these people that prop is removed. The net result is that in DOLs proceedings they are at a real disadvantage against an organ of the State (the Local Authority) who are publicly funded. There is no logical reason for them (and the Guardian) to be treated differently from respondents in care proceedings. Instead, there is a compelling case for them to be treated the same – on grounds of fairness, equality of arms and the simple economic consideration that overall, it should prove cheaper for them to be represented than not.*

Comment

This case is another very sad account of a breakdown in relationship between the family of a young person with additional needs and the statutory authorities involved in providing care and support. A cognitive assessment, functional analysis and PBS plan were due from the Maudsley Hospital, together with a medication review – one wonders whether any of the parents' concerns or views about how best to

support E might turn out to be validated as part of that process? The contrast with proceedings in the Court of Protection is interesting – the independent expert assessment in the CoP would be of E and his needs, not of his parents.

Very restrictive medical treatment and finely-balanced decisions

Newcastle Upon Tyne NHS Foundation Trust v MB [2022] EWCOP 43 (30 September 2022)(Morgan J)

Best interests – medical treatment

Summary

This case concerns the medical treatment of MB, a 30-year-old man suffering from neuropsychiatric symptoms. In May 2022 he was given a working diagnosis, following a brain biopsy, of T-cell cancer of the skin, brain and bone marrow. The disease was thought to be affecting his central nervous system, and to be the likely cause of his psychiatric symptoms.

By the time of the application to court, MB was in hospital, deprived of his liberty pursuant to a Standard Authorisation. He was assessed as lacking capacity to consent to the treatment that had been identified as suitable to treat T-cell cancer.

The Trust sought orders for authority to provide a high dose of methotrexate (MTX) under general anaesthetic over several days for up to two cycles, and for deprivation of MB's liberty arising from the use of the chemical restraint and sedation. The need for the anaesthetic and so deprivation of liberty arose from the fact that MB was not compliant with his care and treatment and so all agreed that it was not safe to provide the MTX unless MB was sedated intubated and ventilated.

The particular difficulties in this case were (i) that while there was a working diagnosis of T-cell cancer, there was no '*certain diagnosis*', and so as the Judge pointed out '*it may be that MB is suffering from something else and the diagnosis - and therefore, importantly, that to which the proposed treatment is directed - is not correct*' [21]; and (ii) the mode of delivery of the treatment was novel and the intensivist instructed by the Official Solicitor told the Court that he would not be prepared to undertake the procedure in his ICU.

The focus of the oral evidence was not the issue of capacity, since the parties (and ultimately the court) agreed that MB lacked the capacity to make the relevant decision. Rather it was focused on the question of best interests. By the time of the oral hearing, MB's family were broadly in favour of the treatment being provided. MB on the other hand, who spoke to the Judge, did not accept that he had cancer, and so needed the treatment.

In addition, the views of the clinicians (both treating and experts) were not aligned. The treating clinicians were of the view that the treatment was in MB's best interests, as did Dr Martinez-Calle the consultant haematologist instructed by the Official Solicitor. On the other hand, Dr Chris Danbury, the intensivist instructed by the Official Solicitor considered that the admission to ICU in order to deliver the treatment would do more harm than good.

This was on any view, an extremely finely balanced case.

Viewing the evidence in its totality, the Court concluded that the treatment was in MB's best interests and authorised the plan, concluding:

> *88. I accept that having the treatment may if successful prolong his life and that the starting presumption is protection of his life; that the right to life carries with it strong weight and that even and although the estimate of success is put at 20 % within the context of Article 2 EHCR that is not negligible. Even the most pessimistic*

of the evidence before me does not suggest the treatment is futile.

Out of the Past: Backlog special

Several cases which have previously been reported on in this report have had follow-up judgments published; for reasons we are not clear on, these have now appeared on Bailii nearly a year or more after judgments were given.

London Borough OF X v MR & Ors [2022] EWCOP 29 (13 January 2022)(DJ Eldergill)

Judge Eldergill has reported a brief follow-up to *X v MR, PD and AB* [2022] EWCOP 1. Summarised here, the case related to a residence best interests decision in respect of X, who was 86 years old and had advanced dementia. X was reported to be settled and content at the care home where he resided. The question before the court was whether X should move to a care home specifically for Jewish people, which would likely be able to better meet his religious and cultural needs (though there was evidence that his current care home had made attempts to do so as well). The court ordered that X should move. In the brief follow-up in [2022] EWCOP 22, Judge Eldergill reported that he had received an update on X's progress after his move, and had been told that X's move went smoothly, he was doing 'really well', was getting better care, regularly enjoyed attending synagogue, and overall appeared to have an improved presentation.

AA, Re (Capacity: Social Media and Internet Use) [2021] EWCOP 70 (09 December 2021)(Keehan J)[3]

Capacity – Internet and social media

Keehan J reported a further judgment in the matter of *AA (Court of Protection: Capacity To Consent To Sexual Practices*) [2020] EWCOP 66, which dealt with AA's capacity regarding a number of issues, where AA had a strong interest in autoerotic asphyxiation.

This case concerned a 20-year-old autistic man with an attachment disorder and 'borderline cognitive deficits'. The issue for the court was whether he had capacity in relation to his use of the internet and social media. If he lacked capacity, it was proposed that there would be daily checks of his electronic devices. An independent expert opinion had been sought from a consultant psychiatrist, Dr Ince, who took the view that AA lacked capacity on this issue. AA had previously made very risky decisions, including engaging in autoerotic asphyxiation, and having an online relationship with someone who asked him to send sexually explicit material, although AA had then decided to end that relationship and block the person from contacting him. Dr Ince considered that AA could not 'transpose an acknowledgment of risk in one situation to a different situation' [8] and could not appreciate that doing the same thing again would lead to the same outcome. But the evidence on the ground was that AA had stopped behaving in such risky ways, having received support, and had developed other offline interests which meant that he was using the internet less.

The court declined to accept Dr Ince's opinion and held that AA had capacity to make his own decisions about use of social media and the internet, saying '*Whilst I entirely respect and understand the opinion of Dr Ince, on the basis of the evidence, I reach a different conclusion from him. In the absence of any evidence, for many months now, of AA putting himself at risk of harm in his use of the internet and social media, I am satisfied that there is insufficient evidence for me*

[3] Neil and Arianna having been involved in this case, they have not contributed to the writing of this note.

to conclude that he lacks capacity to make decisions in respect of his use of the internet and of social media.' [16] Even if AA did lack capacity the court was not persuaded that daily checks of his electronic devices would be in his best interests, as they did not protect him and were contrary to his wishes.

Comment

This judgment is another example of the court, not professionals, being the decision-maker on the question of capacity. The lack of evidence of risky behaviour in the recent past was critical to the court's decision, which underlines the need to look at what people do as well as what they say, when assessing capacity.

The Local Authority v A & Ors [2019] EWCOP 68 (18 June 2019)(HHJ Moir)

Following on from our November newsletter, readers may recall that we covered Poole J's decision in *Re A (Covert Medication: Closed Proceedings)* [2022] EWCOP 44. The case concerned the personal welfare of A, a woman of 23 with a diagnoses of mild learning disability and Asperger's syndrome who was found to lack capacity to conduct this litigation or to make decisions about her residence, care, contact with others, and her medical treatment for epilepsy, primary ovarian failure, and vitamin D deficiency.

Prior to Tier 3 Judge, Mr Justice Poole, considering the case, it had been dealt with by Her Honour Judge Moir.

In this judgment, HHJ Moir considered [11]:

1. the validity of a Lasting Power of Attorney for health and welfare held by her mother, B;
2. whether a handwritten document dated 6 March 2019 was an advance decision to refuse treatment ("ADRT");
3. whether it was in A's best interests to receive hormone medication, which would essentially allow A to undergo puberty (which had not been possible previously because of her ovarian failure);
4. whether it was in A's best interests to receive treatment for her epilepsy and vitamin D deficiency;
5. where it was in her best interests to reside, in particular whether she should continue to live in residential care;
6. whether it was in her best interests to receive care in accordance with her care plan; and,
7. what contact it was in her best interests to have with her family.

Judge Moir did not address the issue of covert administration of the hormone medication in this judgment. The focus of this note is therefore the original decision that receiving that treatment was in A's best interests.

The first issue for HHJ Moir was A's capacity to make the relevant decisions. She heard extensive evidence from expert, Dr Ince, and from B (A's mother) and her maternal grandmother. She also undertook a detailed analysis of the written evidence. B's view was that A has a mild form of dyslexia and did not accept that she lacked capacity in any regard but she accepted that she did not understand the endocrinology issue because she had not helped A to understand it [52].

The court accepted the evidence of Dr Ince, which it considered was sufficient to rebut the presumption of capacity in respect (i) conducting the proceedings; (ii) making decisions about her residence and care; (iii) making decisions about her medical treatment; and (iv) making decisions about contact with others. She also concluded that A lacked capacity to execute the lasting power of attorney in favour of her mother at the relevant time.

HHJ Moir considered that the handwritten document, dated 6 March 2018, usefully set out

A's wishes and feelings at the relevant time. It stated t that she wanted to live at home with her mother; she did not want social services involved in her life or a social worker; and she did not want to go to appointments. The Judge concluded that the document was not a valid ADRT because A did not have capacity at the time she completed the document and therefore the requirement in s 24 MCA was not met.

In respect of management of her primary ovarian failure, the evidence was that there was no range of medical opinion because the treatment was *"invariably sex hormone replacement therapy"* [73]. Dr X, the consultant endocrinologist, explained, as summarised by HHJ Moir, that [79]:

> *He told me that the likely success of the treatment was 100 percent. There is no failure rate. He told me it transforms a child into a woman. He said it is the basic human right of every girl to blossom into a woman and he found it inconceivable that it should be blocked. He said failure to treat it was unthinkable and it should have been done five years ago.*

The consensus opinion of the professionals before HHJ Moir had been, at [10], that '*A was at serious risk of health complications, including increased seizures, osteoporosis, fracture risk, and cardiovascular disease*' without the appropriate medication.

B continued to press for an independent assessment of the endocrinological issues and possible treatment, which HHJ Moir considered was *'a perverse position given all the detail provided by Dr X and the level of his expertise.'* [81] She also noted that B's reason for wanting an expert was that *'they have been told different things and have been lied to.* [81]

The Judge concluded that, whilst B said that she accepted the treatment that should be undertaken, she had no confidence that she would encourage A to take the medication or attend hospital appointments. Thus, if A remained in B's care, the administering of the medication would not be supported or occur.

HHJ Moir took into account the Article 8 rights of A, and her right to personal development and autonomy, as well as Article 6(2) of the United Nations Convention on the Rights of Persons with Disabilities states that all appropriate measures should be taken to '*…ensure the full development, advancement and empowerment of women, for the purpose of guaranteeing them to exercise and enjoyment of the human rights and fundamental freedoms set out in the present Convention.'* She determined that the advantages of taking the treatment were *'significant and fundamental'*; balanced against that, it was against A's wishes. [87] In that regard, the court was not satisfied that A had been able to form an independent and informed opinion.

In respect of B, she determined that [88]:

> *Sadly, I find that B has been so obsessed with her own wishes, views, and fears that she is being blinded to the obvious and risk-free advantages to her daughter of encouraging her to undergo the treatment and has, instead, failed to encourage her daughter to engage with the treatment or has actively dissuaded her daughter from doing so. Thus, the prospect that B will in the future support her daughter and positively encourage her to engage with the treatment must be extremely limited. Sadly, it is difficult to reach any conclusion other than B would prefer A not to "grow up" for want of a better description, that she would prefer A to remain the same, dependent upon her mother, and isolated within her mother's sphere without any outside influence or interference.*

The court therefore concluded that it was in A's best interests to undergo the treatment recommendation in respect of her primary ovarian failure.

The court determined that residence in a care home was restrictive, but ultimately in A's best interests. She had already moved into placement

A, and the evidence was that she was coping remarkably well in the new living situation. The court considered that B did not understand A's needs; and that B was a continuing negative influence on A. She determined that A's relationship with her mother was *"enmeshed"* and that it would take a long time to alter and diminish B's influence, so that that A can have the *'the opportunity to experience life as an independent adult with proper support.'* [112]

When the care home is the least restrictive option

Reading Borough Council v P & Ors [2022] EWCOP 27 (19 May 2022)(HHJ Owens)

Best interests – residence

P was an 86-year-old and had moved to the UK from Iran in 2002. She suffered from dementia, and in consequence of this had lost the ability to communicate in English (having grown up speaking Farsi). Until 2020, she lived with her daughter KS. In June 2020, she was admitted to hospital for a number of operations to her hip and developed an infection. There was a dispute over her discharge destination but she was discharged to a care home in February 2021. Proceedings were issued in the Court of Protection, and upon all parties coming to agree it was in P's best interests to remain in the care home, an order was made by consent in May 2021.

Unfortunately, on 1 July 2021, the home served notice, alleging difficulties in their working relationship with KS. P moved to an alternative care home in September 2021 and the matter came back before the court. KS wished for her mother to return to live with her on a trial basis. P's two sons both considered that she should continue to live at the care home, but one of them (SS) considered that if P were to move to live with family on a trial basis it would be better for this to be with him than with KS.

The court noted the history of difficulties between KS and professionals, although noting it was neither necessary nor possible within the confines of the hearing to make any findings of fact. KS was extremely protective of P and probably genuinely believed she was trying to get the best for P, but there was a high risk of difficulties arising with any care agency providing care in KS's flat. Any move would be very disruptive for P given her frailty, and this also told against any trial of living with KS.

The judge also noted the evidence of a deep and permanent rift between P's children, and that P needed to be protected from the consequences of that acrimony. One of the key issues of P living with either KS or SS would be the risk that this prevented her from having as much contact with her family as possible. Ultimately, the risks of fewer family visits for P meant that unusually the least restrictive option in this case was for P to continue living in the care home, which was 'neutral ground' and would enable her to have frequent contact with all her family.

Changes of care plan without court approval

Gloucestershire City Council v AB, SB & NHS Gloucestershire Integrated Care Board [2022] EWCOP 42 (03 October 2022)(Senior Judge Hilder)

The Court has taken the unusual step of publishing the order made in a case, in startling circumstances where a care plan permitting P to self-harm had been introduced without the court – or indeed the parties – being informed despite ongoing proceedings.

AB's case had come before the court in June 2021 under the streamlined procedure. In light of her age (being then 17) it had been removed from the streamlined procedure, and, when she turned 18 and a standard authorisation issued, reconstituted as a challenge pursuant to s. 21A MCA 2005.

The case had been listed for final hearing at the end of September 2022, with questions to be determined regarding AB's capacity to use social media and her best interests in relation to her care and support arrangements. On 21 September 2022, AB's solicitors reviewed the most recent tranche of disclosure they had received and noted that from May 2022 AB had been permitted by her placement to self-harm significantly and retain sharp items, and had been subject to restraint when her self-harm concerned the nursing staff. Both of these were significant changes to her care arrangements and neither had been notified to the parties or the court.

On investigation it transpired that the changes had been implemented by a registered mental health nurse at the placement on the basis that the previous plan (to prevent AB self-harming) was unworkable. During cross-examination, the RMN accepted that this change required to be considered by an MDT including a psychiatrist and/or psychologist. The Trust and ICB agreed that a risk assessment and immediate review were required.

The Official Solicitor submitted that Article 2 of the European Convention on Human Rights gave rise to an operational duty on the public bodies to take reasonable steps to protect AB from a real and immediate risk to her life, and that the current arrangements in respect of self-harm were so risky they should cease. In the exceptional circumstances of the case, the care and support arrangements should be authorised by the court and not under Schedule A1 MCA 2005.

The court invited the parties and provider to consider a hybrid approach to AB's self-harm, in which steps would be taken to prevent implements for self-harm coming into her possession in the first place and support/supervision if AB did come into possession of such an implement or start to self-harm, and this was agreed.

Comment

The fact that changes of this sort were made to the care plan without the approval of the court being sought – or even the parties being informed – is startling. The concession that this should have required MDT involvement was plainly correct, and it is unsurprising that the Official Solicitor contended that the position that the placement could implement their own care plans was clinically, ethically and legally unsustainable. The case is a stark reminder that significant changes to care plans should be notified to supervisory bodies and if necessary court approval sought.

The case is also of interest for the identification that the care and support arrangements fell outside the parameters of Schedule A1. That is clearly right because they went well beyond arrangements to confine the person so as to enable them to receive care and treatment; rather, they constituted (high risk) arrangements seeking to steer a careful line between AB's Article 2 and Article 8 rights.

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Conferences and Seminars

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

13 January 2023	Court of Protection training
26 January 2023	MCA/MHA Interface for AMHPs
1 February 2023	DoLS Authoriser Training (9:00-13:00)
2 February 2023	Necessity and Proportionality Training (morning and afternoon sessions)
16 February 2023	BIA/DoLS update training (9:30-16:30)
16 March 2023	AMHP Legal Update (9:30-16:30)
23 March 2023	Court of Protection training (9:30-16:30)
30 March 2023	BIA/DoLS update training (9:30-16:30)

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

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 February. 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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