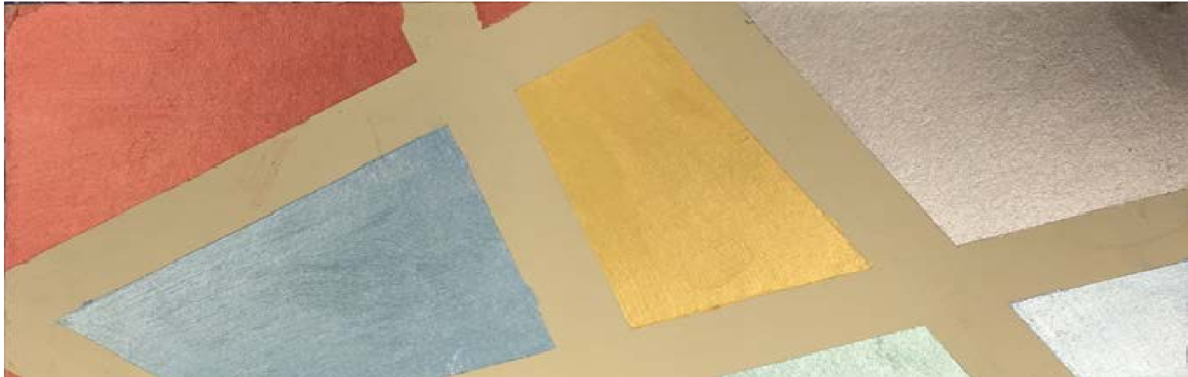

Welcome to the September 2024 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: the Court of Appeal on belief and capacity, and both sexual and medical complexities before the courts;

(2) In the Property and Affairs Report: a guest post updating deputies and attorneys on important responsibilities;

(3) In the Practice and Procedure Report: which decisions are for doctors, and which for the courts; jury-rigging Article 5(4) compliance in community DoL cases, and transparency under the spotlight;

(4) In the Mental Health Matters Report: a Mental Health Bill on the way, the hard edges of the MHA 1983 and the CQC and Valdo Calocane;

(5) In the Wider Context Report: the limits of Article 3 in the context of the inherent jurisdiction, the CQC and covert medication and Lord Falconer's Assisted Dying Bill;

(6) In the Scotland Report: the Scottish Government consults on legislative measures to respond to the Scott Review and a report from the World Congress on Adult Care and Support.

There is one plug this month, for a free digital trial of the newly relaunched Court of Protection Law Reports (now published by Butterworths. For a walkthrough of one of the reports, see here.

You can find our past issues, our case summaries, and more on our dedicated sub-site here, where you can also sign up to the Mental Capacity Report.

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

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Belief and mental capacity – the Court of Appeal decides

Re Sudiksha Thirulamesh (dec'd) [2024] EWCA Civ 896 (Court of Appeal (King, Singh and Baker LJJ)

Mental capacity – assessing capacity

Summary[1]

The Court of Appeal has made very clear how to approach the situation in which a person appears not to believe their doctor. We can do no better by way of summary than reproduce the opening paragraphs of the judgment of King LJ (giving the sole reasoned judgment, with which Singh and Baker LLJ agreed):

> *1. Sudiksha Hemachandran ("Sudiksha") died on 12 September 2023. She was 19 years old. She was born with a rare mitochondrial disorder known as Mitochondrial Depletion Syndrome RRM2B ("RRM2B"), a chronic degenerative disease with no known cure.*
>
> *2. On 20 July 2023, the University Hospitals Birmingham NHS Foundation Trust ("the Trust") made an emergency application to the Court of Protection asking the court to approve a palliative care plan for Sudiksha and for her life sustaining treatment to be withdrawn.*
>
> *3. The issue which came before the late Roberts J ("the judge"), namely Sudiksha's capacity to make decisions in relation to her medical treatment, was both unusual and difficult and is central to this appeal. Whilst the medical evidence was overwhelming that Sudiksha was in multi-organ failure and nearing the end of her life, she was fully conscious and able to communicate through a voice box. She was adamant that she wished to have the opportunity to be considered for experimental nucleoside treatment in America or Canada. She wanted to "die trying to live".*

[1] Alex, Neil and Tor having been involved in this case, and given the commitments of other editors this month, the commentary on this case is very short.

4. On 7 August 2023, the judge made a declaration that Sudiksha lacked capacity "to give or withhold her agreement to medical treatment including palliative treatment".

5. The court having decided that Sudiksha lacked capacity to make decisions about her medical care, the case was listed to be heard on 23 October 2023 with a time estimate of two days in order for the court to "determine [Sudiksha's] best interests in terms of medical treatment".

6. In the event, no best interests decision was ever made by a court as Sudiksha died only 35 days later. Her end of life care was provided under the terms of a treatment plan ("the treatment plan") without any judicial intervention. The plan had been agreed with Thirumalesh Chellamal Hemachandran and Revathi Malesh Thirumalesh ("the parents") some months previously in May 2023.

7. On 5 October 2023, Sudiksha's parents (who had been the 2nd and 3rd Respondents in the capacity proceedings) issued an Appellant's Notice seeking permission to appeal against the declaration of incapacity. Notwithstanding that Sudiksha's death meant that the appeal was academic, I granted permission to appeal and in due course, also permission for MIND to intervene.

8. Mr Bruno Quintavalle represented the parents, Katie Gollop KC and Olivia Kirkbride represented the Official Solicitor, Vikram Sachdeva KC, Catherine Dobson, and Isabella Buono represented the Trust and Alex Ruck Keene KC and Neil Allen represented MIND.

9. Having heard extensive submissions from the parties and from MIND, I would allow the appeal. It follows that the declaration made by the judge on 7 August 2023 that Sudiksha lacked the capacity to give or withhold her agreement to medical treatment, including palliative treatment, will therefore be set aside. That being the case, the presumption of capacity contained in section 1(2) Mental Capacity Act 2005 ("MCA") means that Sudiksha is presumed to have had the capacity to give or withhold her agreement to medical treatment, including palliative treatment, at all times leading up to her death.

10. In reaching that decision, I should be clear that I make no criticism of the judge who demonstrated the same care and compassion in this case as she did in every case she heard during her time as a High Court Judge before her untimely death. The decision she reached was in part at least, influenced by an established legal approach to the relevance of a patient's belief in their illness and prognosis. That approach is, for the reasons set out in this judgment, wrong and contrary to Court of Appeal authority.

Breaking matters down more, however, at first instance, Roberts J had found that Sudiksha was:

93. […] unable to make a decision for herself in relation to her future medical treatment, including the proposed move to palliative care, because she does not believe the information she has been given by her doctors. Absent that belief, she cannot use or weigh that information as part of the process of making the decision. This is a very different position from the act of making an unwise, but otherwise capacitous, decision. An unwise decision involves the juxtaposition of both an objective overview of the wisdom of a decision to act one way or another and the

> *subjective reasons informing that person's decision to elect to take a particular course. However unwise, the decision must nevertheless involve that essential understanding of the information and the use, weighing and balancing of the information in order to reach a decision. In [Sudiksha's] case, an essential element of the process of decision-making is missing because she is unable to use or weigh information which has been shown to be both reliable and true."*

Further, Roberts J had held:

> *98. As to the nature of the impairment of, or disturbance in the functioning of, the mind or brain which prevents [Sudiksha] from understanding, using and weighing the information which she has been given, it is accepted that [Sudiksha] does not suffer from any recognised psychiatric or psychological illness. Dr Mynors-Wallis struggled to identify precisely how to 'label' [Sudiksha] condition. His evidence was that her beliefs, which he accepted to be false, did not amount to a delusion because there was an understandable basis for her views which derived from, or coincided with, the views held by those she loved and trusted. His concern about making the causal nexus between a lack of ability to make a decision and the impairment in question was that none of the treating clinicians had identified a physical problem in her brain or that her recent respiratory arrests had affected her the functioning of her brain. That much is agreed.*

On the appeal, and identified by King LJ, the central question for the Court of Appeal, was as to the relevance of Sudiksha's belief in her illness and prognosis. The Trust's position in writing was that:

> *"where there was an objectively verifiable medical consensus as to the consequences of having, or not having, treatment, a person must believe, or accept as true, the information which informs the matter in order to understand it for the purposes of section 3(1) MCA". Mr Sachdeva argued that the requirement of belief was not an attempt to add a gloss to the statute, but rather that it followed from the ordinary reading of the requirement of section 3(1) MCA that a person must understand information relevant to a decision about medical treatment. Relevant information, he submitted, includes information as to the consequences of having or not having medical treatment. If a person does not believe relevant information that is objectively true, then the person will proceed on the basis of incorrect information and will, under section 3(1)(a) be unable to make a decision for him or herself.*

The Trust's position relied on the observations made by Munby J (as he then was) in *Local Authority X v MM* [2007] EWHC 2003 (Fam); [2009] 1 FLR 443 (*"Re MM"*) to the effect that:

> *81.* [….] *If one does not "believe" a particular piece of information then one does not, in truth, "comprehend" or "understand" it, nor can it be said that one is able to "use" or "weigh" it. In other words, the specific requirement of belief is subsumed in the more general requirements of understanding and of ability to use and weigh information."*

That observation (pre-dating the MCA 2005) had led the courts to proceed on the basis that "in order to 'understand' information for the purposes of section 3(1)(a) MCA, the patient concerned must believe that information" (paragraph 55). Unfortunately, however, King LJ noted (at paragraph 54), Munby J had founded

himself upon a passage in an earlier judgment in *Re MB (Medical Treatment)* [1997] 2 FLR 426 which did not, in fact, say what he had identified it as saying. Rather, Butler-Sloss LJ in *Re MB* had been saying that a lack of belief in the relevant information *may* indicate that the person does not have capacity to make the decision.

As King LJ noted:

> *57. During the course of submissions, Mr Sachdeva, having heard the submissions of the other parties and in discussions with the Court as they looked together with him at Re C and at the use of the word may by Butler-Sloss LJ in Re MB, refined his submissions, so that his final position on behalf of the Trust was that:*
>
> > *"Where there is objectively verifiable medical consensus as to the consequences of not having medical treatment, if a person does not believe or accept that information to be true, it may be that they are unable to understand it and/or unable to weigh it for the purposes of the MCA."*
>
> *58. This approach dovetails with that of both the Official Solicitor and of MIND (Mr Quintavalle on behalf of the appellants, chose not to concentrate to any extent on this aspect of their grounds of appeal). The Official Solicitor submitted that a person who does not believe relevant information, whether it be factual or opinion, may lack capacity, but equally they may not. The meaning of each of the words "understand", "use" and "weight" is, she submits, different from the meaning of the word "believe."*
>
> *The statutory language Ms Gollop submits is complete in meaning: there is no missing meaning, and no implicit or subsumed meaning that needs to be made explicit and no addition or embellishment is required. I agree.*
>
> *59. As McFarlane LJ said in PC and NC:*
>
> > *"37. The central provisions of the MCA 2005 have been widely welcomed as an example of plain and clear statutory language. I would therefore deprecate any attempt to add any embellishment or gloss to the statutory wording unless to do so is plainly necessary."*
>
> *60. Nothing in the recent approach of the Supreme Court (in JB) would appear to indicate anything to the contrary.*
>
> *61. It follows that in relation to the judgment with which I am concerned, in order to understand and/or to use and weigh up the relevant information, Sudiksha's belief as to her prognosis and the likelihood of her receiving effective nucleoside treatment was relevant, but not determinative as to whether she was able to make a decision under section 3 and therefore satisfy the functional test.*

King LJ then undertook a detailed analysis of the evidence before Roberts J and the way in which Roberts J had approached that evidence, before drawing the threads together in respect of this aspect of the appeal as follows:

> *123. As discussed above in my judgment from paragraphs [48] to [60] above, there is no specific requirement*

of belief, whether subsumed into the general requirement of understanding or in the ability to use and weigh information or otherwise. In as much as this Court is influenced by any of the pre-MCA cases, in my view the proper approach is that of Butler-Sloss LJ in Re MB: an absence of belief may but not inevitably will, on the facts of a particular case, lead to a clinician or a court to conclude that the functional test in section 3(1) is not satisfied and that the person in question does not have the ability to make the decision in question.

124. All that is required is an application of the statutory words without any gloss. "Does this person have the ability to understand?", "Is this person able to use and weigh this information?" The danger is that the introduction of the word "belief" is either the same as the statutory test, in which case it is otiose or, if that is not the case, there is the risk that by introducing a hard-edged requirement of 'belief' people will look for something different from the statutory test which is wrong in law. All that is required is the application of the words of the statute.

125. Unsurprisingly, both the judge and Dr Mynors-Wallis approached the case on the basis that Sudiksha's inability to believe that she was going to die soon and that nucleoside experimental treatment was not going to help, led inexorably to the conclusion that she was unable to satisfy the functional test as she did not understand the information and was unable to weigh and use it.

126. The judge at [93] agreed with Dr Mynors Wallis that Sudiksha was "unable to make a decision for herself in relation to her future medical care, because she does not believe the information she has been given by her doctors, absent that belief, she cannot use or weigh that information as part of the process of making the decision".

127. She then moved on to consider (essentially by reference to Dr Mynors-Wallis' first report) whether Sudiksha was unable to make a decision in relation to her medical treatment because of an impairment of mind. The judge's approach at [103] (paragraph [114] above) to belief/acceptance again fed into this critical issue: "her complete inability to accept the medical reality … is likely to be the result of an impairment of mind".

128. Whilst the wording of Ground 6 is somewhat confusing, the appeal has been argued by all parties on the basis that the alleged error of law on the part of the judge was in relation to her approach to the statutory test in saying that Sudiksha's refusal or inability to believe the 'information' alone resulted in her failing the functional test in section 3(1) MCA. It follows in my judgment that the appeal must succeed on this ground as, for the reasons set out above, the judge made an error of law in regarding the absence of belief as determinative of the functional test. This was an error made through no fault of her own given that she was applying the test as set out by Munby J in Re MM.

129. It follows that the Trust's concession was well made. The proper application of the statutory test does no more than reflect that, where there is an objectifiable verifiable medical consensus as to the consequences of having or not having medical treatment, if the patient does not believe or accept that information to be true, it may be that they are unable to understand and or use and weight the information in question.

King LJ went on to note that it was not necessary for the Court of Appeal to determine whether

"*upon the application of the less absolute test in relation to belief, the court would have still concluded that Sudiksha was unable to make a decision for the purposes of the functional test*" (paragraph 130). This was because the Court of Appeal found that Roberts J had fallen into further error by rejecting the unanimous expert evidence as to capacity. She started with the important proposition:

> *132. That judges are entitled to disagree with an expert witness needs no rehearsing. In AB v BG (Re G and B (Fact -Finding hearing) [2009] EWCA Civ 10, Wall LJ ("AB v BG") said at [17] that that proposition has an "equally obvious corollary". There must, he said, be "material upon which the judge in question can safely found his or her disagreement, and he or she must fully explain the reasons for rejecting the expert's evidence."*
>
> *133. Turning once again to Kings College, MacDonald J said:*
>
> > *"39. Finally, whilst the evidence of psychiatrists is likely to be determinative of the issue of whether there is an impairment of the mind for the purposes of s 2(1) , the decision as to capacity is a judgment for the court to make (see Re SB [2013] EWHC 1417 (COP)). In PH v A Local Authority [2011] EWHC 1704 (COP) Baker J observed as follows at [16]:*
> >
> > > *'In assessing the question of capacity, the court must consider all the relevant evidence. Clearly, the opinion of an independently-instructed expert will be likely to be of very considerable importance, but in many cases the evidence of other clinicians and professionals who have experience of treating and working with P will be just as important and in some cases more important. In assessing that evidence, the court must be aware of the difficulties which may arise as a result of the close professional relationship between the clinicians treating, and the key professionals working with, P.'"*
>
> *134. Mr Quintavalle in oral argument, sought to go significantly further than either AB v BG or Kings College. He submitted that a judge cannot disagree with the opinion of an expert absent there being available to the court other alternative expert medical evidence in support of the judge's view. In other words, Mr Quintavalle appeared to submit that a judge may not disagree with a unanimous view of experts, but may only decide as between more than one opposing expert view. That cannot be right, although it is undoubtedly the case that where the judge disagrees with a unanimous view which has been expressed by appropriate experts, a reader will look carefully to understand the judge's "full explanation" for having rejected that common view .and for the identification by the judge of the material upon which their disagreement is based.*
>
> *135. In the present case, the judge was faced with; the united view of Dr Bagchi and Dr Mynors-Wallis, the endorsement of the Official Solicitor (who had the advantage of having ascertained*

Sudiksha's wishes) and of Dr Tunnicliffe's virtual concession that his 'delusion' position was not sustainable and that what he was in reality concerned about was the right best interests decision for Sudiksha.

136. Critically also, the judge's reasons for rejecting the views of the experts who (notwithstanding their error in relation to belief) were of the view that Sudiksha had capacity, had to be considered and explained against the statutory presumption of capacity, the principle of autonomy and the fact that an unwise decision is not an incapacitous decision.

137. In my judgment, the judge fell into error in her approach which was essentially to adopt Dr Mynors-Wallis' first report with no analysis as to why it was to be preferred to his second report which had been written having seen and assessed Sudiksha and which dovetailed with Dr Bagchi who had had the advantage of seeing her on a number of occasions including in the absence of her family.

138. Once one displaces an absolute requirement for "belief", then, where a 19-year-old young woman, fully conscious and suffering no identifiable mental illness or loss of brain function and with the full support of her close knit family, refuses to accept that her death is imminent but says loud and clear to two psychiatrists that she wants to "[d]ie trying to live", it will take a great deal to displace the principle of autonomy and the presumption of capacity, no matter how unwise her decision to eschew palliative care may have seemed to a more mature mind.

139. It follows that against that backdrop, the judge in my judgment, failed to give sufficient reasons for disagreeing with the unanimous view of the experts that Sudiksha had capacity to make decisions as to her medical treatment.

At paragraph 140, the Court of Appeal took the other grounds of appeal shortly. Ground 4 was entirely specific to the facts of the case, so I do not set out here.

i) Ground 3: professional diagnosis of an impairment of the mind:

Re D (Children) [2015] EWCA Civ 749 did not, as implied in this ground, say that a professional diagnosis of an impairment of mind is required before it can be said to have been established. In Re D at [30], I simply said that the diagnostic test[2] will require evidence from a suitably qualified person, which will usually be a person with medical qualifications. This was said in the context of a case where it was agreed that the person in question suffered from significant learning difficulties. In case there is any room for misunderstanding, I make it absolutely clear that I endorse the approach of MacDonald J in North Bristol that no formal diagnosis of impairment is required.

[…]

iii) Ground 5: Application of Re JB to the present case:

Mr Quintavalle submitted that the test in JB did not apply because in JB, unlike the present case, there was no doubt

[2] King LJ had earlier noted the submission made on behalf of Mind that, rather than "diagnostic test," "a more appropriate term would be to refer to the 'impairment test rather than the diagnostic test given that […] no diagnosis of mental illness is required in order to satisfy the test (see *North Bristol NHS Trust v R* [2023] EWCOP 5 ("*North Bristol*") at [48])" (paragraph 40).

that the patient concerned had an impairment of mind and the issue there was as to whether, notwithstanding that impairment, the patient could consent to treatment. Mr Quintavalle drew the attention of the Court to the Mental Capacity Act 2005 Code of Practice ("the Code") which stipulates the two-stage test of capacity, the first stage (at 4.11) being to establish whether someone has an impairment i.e. the diagnostic test. In this context he draws the attention of the court to section 42(5) MCA which requires the Court to "take into account" the Code.

Responding to this submission, Mr Sachdeva rightly drew the Court's attention to Lawson, Mottram and Hopton, Re (Appointment of personal welfare deputies) [2019] EWCOP 22; [2019] 1 WLR 5164 at [16] which makes it clear that it is the wording of the statute as authoritatively interpreted by the Court which must prevail over the Code. In my judgment, this and indeed any court, is in any event, bound by the Supreme Court decision in JB namely that questions under section 2(1) MCA should be first as to whether P is unable to make a decision for themselves by reference to section 3(1) the functional test. If they are not so able, consideration is given at the second stage to whether that inability is because of an impairment of, or a disturbance in, the functioning of the mind or brain (section 2(1), the diagnostic test).

I should say for completeness sake, that the Code with which the Court is concerned was first published in 2007. A consultation ran between March and July 2022 in relation to the proposed updating and revision of the Code. The Consultation said that the Code was to be revised because: "the existing Code guidance needs updating in light of new legislation and case law, organisational and terminological changes, and developments in ways of working and good practice". The draft new Code, dated June 2022, adopts the JB approach to assessment of capacity at chapter 4.

Commentary

Given the clarity of the judgment (which is not being appealed), it might be thought that there is not a great deal to say by way of commentary, save to note that the Court of Appeal were not ruling out the relevance of (dis)belief altogether, as some seem to have suggested. An apparent lack of belief in what is being said is undoubtedly a legitimate reason to consider whether the person has capacity to make the relevant decision. What the Court of Appeal has made crystal clear is that that lack of belief cannot, itself, serve as a legally defensible conclusion that the person lacks capacity.

The Court of Appeal, life-sustaining treatment and 'covert consciousness'

Re PC [2024] EWCA Civ 895 (Court of Appeal (Bean, King and Baker LJJ)

Best interests – medical treatment

Summary

The Court of Appeal has refused permission to appeal the decision of Cusworth J in *NHS North Central London ICB v PC et al* [2024] EWCOP 31. The case concerned a 31 year old woman, who suffered a cardiorespiratory arrest and collapsed at home. A lack of cardiac output for about 30 minutes led to her brain being deprived of oxygen, which caused a severe hypoxic ischaemic injury. She was left in a Prolonged Disorder of Consciousness ('PDOC'), at the low end of the spectrum of awareness, for four years and was now 35. An application was made by the ICB, who commissioned her inpatient hospital care, that it was not in her best interests to

continue clinically assisted nutrition and hydration in circumstances where there was a lack of agreement from some members of her family. A paper prepared by the second opinion doctor required by the RCP PDOC guideline process, Professor Wade, was circulated shortly before the hearing, indicating, as King LJ put it, that:

> *50. Professor Wade's position had evolved from a view that it is unlikely that a person in PDOC will experience pain but that it "cannot be excluded", to "we have no convincing evidence that an unconscious person cannot experience pain". What the judge knew and was entitled to take into account was that PC was and is exhibiting significant and distressing (for all concerned) pain behaviours in the form of crying, groaning and grimacing which behaviours appear to respond to pain relieving medication. Further, that so far as expert understanding is concerned, the level of uncertainty about how pain is experienced, if at all, by people in PDOC is such that current policy is to treat people who exhibit pain behaviours in ways designed to minimise and control pain.*

However, Professor Wade's:

> *51. [...] evolving view about this issue had no impact upon his evidence as to PC's diagnosis, level of awareness or need for further assessment of her condition, all of which remained constant throughout, as did that of Dr B and Dr A.*

PC's mother sought permission to appeal on four grounds.

> *Ground 1: The decision not to adjourn to obtain expert medical evidence was unfair in circumstances where the only evidence was from a second opinion doctor who fundamentally reversed his opinion on the key point in the case (PC's experience of her life) while giving evidence.*
> *Ground 2: The Court conducted its own assessment of PC's experience of pleasure, contrary to authority.*
> *Ground 3: Failing to determine the relevance of "covert consciousness" to the assessment of people in a persistent disorder of consciousness.*
> *Ground 4: It was an error, and contrary to authority, to decide that it was appropriate to cease treatment for someone with a low burden of care and no expressed wishes not to have care. That decision failed to pay lawful respect to the sanctity of life and PC's right to life.*

Grounds 2 and 3 were dismissed crisply:

> *92. So far as Ground 2 is concerned, the extensive independent evidence gathered over a number of years was that PC derived no experience of pleasure. The judge summarised the evidence before him accepting it, as he was bound to do absent any evidence to the contrary. He did not conduct his own assessment. Permission to appeal on this ground is refused.*
>
> *93. So far as Ground 3 is concerned, Mr Lawson's exploration of the discrete issue of 'covert consciousness' in cross examination was very limited and was in the context of an academic paper by Professor Adrian Owen called "The Search for Consciousness". This brief paper explores technological developments whereby using functional magnetic resonance imaging ("fMRI") there may be demonstrated, in certain cases, residual cognition and covert awareness at some deep level. It remained however impossible to establish any form of traditional communication at the bedside. The paper records that the use of fMRI "with*

> *entirely physically non-responsive patients is still very much in its infancy" although the paper says, it has the potential to improve diagnosis.*
>
> *94. Mr Lawson did not suggest that fMRI should or could be conducted on PC. This means that the judge and any other expert could only properly base their conclusion as to whether there was a correct diagnosis on the evidence available which was already before the court. The judge was entitled to conclude that PC was in a state of PDOC and that her level of awareness had been established by appropriately qualified experts. It was therefore unnecessary to have dealt expressly with 'covert consciousness' when all the evidence collected following full assessment in compliance with the PDOC Guidelines, and specifically relating to her current presentation, did not raise any clinical uncertainty. It follows that permission to appeal is also refused on this ground.*

On ground 1, King LJ reminded herself that:

> *96. Pursuant to r.15.3(1) Court of Protection Rules 2017, the Court of Protection has a duty to restrict expert evidence to that which is "necessary to assist the court to resolve the issues in the proceedings". Those representing MC had to satisfy the judge that, notwithstanding the overwhelming evidence in relation to the diagnosis of PDOC and as to PC's level of awareness, further neurological evidence was necessary in order to resolve the proceedings. Far from answering that question, those representing MC had not complied with r.15.5 (2) and (3). No expert had been identified, there was no draft letter of instruction, no indication of the issues to which expert evidence would relate or the questions which the expert would be requested to answer. The grounds in support of the application to adjourn simply stated that "it is appropriate to carry out further investigations of [PC's] awareness".*
>
> *97. In his helpful oral submissions, Mr Lawson focused on: (i) the issue that there had not been adequate assessment of PC, and that both Professor Wade and the nursing home had been in breach of the PDOC Guidance, and (ii) that Professor Wade's evidence as to 'pain' was a central point and that having changed his view on PC's ability to experience pain, it was unfair on the parties not to enquire into both that change of evidence and her awareness.*
>
> *98. Mr Lawson submitted that there had been a departure from the PDOC Guidance in that there had wrongly been no full assessment of consciousness for some years. There was, he said, sparce evidence of the level of PC's consciousness and there was accordingly a need for a repeated assessment 4 years down the line. There was he said an "uncertainty as to diagnosis" which required further investigation.*
>
> *99. So far as 'pain' was concerned, Mr Lawson said that it was unfair of the court to proceed on the basis of "shifting sands". Professor Wade's views on pain were, Mr Lawson said, central to the decision the court had to make, and an acceptance of his new position was not a satisfactory basis for decisions as to PC's best interests.*
>
> *100. An appeal against a decision to adjourn a final hearing is a case management decision which has to be considered by an appeal court on the basis of whether the decision is fair. In Re P (A Child)(Fair Hearing)[2023] EWCA Civ 215, Peter Jackson LJ*

distilled twelve key principles from a range of appellate and ECHR authorities concerning the issue of whether it is fair to adjourn proceedings. It is not necessary to rehearse those principles here, although it is worth noting that Peter Jackson LJ followed his itemisation of the propositions at [46] by saying that: "[t]he essential touchstone is fairness and the weight to be given to any individual proposition or other relevant factor must be a matter for the judgment of the court in the case before it".

101. It should be borne in mind that the PDOC Guidance is just that, guidance, but in any event on an analysis of the guidance, there is in my judgment no basis whatsoever for the submission that the Integrated Care Board were in breach of the PDOC Guidance by not having repeated a full multidisciplinary assessment since PC moved to the nursing home, or that the annual reviews were inadequate. It is abundantly clear that there was no evidence of any improvement or increase in awareness on PC's part by the demonstration of pleasure. On the contrary, the only significant change was the increase in her crying and distress behaviours which was appropriately investigated.

102. As was acknowledge by the judge at [40], the evidence of Professor Wade as to PC's likely awareness of pain evolved during the hearing and it is undoubtedly the case that his view as to whether PC may suffer pain has changed. Significantly however, his evidence as to PC's diagnosis, her level of awareness and the need for further assessment of her condition was unaffected by his change in view with regard to her likely experience of pain. It was therefore wrong for it to be asserted on behalf of MC that Professor Wade had "fundamentally reversed his opinion on the key point in the case". In my view, as was submitted by Mr Hadden on behalf of the Integrated Care Board, Professor Wade's expanded definition of pain and his recognition that PC may have some experience of 'pain' should not be conflated with any change in his opinion regarding PC's level of awareness or consciousness, an opinion that was on all fours with all the clinical evidence and the annual reviews carried out by reference to the WHIMs and CRS-R tests.

103. The judge was entitled to conclude on the evidence that so far as PC was concerned at [57] "there was no evidence of any enjoyment of life. The only evidence is of her exhibiting discomfort and pain".

104. Mr Lawson has neither at first instance nor on his application for permission to appeal identified an appropriate expert or told the court what difference expert neurological evidence would bring to the determination of PC's best interests. The judge had the benefit of all the assessments set out above. The Official Solicitor gave careful consideration as to what medical evidence was required and at her request, Professor Wade answered the various additional questions she had posed in addition to having conducted a full and formal assessment such as is required by the guidance when an application to the court for an order in relation to the withdrawal of CANH is contemplated.

105. In my judgment, there is no real prospect of a successful appeal

> *against the judge's findings that: (a) no amount of further assessment would answer the question whether PC is capable of feeling pain; and (b) there is no evidence suggesting or indicating that PC is functioning at a higher level than all the previous assessments, or that this issue requires further investigation. Permission to appeal is refused on Ground 1.*

King LJ did, however, note that:

> *106. I should say for completeness that whilst in this case it has not led to the granting of permission to appeal, I can understand that those representing PC felt 'wrong footed' by the late introduction of the Pain Paper which was, as I understand it, introduced other than by court direction or agreement between the parties. I would remind legal representatives who have the lead in the instruction of experts, that the filing of additional expert evidence should be done following an application to the court, which application can, no doubt, be dealt with on paper if the parties are in agreement.*

As to ground 4, the case put to the court was that there was "*a compelling issue of principle for this court to consider, namely whether it is right in any case where there was a low burden of care and no expressed wishes on the part of a patient not to have care for a judge to make an order that it is in the best interests of that patient to withdraw CANH*." King LJ was clear that:

> *109. In my judgment, there is no need for this court to undertake such a task. The legal principles applicable to these cases are clear and well established. Whilst Mr Lawson seemed to suggest that the time might have come to update or clarify the principles set out in Aintree Hospital NHS Trust v James [2013] UKSC 67 ("Aintree"), Baroness Hale's judgment remains the lodestar which guides the courts when considering these anxious cases and it therefore remains the case that the sanctity of life is not absolute and that life sustaining treatment can nevertheless be withdrawn where it is not in the best interests of the patient. Time and again judges rightly have in mind [36] of Aintree:*
>
> > *"36. The courts have been most reluctant to lay down general principles which might guide the decision. Every patient, and every case, is different and must be decided on its own facts. As Hedley J wisely put it at first instance in Portsmouth Hospitals NHS Trust v Wyatt [2005] 1 FLR 21, "The infinite variety of the human condition never ceases to surprise and it is that fact that defeats any attempt to be more precise in a definition of best interests" (para 23). There are cases, such as Bland, where there is no balancing exercise to be conducted. There are cases, where death is in any event imminent, where the factors weighing in the balance will be different from those where life may continue for some time."*

On the facts of the case, moreover:

> *110. In any event, there is no merit in the individual features upon which the need for guidance was said to be based. The judge had well in mind the sanctity of life and said in terms at [62] that "…the*

> *simple preservation of life…. is of course a fundamental principle of the utmost importance". Mr Lawson sought to suggest that PC has a 'low burden of care'. Whilst it is undoubtedly the case that PC is stable as to her base line and is not the subject to regular intrusive treatment such as ventilation or regular suctioning, the judge unsurprisingly found as a fact that "the burden of her condition on PC is a heavy one". PC is reliant on nursing care for everything, and her parlous condition is as found as by the judge as set out at [79] above and included her displays of the pain behaviours which have been described. Finally, the judge gave detailed consideration as to the sparse evidence of PC's wishes and feelings and was conscious that PC had not expressed a view as to whether to receive CANH or not to receive CANH. This was a factor which he properly weighed in the balance together with the burden of care and the sanctity of life.*

King LJ, with whom Baker and Bean LJJ agreed, therefore refused permission to appeal.

Comment

As this was a decision refusing permission to appeal, the decision has no wider precedent value (without diminishing at all its magnitude for the family and the medics involved). It is, however, clear that the appellate courts are not sympathetic to attempts to revisit the established principles relating to life-sustaining treatment authoritatively laid down in *Aintree v James*.

Although the Court of Appeal did not refer to this, it is perhaps worth noting the fMRI scanning process relied upon by the appellant was also considered in the RCP PDOC guidelines [3] at section 2.4, which make clear that such scanning (along with electrophysiology):

> *do not form part of the standard assessment battery, nor do they represent a 'practicable step' required by s.1(3) MCA to support a person's capacity to make relevant decisions. They should be only applied in the context of a registered research programme.*

[3] Full disclosure, I was on the working group drawing up these guidelines.

Futility and best interests before the Court of Protection

Re XY [2024 EWCOP 37 (T3)] (Hayden J)

Best interests – medical treatment

Summary

When medical treatment can be considered to be a futile is an important, but sometimes difficult, question. What can make it difficult in the context of those with impaired decision-making capacity is the need to ensure that the concept is not 'coding' judgment about other matters, above all judgments about the quality of life of the patient (an issue discussed in this important article by Cressida Auckland). In *Re XY* [2024 EWCOP 37 (T3)], the issue of futility arose in the context of a decision whether continuing life-sustaining treatment was in the best interests of a man who in a prolonged disorder of consciousness. The treating Trust wished to withdraw cease mechanical ventilation and the provision of clinically assisted nutrition and hydration on the basis that its continuation was no longer in XY's best interests. He was Muslim, and as Hayden J identified:

32. XY's daughter (DE) told me that the course proposed by the doctors would be contrary to Islamic faith, as understood by her father. She told me that the Quran decreed that "he who kills a man, kills mankind; he who saves a man, saves mankind". This is also present in the Torah and has resonances in the Bible. Thus, it is a facet of each of the Abrahamic faiths. All the family share this belief. By this I mean that each of them told me that A would wish to continue in his present circumstances, even if in pain, because he would have known that he would continue to provide succour to his family. I have come to the very clear view that whatever their understanding of the medical evidence might be, the loss of A is unbearably painful to this family and dominates their response. F told me that if she were in XY's position, she too would wish to endure similar circumstances to comfort her own children by her continued presence. I accept the sincerity of her statement and consider it reflected her honest position. It is argued by Mr Mant, Counsel on behalf of the family, that F's reasoning is entirely consistent with the way XY has lived his life, putting his family first at every turn. I find this to be a sensitive and well-reasoned submission.

XY’s Islamic beliefs were also underpinned an alternative plan proposed by the family, namely:

35. […] *withdrawal of ventilation but reintroduction of CANH after a period of intermission, required for medical reasons. I need not burden this judgment with those reasons. There is agreement that XY would not be resuscitated in the event of cardiac arrest. It was suggested that alongside this, there would be no antibiotic treatment for almost inevitable infection, consequent upon micro aspiration. I should say that this second option was contemplated by the family but I did not sense any real enthusiasm for it. Its primary objective was centred upon what XY might have wanted in the circumstances that he found himself. His inevitable death on this alternative plan would not be in consequence of a particular action by man but more easily reconcilable with his Islamic beliefs. It was not constructed as casuistry; it was a sincere endeavour to reconcile the severity of XY's medical situation with the sincerity of his beliefs.*

Hayden J identified that:

35. […] *Many people would recoil from XY's present circumstances and profoundly wish to be released from them as quickly as possible. Where those wishes are identified, the Court of Protection is vigilant to promote the individual's autonomy. However, the Court is similarly obliged to promote the autonomy of those whose views many might disagree with. The essence of autonomy is the promotion of an individual's right to take their own decisions. The important proviso is whether those decisions are lawful or whether they require others to act in a way that represses their own autonomy, morally and ethically.*

Hayden J could not countenance the alternative plan:

36. […] *Ms Paterson KC, Counsel on behalf of the Official Solicitor, highlighted an important dissonance in the reasoning underpinning the alternative plan. In their assertion that XY would have preferred to remain in this profound disorder of consciousness, from which their lies no recovery, the family have attributed to him a degree of awareness which, I have found, is not supported by the evidence. Accordingly, their view that he would*

choose his present situation to afford comfort to them is based on their false premise of what his situation actually is. The severe brain stem dysfunction that XY has sustained is consistent with the view that perhaps even basic pain sensations may not be experienced or perceived. The continuing lack of any detectable response on the EEG is also supportive of this. Thus, in a very real sense, A is no longer there for his family. Grief, by its very nature, sadly, sometimes alters both reasoning and perception.

37. Having heard so much about the man XY has been, and listened to the powerful tributes paid to him, it is clear to me that the code by which XY has lived his life is predicated on principled beliefs. Those principles incorporate honesty, integrity, duty and love of his family, as well as humanity more generally. The 'alternative plan', as Ms Paterson identifies, is predicated on an inaccurate assumption. The responses that the family believe they see are misinterpretations. They superimpose upon XY, that which he cannot achieve or experience. The distortion of these relationships, at the end of XY's life, especially in such a close and loving family, runs counter to everything that each of them believes in. Of course, I include XY centrally in this. It does not sit in any way comfortably with the man he has been or the integrity that he has shown throughout his life. I do not believe, from all I have been told, that he would wish those who he has loved to believe that he was still there with them, in any meaningful sense, when the awful truth is that he no longer is.

Hayden J, finally, also agreed that:

38. […] *burdensome treatment of the kind contemplated here, can only be truly ethical where it can achieve benefit for the patient. Here, the treatment is futile. Dr A believes that XY is no longer receiving treatment in any real sense of the word i.e., it is not treating any condition. In short, it generates harm, not benefit and is irreconcilable with his professional oath. I entirely understand why he has come to that conclusion and for my part, in the light of my analysis above, cannot see how he could have arrived at any other. I would emphasise that his commitment to XY and his family has been unfailing.*

Hayden J therefore made the declarations sought by the Trust.

Comment

As noted at the outset, futility can be a difficult concept. It must be correct that a medical intervention which is not treating a condition is futile. However 'treatment' is a slippery word. Lady Hale in *Aintree v James* made clear that an intervention can still be treating a condition even if it is not curing it – if, for instance, it is maintaining the person's quality of life at a level they consider acceptable, even if, for others, such a situation might appear intolerable. See paragraph 43:

[i]*t is setting the goal too high to say that treatment is futile unless it has "a real prospect of curing or at least palliating the life-threatening disease or illness from which the patient is suffering". This phrase may be a partial quotation from Grubb, Laing and McHale, Principles of Medical Law (3rd edition 2010), para 10.214, where the authors suggest that "Treatment can properly be categorised as futile if it cannot cure or palliate the disease or illness from which the patient is suffering and thus serves no therapeutic purpose of any kind". Earlier, they had used the words "useless" or "pointless". Given its genesis in Bland, this seems the more likely meaning to be attributed to the word as used in the*

> *Code of Practice. A treatment may bring some benefit to the patient even though it has no effect upon the underlying disease or disability.*
>
> [….]
>
> *43. I also respectfully disagree with the statement that "no prospect of recovery" means "no prospect of recovering such a state of good health as will avert the looming prospect of death if the life-sustaining treatment is given". […] where the patient is close to death, the object may properly be to make his dying as comfortable and as dignified as possible, rather than to take invasive steps to prolong his life for a short while (see paras 62-63). But where a patient is suffering from an incurable illness, disease or disability, it is not very helpful to talk of recovering a state of "good health". The patient's life may still be very well worth living. Resuming a quality of life which the patient would regard as worthwhile is more readily applicable, particularly in the case of a patient with permanent disabilities. As was emphasised in Re J (1991), it is not for others to say that a life which the patient would regard as worthwhile is not worth living.*

In a case such as XY's, therefore, it might be thought that talking of futility in the way framed by Dr A and Hayden J in fact simply brings matters full circle back to the interpretation of XY's will and preferences (to use the language of the CRPD), because it required consideration of whether he would perceive the treatment to be achieving any purpose. And, arguably, on the case put forward by the family, was achieving a purpose – it was keeping XY alive, and not contravening his Islamic faith. Indeed, Dr A himself tacitly acknowledged this, identifying earlier at paragraph 18 that, whilst he himself could not reconcile continued treatment with his clinical ethics, there would be other clinicians who would be prepared to take a contrary course if the court authorised it.

If treatment was truly futile, in the sense that it could not achieve any purpose – i.e. it would simply not work to keep XY alive – then this would have been a rather different application. Put another way, Dr A's views and those of the Trust would have been determinative of the issue, because no one could compel them to provide the treatment, as opposed to being a significant part of the mix alongside P's wishes.

One final, unrelated, procedural observation: the neutral citations for Court of Protection cases have now changed so that they identify at the end what Tier of judge has heard it: Tier 1 (District Judge), Tier 2 (Circuit Judge) or Tier 3 (High Court Judge).[4] This is extremely useful, because it makes clear what cases are (or could be) setting precedents, and what cases are in effect worked examples. For more on how to read a Court of Protection judgment, see here.

Following through a decision to withdraw life-sustaining treatment

NHS NW London ICB [2024] EWCOP 35 (Theis J)

Best interests – medical treatment

Summary

In this case, the Vice-President of the Court of Protection, Theis J, gave a careful and considered judgment about the continuation of clinically assisted nutrition and hydration ('CANH') of Z, a 70 year old man in a prolonged

[4] Before people write in, we know that a judge sitting in the Court of Protection is sitting as a CoP judge, not as a High Court judge, but the tiering system is identifying what level they are at when not exercising functions as a nominated CoP judge.

disorder of consciousness. Of enormous importance to the family, the majority of the issues in the case will be familiar to those working in the field, and we do not set them out here. A novel point raised, though, was raised by the man's sister, given the evidence before the court that death following the withdrawal of CANH would usually take 1-3 weeks. Z's sister was clear that he would not wish to be in his current state, but that:

> *32. In her view Z would, like most of us, want 'a quick painless passing, knowing how [Z] was also very practical and pragmatic I believe that given all the aspects of this tragic situation and available options now he would not see a managed withdrawal of the CANH as the worst thing and that he would consent to this.'*

At paragraph 70, Theis J noted:

> *As Mr Patel observed when the time comes for us all everyone would want what W says Z would want; a quick and dignified death. That is not an option in this case. What I have to do is look at the wide canvas of evidence and consider what is in Z's best interests as between the available options.*

At paragraph 71(1), she noted, in this context, that one of the benefits of continuing treatment could be said that could be said to:

> *the hope that Z would die quickly through some other cause, such as a cardiac arrest. Whilst that is a consideration, the reality of the medical evidence is that this is not more than a hope if CANH is continued. Even if such an event does take place, it may and probably will involve other complications.*

She noted at paragraph 71(9):

> *In seeking to understand Z's wishes and feelings, beliefs and values there is unanimity that he would not want to live in his current condition. I agree. There are then differing views about what his wishes would be if he could not die swiftly. No one suggests Z had this discussion with them. W relies on the fact that he searched dying with dignity after his diagnosis. What W says is that Z would find it difficult to accept the changes to his body brought about if CANH was discontinued. Even accepting that some changes may take place it has to be balanced with the alternative which is for him to remain living, possibly for a number of years, in a way that everyone accepts he would not want. As Dr H described he did not believe that Z would wish to be 'remaining alive at all costs in a state of permanent unconsciousness from which all semblance of a treasured identity has since departed'.*

Comment

For those who want to understand more about the dying process following the withdrawal of CANH, we would recommend this article by Lynne Turner-Stokes and others. As the Royal College of Physician's guidance on PDOC makes clear (see section 5B), there are steps that can lawfully be taken to seek to palliate any distress that may be suffered by the patient in the period after withdrawal. The doctrine of double effect makes clear that it is lawful for such steps to be taken, even if they have the incidental effect of shortening the person's life. However, Z's sister, and Theis J, were undoubtedly right that the law as it stands does not allow for active steps to be taken to bring about the end of a person's life after life-sustaining treatment that been withdrawn. And, even if were assisted dying to be made legal under the political proposals that are regularly put forward, they would not change the position in cases such as

Z, because they have always been predicated on a current, capacitous, request by the individual; in a case such as Z's, there would be no such possibility of a request being made. This article provides a fascinating and provoking thought experiment which teases out some of the implications of the fact that it is lawful to stop life-sustaining treatment in a case such as that of Z's, but not lawful then to take steps actively to bring about their death.

Short note: ARFID and the Circuit Judge

It is only (relatively) recently that it has been accepted that serious medical treatment cases can be heard before Tier 2 (Circuit) Judges.[5] The decision in *Health Body A v JW* [2024] EWCOP 40 (T2) breaks no legal ground, but merits noting as an example of such a case (referred to the Vice-President but then released to a Tier 2 Judge). It concerned the administration of dental treatment including possible extraction under general anaesthetic in respect of a young woman diagnosed with learning disability, autism and Avoidant / Restrictive Food Disorder ('ARFID'). The judgment is notable for the careful self-directions of HHJ Howell as to the law, and the equally careful application of that law to the facts before her. That having been said, one tantalising point that in the judgment is HHJ Howell's reference to the observation of Munby J (as he then was) in *A Local Authority v MM and Another*[2007] EWHC 2003 (Fam) to the effect that if one does not believe a particular information one does not, in truth, understand, use or weigh it. After HHJ Howells had heard the case (and, it is likely, after the procedures in question had been carried out), Munby J's observations about belief were held to be wrong by the Court of Appeal in *Re Sudiksha Thirumalesh (dec'd)* [2024] EWCA Civ 896. Tthe judgment in the *JW* case does not contain enough detail about JW's problems with decision-making (her lack of capacity in the material domains being agreed) to identify whether HHJ Howells had been led up the garden path in her analysis of JW's capacity.

Sexual capacity in context

PS v A Local Authority, WP, DT & RS [2024] EWCOP 42 (T2) (HHJ Burrows)

Mental capacity – sexual relations

Summary[6]

This case concerned PS, a 79 year old lady with what was described as an extremely serious memory impairment related to alcohol use. She had been in a sexual relationship and lived with WP for almost twenty years. By the time the matter came before the court PS was residing in a care home, but it was common ground that both PS and WP wished for their sexual relationship to continue. However the care home had put in place a protocol to prevent the couple having time alone together in PS's room because of concerns that PS lacked the capacity to consent to sex.

The issues in the case centered on PS's capacity to make decisions about contact and engaging in sexual relations. The expert found that PS was unable to assess risks that a person with whom she was having contact with may pose to her. In addition, she was liable to misidentify people – she had for example mistaken other men for WP. HHJ Burrows perhaps unsurprisingly therefore

[5] There is a separate question as to what "serious medical treatment" means given the withdrawal and non-replacement of the Practice Direction governing such cases.

[6] Neil having been involved in the case, he has not contributed to this note.

found that she lacked the capacity to make decisions about contact with people in general and WP in particular.

With respect to PS's capacity to engage in sexual relations, HHJ Burrows held that given PS's age, the relevant information did not include the fact that pregnancy could result from sexual intercourse. Further, HHJ Burrows held that as WP and PS were in a monogamous stable sexual relationship, the risk of transmission of sexually transmitted infections could also be excluded as part of the relevant information. He accepted that PS could understand, retain etc the mechanics of the sexual act and the fact that the other person must consent to the sexual activity. He also accepted the expert's view that PS understood that she must also consent to the sexual activity. There was some discussion about whether or not PS had the capacity to change her mind once sexual activity had started. HHJ Burrows came to the view that if she did so, this would become apparent from her behaviour and WP would need to stop the activity. Unsurprisingly, he concluded that PS had capacity to consent to sexual relations and the presumption of capacity had not been displaced. However, importantly, he held that

> *the presumption or assumption of capacity only survives in the event that a proper protective care plan can be put in place to enable PS to enjoy sexual activity with WP if she (and he) want it. As I said using other words during the hearing, that will be a challenging TZ care plan*[7]*. That will require a set of arrangements that enables the couple to have time together in privacy when they wish.*

Comment

Some might think that in his approach to sexual capacity, HHJ Burrows came as close as it is possible to the line in terms of maximising PS's capacity to make decisions in relation to sexual relations. Some might also think that the case suggests that the bedroom is peculiarly unsuitable for the sort of legal exercises that are required by the (statutory) law as it stands.

What is also particularly interesting about this case is the separate consideration HHJ Burrows gave to PS's capacity to make decisions about contact with people in general, and then with WP in particular. HHJ Burrows took this approach because PS's deficits in the functional part of the capacity test arose from her seriously impaired short-term memory. However, because WP had been her partner of many years, she had "*a strong sense of memory of him at a very deep level*". In other words, HHJ Burrows felt, it was important to consider whether this might mean that she retained capacity to make decisions about contact with him. In fact, he found that she "*had no ability to initiate or refuse contact within the context of her relationship with WP, other than simply following her basic feeling that she knows him, and he is her husband/partner*."

Short note: a tantalising (non) decision about sexual relations

The decision of Theis J in *NHS Birmingham and Solihull ICB v JI* [2023] EWCOP 66 has only

[7] This refers to the case of *A Local Authority v TZ* [2014] EWHC 973 (COP) in which Baker J (as he then was) grappled with the appropriate way to provide support to TZ who had capacity to make decisions about sexual relations, but not about contact. Baker J found that TZ lacked the capacity to make decisions about whether an individual with whom he may wish to have sexual relations is safe and the capacity to make a decision as to the support he required when having contact with such an individual. A TZ care plan therefore is shorthand for the care plan that sets out the support to be provided to a 'P' in having a sexual relationship should (s)he wish to do so.

recently appeared on Bailii (having been decided in December 2023). It is a decision which is tantalising, as it looks at the outset as if it is going to put further flesh on the bones of the decision of the Court of Appeal in *Re C* [2021] EWCA Civ 1527, in particular as regards the extent to which the Court of Protection can endorse care packages which involve support for individuals accessing paid sexual services short of sexual relations (in the case in question private lap dancing) at an establishment called 'Adult World.' This had been going on for a number of years, generally at JI's request. However, in light of the decision in Re C, the ICB and the local authority, who jointly commissioned JI's care package, decided:

> 9. […] *that the support workers are at risk of committing an offence under section 39 of the Sexual Offences Act, in that it could be said that the care workers cause JI to engage in sexual activity, or they are creating the circumstances for the sexual activity to take place. The Integrated Care Board considers the risk of this is more than fanciful. As a consequence, they have made the decision to phase these visits out gradually to manage the impact on JI.*

The Official Solicitor sought the following declarations under s.15 MCA 2005:

> *1) That it is lawful for JI's support workers to continue to support him to attend Adult World for the two further visits planned by the Integrated Care Board and the Local Authority.*
>
> *2) Also to declare, as would inevitably follow, it will be lawful for them to continue to provide the same on a longer term basis in line with the proposal set out by Mr P in his statement, namely the management of such visits as I have just summarised, and then at the end of the declaration it would say if the Integrated Care Board are willing to commission that support.*

Theis J, however, declined to make the declarations sought, because of the evolving nature of JI's circumstances. Importantly, she noted:

> *23. Firstly, the Integrated Care Board have made their decision in the context of other services they are going to put in place as set out in Mr G's statement. Those are at the very early stages of being put in place and will be reviewed at the 12 weekly review that is going to take place in February.*
>
> *24. Secondly, that review may result in changes to the current care plan so that the visits to Adult World may be reinstated, may be less frequent, or may not occur at all. Mr Patel has rightly been clear that the door in relation to consideration of these matters is not closed.*
>
> *25. Thirdly, any decision about best interests is multifaceted, and it is important that the most up to date factors and relevant evidence to best interests are taken into account in considering whether the Court should take the step that the official solicitor invited the Court to do.*
>
> *26. Fourthly, the declaration being sought by the official solicitor is being made in what I consider to be an evidential vacuum. It may no longer be an issue in March, I do not know, there may be other ways JI can explore his sexual identity or urges, and as I had indicated in the documents that the Court has got, JI chose not to pursue that activity in November as a result of him prioritising his financial resources in a different direction.*

> *27. Fifthly, this is a different situation at this moment in time than that envisaged by Baker LJ in paragraph 75 of Re C. The situation he was envisaging is that there was an actual care plan in place. In relation to the future declaration sought on behalf of the official solicitor, that care plan is not yet in place, and that will be the position when the Court reconsiders this case in March.*
>
> *28. Finally, generally the evidence and analysis that supports the various positions needs updating, particularly in the light of the additional support that is going to be put in place. Mr G, the allocated social worker, has just taken over, and Mr A has only just taken over from Mr P who has been involved for a significant period of time, so for those very brief reasons I decline to determine the issue in relation to the declaration sought on behalf of the official solicitor at paragraph 24(2) of the position statement.*

Theis J also further emphasised the need for there to be in place a care plan complying with the guidance of Baker J (as he then was) in *A Local Authority v TZ (No. 2)* [2014] EWCOP 973, given that JI had capacity to make decisions about sexual relations, but lacked capacity to make decisions about contact.

Procedurally, Theis J also expressed displeasure at the fact that the directions made had not bene complied with – noting that they were not

> *34.* […] *optional extras that can just be complied with or not at will. It has caused enormous inconvenience, no doubt to the parties in the case, but also to the Court to be able to have to manage the reading and getting back on top of the difficult issues in this case.*
>
> […]
>
> *37.* […] *If there is very good reason not to comply with a direction the Court, of course, will always consider any request, but it is causing real problems in managing cases, managing Court lists and managing hearing times caused by a culture of casual non-compliance with court orders.*

2023-2024 DoLS statistics

The DoLS statistics for England for the year 1 April 2023 to 31 March 2024 were published on 22 August 2024. They show that, despite heroic efforts by local authorities up and down the country, they continue to fight a losing battle actually to secure that all those requiring the safeguards are provided with them.

In headline terms:

- There were an estimated 332, 455 applications for DoLS received during 2023-24. This is an increase of 11% compared to the previous year.
- The number of applications completed in 2023-24 was estimated to be 323,870. The number of completed applications has increased over the last five years by an average of 9% each year.
- The reported number of cases that were not completed as at year end was an estimated 123,790, a 2% decrease the previous year, and the proportion of standard applications completed within the statutory timeframe of 21 days was 19% in 2022-23, the same as the year before. The average length of time for all completed applications was 144 days, compared to 156 days in the previous year.
- Data new for this year show that:
- An estimated 162,655 cases were closed without any assessments as at year end: i.e. there had been no substantive consideration

of whether the person met the criteria under Schedule A1.

- Only 3% of cases of applications had been fully completed and fully assessed were not granted. Of the 4,315 cases which were assessed and not granted, 51% were not granted because of a change in the person's circumstances (for instance they had been discharged from the hospital in question), 25% because the person had died; only 915 were not granted because one or more of one of the DoLS criteria were not met. Of these, 305 in fact had the relevant decision-making capacity, 20 were ineligible applying the MCA/MHA interface in Sch 1A, the assessment process found that deprivation of liberty was not in the person's best interests, necessary and proportionate in 25 cases, and 5 failed the no refusals test.

The changes in the data recording make it difficult to work out how many people died whilst waiting for the assessment procedure to be completed – in 2022-2023, it was 50,000, and it is a reasonable guess that a very significant number, again, died this year in similar circumstances.

The DoLS statistics only tell part of the story, because the framework does not apply where the person is not yet 18, or is deprived of their liberty other than in a care home or hospital. There were 1,211 applications to the Court of Protection for judicial authorisation of deprivation of liberty in the first quarter of 2024, but it is very difficult to get a sense of by a factor of how many this number is short of the number of applications that should be made.

Alex has made some modest suggestions about how embattled public authorities can seek to respond to the situation in light of the indefinite delay to the LPS here. He has also given some thoughts about care providers and legal ice here.

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

Arianna Kelly: Arianna.kelly@39essex.com
Arianna practices in mental capacity, community care, mental health law and inquests. Arianna acts in a range of Court of Protection matters including welfare, property and affairs, serious medical treatment and in inherent jurisdiction matters. Arianna works extensively in the field of community care. She is a contributor to Court of Protection Practice (LexisNexis). To view a full CV, click here.

Nicola Kohn: nicola.kohn@39essex.com

Nicola appears regularly in the Court of Protection in health and welfare matters. She is frequently instructed by the Official Solicitor as well as by local authorities, CCGs and care homes. She is a contributor to the 5th edition of the *Assessment of Mental Capacity: A Practical Guide for Doctors and Lawyers* (BMA/Law Society 2022). To view full CV click here.

Katie Scott: katie.scott@39essex.com

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

Nyasha Weinberg: Nyasha.Weinberg@39essex.com

Nyasha has a practice across public and private law, has appeared in the Court of Protection and has a particular interest in health and human rights issues. To view a full CV, click here

Simon Edwards: simon.edwards@39essex.com

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

Adrian Ward: adrian@adward.co.uk

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

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

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

Conferences

Members of the Court of Protection team regularly present at seminars and webinars arranged both by Chambers and by others.

Alex is also doing a regular series of 'shedinars,' including capacity fundamentals and 'in conversation with' those who can bring light to bear upon capacity in practice. They can be found on his website.

Adrian will be speaking at the European Law Institute Annual Conference in Dublin (10 October, details here).

Peter Edwards Law have announced their autumn online courses, including, Becoming a Mental Health Act Administrator – The Basics; Introduction to the Mental Health Act, Code and Tribunals; Introduction – MCA and Deprivation of Liberty; Introduction to using Court of Protection including s. 21A Appeals; Masterclass for Mental Health Act Administrators; Mental Health Act Masterclass; and Court of Protection / MCA Masterclass. For more details and to book, see here.

Advertising conferences and training events

If you would like your conference or training event to be included in this section in a subsequent issue, please contact one of the editors. Save for those conferences or training events that are run by non-profit bodies, we would invite a donation of £200 to be made to the dementia charity My Life Films in return for postings for English and Welsh events. For Scottish events, we are inviting donations to Alzheimer Scotland Action on Dementia.

Our next edition will be out in October. Please email us with any judgments or other news items which you think should be included. If you do not wish to receive this Report in the future please contact: marketing@39essex.com.

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