HILL DICKINSON

June 2021

Court of Protection

Welcome

To this second edition of our COP newsletter for 2021. The courts have been busy, as can be seen from the newsletter and other cases reported on Bailii and the Court of Protection Hub.

>>> continues on page 2

HILL DICKINSON

Welcome

>>> continued from page 1

As an addendum to the brief article on 'Hybrid Courts', the president of the Family Division, Sir Andrew McFarlane, launched a two-week rapid consultation on remote, hybrid and in-person hearings on 10 June 2021 (consultation closed 27 June 2021). This consultation will focus on the recovery following the Covid-19 pandemic, identifying good practice from remote and hybrid hearings, and providing an evidence base to assist with decision-making on future ways of working. I understand that the findings will be published in time for the president's conference in July 2021, so watch this space.

The DHSC has also, on 11 June 2021, published six more factsheets about the Liberty Protection Safeguards (LPS), which – with my thanks to Alex Ruck-Keene – can easily be accessed by following this link to his website:

While on the subject of LPS, it remains to be seen whether the new proposed implementation date of April 2022 will be met, as we are still waiting for the draft supporting Code of Practice (as part of the overall updated MCA code) and regulations. Nonetheless, there is plenty that can be done in preparation and we are offering support for planning, training and implementation. Watch out for our webinars in July and October 2021, and February 2022, and do contact the team if you would like to discuss how we can help.

Finally, as always, if there are any particular matters or issues that you would like us to cover in future editions, please let Emma Pollard or me know.

Kiran Bhogal
Partner and Head of Health Advisory London
kiran.bhogal@hilldickinson.com

Court of Protection cases from April to June 2021

Here is a round-up of the key Court of Protection cases from this quarter which we believe our readers will be most interested in. We have highlighted the key issues arising in each case, please follow the links within the case summary to access the full judgment. Contact our team to discuss any particulalr case in more detail.

Treating anorexia: *A Mental Health Trust -v- ER & Anor* [2021] EWCOP 32 (30 April 2021)

ER has suffered with an eating disorder in various forms since she was a teenager. She is now 49 years old; over the past two years she has significantly physically deteriorated and is in renal failure.

The parties agreed that ER lacks capacity to make decisions concerning her anorexia but has capacity to make decisions for treatment in respect of her physical health problems. The parties also agreed that treatment for anorexia, including being admitted to a psychiatric hospital or specialist eating disorder unit, should not be forced upon ER against her wishes.

Despite there being agreed evidence before the court of ER lacking capacity to make decisions concerning her anorexia, the court heard from the consultant psychiatrist and clinical lead for eating disorders in the North West before making a declaration to that effect. The court then went on to make the declarations sought by the parties in the terms set out above. The relevant local authority and CCG were also joined as parties and directed to propose further support in the community, as it was considered that this could much improve ER's mood and potentially improve her short-term physical health.

COVID-19 vaccination: *SS -v- London Borough of Richmond Upon Thames & Anor* [2021] EWCOP 31 (30 April 2021)

In contrast to previous cases concerning COVID-19 vaccinations (the vaccine), Hayden J deemed it not to be in the best interests of SS, an 86-year old woman with a diagnosis of dementia, to have the vaccine. This was because (a) SS has a history of declining vaccinations which pre-dated her dementia diagnosis; and (b) she would require significant restriction and restraint in order for the vaccine to be administered, which was likely to diminish the trust that had been built up between SS and her carers.

Capacity to decide to engage in sexual relations: *A Local Authority -v- DY & Others* [2021] EWCOP 28 (10 May 2021)

Knowles J held that an 18-year old woman did have capacity to decide to engage in sexual relations on a general non-specific basis, notwithstanding her diagnoses of two chromosomal duplicities, fetal alcohol spectrum disorder, a moderate learning disability and developmental trauma disorder or complex post-traumatic stress disorder.

It was considered that the local authority's concerns about the risk of DY being abused or exploited could be addressed through an appropriate package of care and contract arrangements, decided in DY's best interests. This case serves as a useful reminder not to set the bar too high when it comes to analysing capacity (ie P's understanding of the distinction between consenting to sexual relations within and outside a relationship), and not to make applications for a prospective declaration (ie whether DY had capacity to engage in sexual relations in specific circumstances) as the Local Authority sought which, while permissible pursuant to section 15 of the Mental Capacity Act 2005, are exceptions to the general approach that capacity to decide to engage in sexual relations should be assessed on a general non-specific basis.

Please see the below article: *P's right to have sex with a sex worker* for an analysis of another recent case relating to capacity and sex.

Pregnancy and agoraphobia: *A NHS Foundation Trust -v- An Expectant Mother* [2021] EWCOP 33 (13 May 2021)

This case concerned an expectant mother who suffers from such severe agoraphobia that there was a risk that she may not be able to travel to hospital for the birth of her baby, even if that became a medical imperative. The evidence was that the agoraphobia exerted a significant effect on her ability to weigh matters in the balance if the activity entailed her leaving her home. This had been the case throughout her pregnancy, with her being unable to attend hospital for scans.

Holman J concluded the expectant mother lacked capacity to make decisions about whether her baby should be born at home or in hospital, and declared it to be in her overall best interests for her to be transferred to hospital for a planned delivery. He also concluded it to be in her best interests for some trained and professional force and restraint to be used to transport her to hospital, if the necessity arose.

Discontinuing dialysis: *University Hospital Birmingham NHS Foundation Trust -v- AI & K* [2021] EWCOP 37 (26 May 2021)

The Trust in this case sought a declaration that it was both lawful and in the best interests of AI, a 48-year old man reaching the end of his life, to discontinue any further attempts to provide dialysis.

AI had a recent history of non-compliance with dialysis while in the community leading to emergency admissions to hospital. There was concern that although AI was assessed as lacking capacity to make decisions surrounding his dialysis treatment on account of diagnosed schizophrenia, his wishes and feelings, which often saw him only becoming compliant with dialysis when he was physically weak, should not be overridden.

In his judgment, Hayden J noted that AI had consistently indicated that he did not want further dialysis. On the medical evidence before the court, Hayden J was satisfied that reinstating dialysis created significant risks in light of the deterioration in AI's health. Declarations were made that it was lawful and in AI's best interests not to receive further dialysis against the wishes of his family.

>>> continues on page 4

>>> continued from page 3

A DoLS authorisation can be valid despite the wrong patient name being used repeatedly: *YC and (1) The City of Westminster (2) SC [2021] EWCOP* (27 May 2021)

This case concerned YC, an 86-year old with dementia who lives in a care home. In June 2020, the local authority granted a standard authorisation, authorising the deprivation of liberty in YC's best interests. The 'Evidence of Supervisory Body Scrutiny' section of Form 5, which provides the formal authorisation of the deprivation of liberty, erroneously referred to YC as "Ms Hull" a total of 19 times.

YC's representative had sought a declaration that the standard authorisation was invalid, because these errors indicated a lack of adequate scrutiny and called into question the validity of the decision made by the supervisory body. Her Honour Judge Hilder (Senior Judge of the Court of Protection) heard the case on appeal and was "satisfied that the first instance judge was entitled to conclude that the errors identified in the Form 5 Standard Authorisation relating to YC were merely 'typographical'", and the appeal was dismissed.

HHJ Hilder was however clear that "the errors in this case should not have happened" and due care must be taken when completing DoLS documentation. A salient reminder to those completing forms, whether for deprivation of liberty or otherwise, to ensure that the forms are accurately and properly completed.

Rachel Kelly-Brandreth
Associate

Depriving 16/17 year olds of their liberty in hospital

When a 16/17-year old lacks capacity to make care and treatment decisions and is deprived of their liberty in a hospital setting, an application to the Court of Protection will normally be required to ensure that the deprivation of liberty is authorised and therefore lawful. This is necessary because the Deprivation of Liberty Safeguards (DoLS) do not apply to those under the age of 18.

In one recent case, we obtained supporting evidence from the family, which enabled the judge to consider the application and make an order authorising the deprivation of liberty on the papers, without the need for an oral hearing.

In brief, a deprivation of liberty occurs when:

- a person is confined in a particular restricted place for a non-negligible length of time;
- the person lacks capacity to consent to these arrangements; and
- the trust (as a state body) is responsible for the person's confinement.

The 'acid test' for deprivation of liberty was defined in *Cheshire West and Chester Council -v- P* [2014] UKSC 19 as occurring when a person is under continuous supervision and control and not free to leave.

16/17-year olds

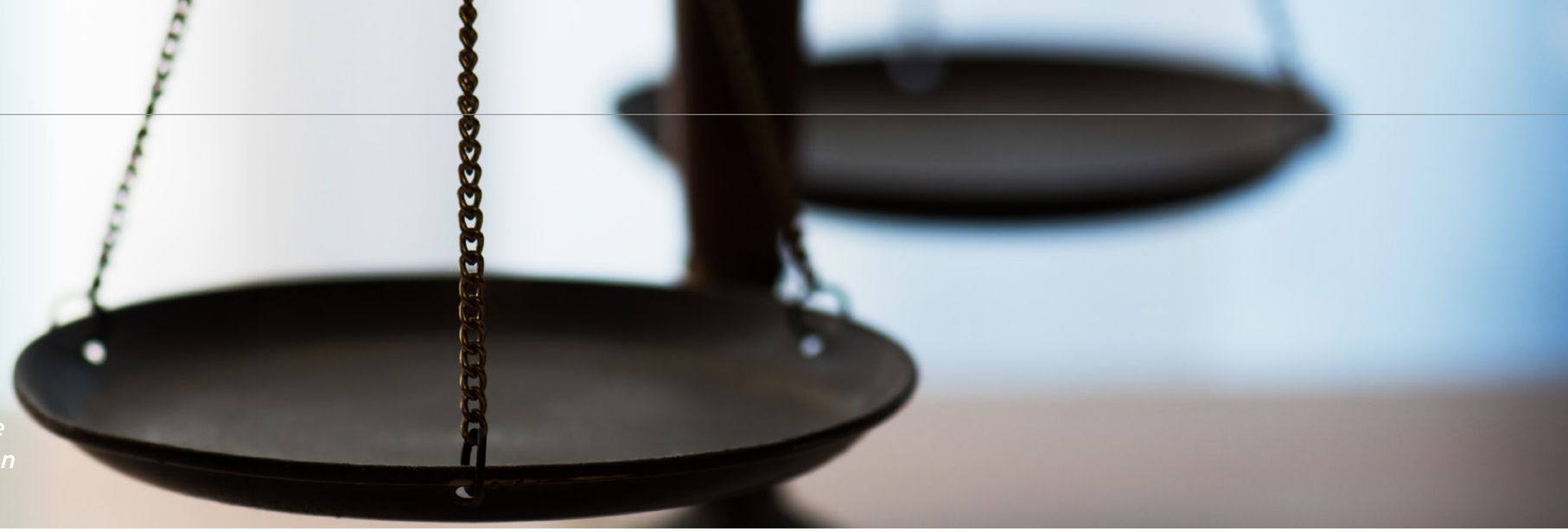
- While the Mental Capacity Act 2005 applies to those over the age of 16, the DoLS only apply to those over the age of 18.
- In *Re D (a child)* [2019] UKSC 42, the Supreme Court recognised that 16/17-year olds who lack capacity deserve the same protection of their liberty as adults. The Supreme Court also confirmed that where a 16/17-year old lacks capacity to consent to arrangements that meet the 'acid test' for a deprivation of liberty, parental consent will not stop that amounting to a deprivation of liberty and, unless legally authorised (ie by the court), the deprivation will be unlawful.
- Therefore, parental consent cannot be given on behalf of a 16/17-year old to care or residence arrangements that would otherwise amount to a deprivation of liberty.
- Where a 16/17-year old is willing and able to consent to the arrangements amounting to a deprivation of liberty and does so, there will be no deprivation of liberty.
- However, where a 16/17-year old does not consent, or does not have capacity to consent, to a deprivation of their liberty, they will be deprived of their liberty.
- Where there is concern that arrangements for a 16/17-year old amount to a deprivation of liberty, consideration should be given to whether (a) the arrangements can be revised so that there is no deprivation of liberty or (b) the 16/17-year old is able and willing to consent to the arrangements if supported to do so.
- If the deprivation of liberty is considered to be in the 16/17-year old's best interests and is the least restrictive option in order to meet their needs, it will be essential to take steps to have the deprivation of liberty authorised by the court and regularly reviewed.

Practical tips to consider

Complete a capacity assessment of P (16/17-year old) to ascertain whether P has capacity to consent to the deprivation of liberty.

- Hold a best interests meeting on the available options and benefits and burdens of those options—all those with an interest in P's welfare should be invited to attend and P should be encouraged to participate.
- Confirm the arrangements in place and whether these amount to a deprivation of liberty – essentially, what is the care plan that the court is being asked to authorise?
- Involve the family or people closest to P and explain to them the need for an application to the Court of Protection to be made to authorise the arrangements that amount to a deprivation of liberty.
- If those closest to P are in full agreement with the arrangements that amount to a deprivation of liberty, is someone close to P willing and able to act as their litigation friend for the purposes of the court proceedings? If so, a witness statement should be obtained from them to support the application to court.
- Consideration should be given as to whether the court should be invited to deal with the matter on the papers in straightforward cases where all involved are supportive of the arrangements that amount to a deprivation of liberty. Obtaining a statement from P's proposed litigation friend may increase the likelihood of the matter being dealt with on the papers. This can be beneficial because it avoids P and those close to P having to deal with the stress of court proceedings while P is in hospital, and reduces the costs and resources that NHS trusts would normally incur when attending an oral hearing.

Ellie Maudsley
Paralegal



Hot off the Press:

Reporting Restriction Orders

Article 8 (right to private and family life) -v- Article 10 (right to freedom of expression) of the European Convention of Human Rights (ECHR)

The president of the Family Division, Sir Andrew McFarlane, on 23 June 2021, handed down judgment in the case of *Haastrup -v- King's College Hospital NHS Foundation Trust* and *Abbasi & Anor -v- Newcastle upon Tyne Hospitals NHS Foundation Trust* [2021] EWHC 1699 (Admin) (23 June 2021) (bailii.org).

It is common, in serious medical treatment cases, for the Court of Protection or the High Court to make a Reporting Restriction Order (RRO) prohibiting the publication of the name of the individual at the centre of the case (P), P's family and those healthcare professionals involved in providing care and treatment to P. The duration of such Orders varies but, often, a RRO will remain in place long after proceedings have concluded, including the death of P. If parents in the case of children, as was the case here, wish to publish any information relating to the care and treatment received during the lifetime of those children, they need to apply first to the court to request that the RRO be lifted. Hence the applications made by Mr Haastrup and the Abbasis.

The arguments

Both sets of parents argued that, as the underlying inherent jurisdiction proceedings had concluded, the RRO had served its purpose and that they should be *"released from the RRO"* so that they may speak publicly about their experiences and, in so doing, be free to identify NHS staff who were involved in caring for their child. They also argued that the court had no jurisdiction to make a fresh injunction or to continue or remake the RROs in the absence of a proper purpose for existing proceedings (when there was none) or a legally recognised cause for a new injunction (which again there was none).

The hospital trusts maintained that the RROs should remain indefinitely, as there was an extant RRO and so the underlying proceedings continued to exist (the parents having each made an application within the proceedings for the discharge of that order). Each hospital trust asserted ECHR Article 8 rights on behalf of their staff members. They did so on the basis that neither set of parents had identified any individual staff members whom it was proposed would be named (despite express requests to do so) and on the basis that no individual staff member had consented to be named and thereby waived what rights they may have under Article 8.

PA Media (formerly 'The Press Association') as intervenors, supported the hospital trusts in asserting that the court must have jurisdiction to regulate and, if necessary, prevent the publication of information identifying individual clinical staff. On the facts of these two cases, it submitted that neither application for the discharge of the RROs was made out. The practice currently undertaken by most judges of the Family Division and Court of Protection, by which clinicians involved in these cases are not named, was endorsed and the decision of Lieven J in *Re M* at first instance[1] and the Court of Appeal[2] described as the single most relevant authority.

The issues in the case

The court focused on two main issues, namely, its jurisdiction and the evaluation of the competing Article 8 and Article 10 ECHR rights of NHS doctors and staff on the one hand, and parents on the other.

In response to the question: Does the High Court have jurisdiction to maintain, or to re-impose, an RRO protecting the anonymity of clinicians and other treating staff involved in the care of a deceased child, who was the subject of 'end of life' proceedings under the inherent jurisdiction, where the RRO remained in force for a significant period following the child's death? – the court said, yes, it does.

1. *Manchester University Foundation NHS Trust v N [2020]* EWHC 6 (Fam) (Lieven J)
2. *Re M (Declaration of Death of a Child) [2020]* EWCA Civ 164 (Sir Andrew McFarlane P, Patten and King LJJ)

On the question of the competing Article 8 and Article 10 rights of the ECHR, the court concluded that the continuation of the RRO in each case was justified and proportionate having applied the approach described by Lord Steyn in *Re S* (see further below).

The applications made by each parent for the discharge of the RRO in their respective cases, were therefore, refused.

The court's analysis

In his judgment, the president said: "In determining where the balance lies, the approach remains as stated by Lord Steyn in Re S, without gloss, so that neither the Article 8 rights of the NHS staff, nor the Article 10 rights of the parents, as such, have precedence. An intense focus is therefore required on the comparative importance of the specific rights being claimed with respect to each".

He went on to say that, the hospital trusts had placed before the court a "strong and coherent" body of evidence, which showed the potential for individuals to become vulnerable to physical or personal attacks and to suffer adversely in terms of their mental health and wellbeing. Further, "the experience of professionals and the court in cases of Charlie Gard, Alfie Evans and others, lead this factor now, in 2021, to attract significantly more weight than would have been the case a decade earlier"; and "When the strong and detailed case in favour of the continued protection of staff anonymity is put against the unelaborated and simple assertion of the right to free speech, the result of the balancing exercise is plain to see and does not require an intense focus to detect".

Conclusion

The judgment is well worth a read to get an understanding of how the balancing exercise is undertaken between competing rights such as Article 8 and Article 10. It also provides an analysis of the *horizontal* (conflict between two groups of individuals) and *vertical* (conflict between the state and individuals) rights as well as the court's 'constitutive' and 'adjudicative' jurisdiction (the former being a court's power to decide an issue and the latter, being the manner in which the decision is made).

It will be reassuring for NHS staff and healthcare professionals to know that the court considered that the time had now come for a line to be drawn under previous case law in so far as those cases purported to establish anonymity only where there were compelling reasons to do so. That approach in law is not to be followed and any application would need to turn on its own facts, including the overall context, where that is made out, as to the significant negative impact that the unrestricted and general identification of treating clinicians and staff may generate.

As the president said: "Why should the law tolerate and support a situation in which conscientious and caring professionals, who have not been found to be at fault in any manner, are at risk of harassment and vilification simply for doing their job? In my view the law should not do so, and it is wrong that the law should require those for whom the protection of anonymity is sought in a case such as this to have to establish 'compelling reasons' before the court can provide that protection".

King's College Hospital NHS Foundation Trust was represented by Gavin Millar QC, Matrix Chambers, and Fiona Paterson, 39 Essex Chambers, instructed by Kiran Bhogal of Hill Dickinson LLP.

Kiran Bhogal
Partner

The involvement of the European Court of Human Rights and the United Nations in withdrawal of treatment cases

In the March 2021 edition of our *Court of Protection Newsletter*, we analysed the High Court and Court of Appeal decisions in *K (a Child) [2021] EWHC 5 (Fam),* a withdrawal of treatment case in which the NHS trust applied to the High Court under its inherent jurisdiction, for a declaration that it was lawful and in K's best interests for mechanical ventilation to be withdrawn.

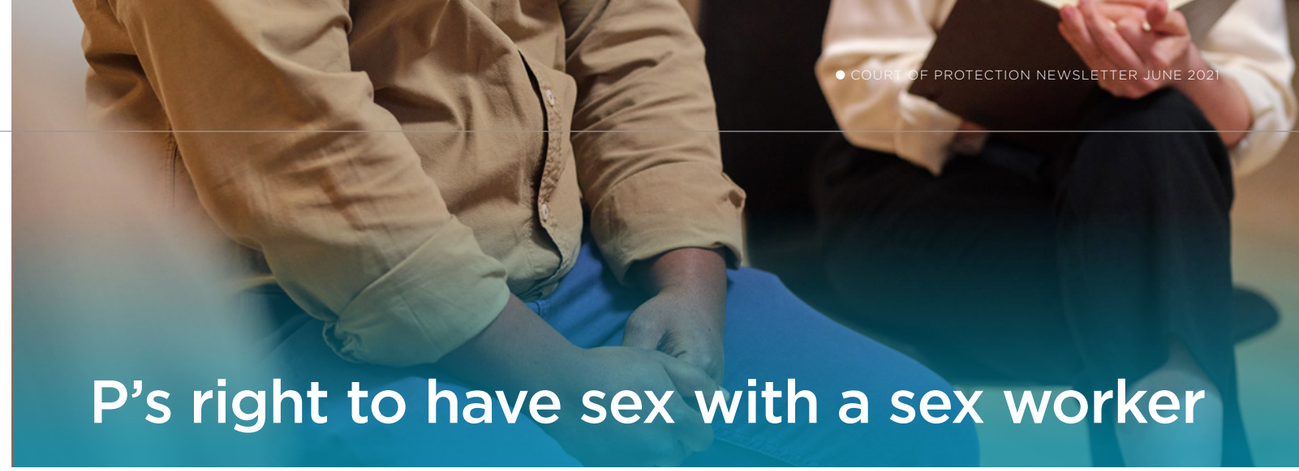
The High Court granted the declarations sought and K's mother sought permission to appeal the declarations but permission was refused/dismissed by the Court of Appeal. K's mother then made the following applications for permission to appeal: (a) to the Supreme Court directly but permission was again refused; and (b) to the European Court of Human Rights (ECHR), which is not unusual in cases of this nature (see further below).

What was, however, unusual was the concurrent appeal to Her Majesty the Queen for a 'royal prerogative of mercy', which historically has been used by monarchs to grant pardons to those convicted of criminal offences. Putting to one side the appropriateness of this in the context of withdrawal of treatment applications, as far as we are aware, there has been no response to this request.

As regards the ECHR application, following a short stay, the ECHR determined the application made by K's mother inadmissible. The ECHR would usually be the last avenue for appeals and end the legal proceedings. However, in this case K's mother went on to make an application to the 'United Nations Committee on the Rights of Persons with Disabilities' (CRPD), on grounds that K had been discriminated against because of her disabilities. This application was also deemed inadmissible. Two further applications were then made in the High Court to (a) vary the earlier order that declared withdrawal of treatment to be lawful and in K's best interests; and (b) request a stay, which were also dismissed.

This case serves as a useful reminder to NHS trusts that there are other avenues of appeals beyond the ECHR that may be pursued.

Emma Pollard
Associate



P's right to have sex with a sex worker

In one of the Court of Protection's most anticipated landmark judgments of the year, Hayden J (vice president of the Court of Protection) considered the novel, legal, ethical and human rights issues relating to the facilitation of an incapacitated individual's access to a sex worker.

The application made by a local authority concerned C. C has capacity to engage in sexual relations and have contact with a sex worker, but needs support from care staff in order to facilitate such contact as he lacks capacity to make decisions about his finances, the internet and his care and support.

The issue before the court was whether a care plan to facilitate C's contact with a sex worker could be implemented without an offence under the Sexual Offences Act 2003 (SOA) being committed by the care staff assisting C in having this contact.

The key provisions of the SOA considered during the proceedings were:

- Section 39: care workers causing or inciting sexual activity—a person commits an offence if they intentionally cause a person with a mental disorder for whom they provide care to engage in a sexual activity.
- Section 42: care workers: interpretation—this defines care workers as including anybody who has regular contact with P-
- Section 53A: paying for sexual services of a sex worker subjected to force/exploitation/working for a 'pimp'—which brings about issues of protection of P from prosecution.

Hayden J concluded that the assistance C would require from carers to access a sex worker would not fall within the 'causing or inciting' interpretation when applying their obvious meaning. It would not be unlawful for C's carers to support him to have access to a sex worker. This provides the gateway opportunity for a care plan to be prepared and assessed in order to consider whether being supported to access a sex worker would be in C's best interests.

What does this mean for statutory bodies?

The judgment only covers the principle of whether facilitating contact with a sex worker could be implemented without an offence under the SOA being committed, and not the practicalities associated with that contact. Any access to a sex worker will be contingent on a workable care plan that is considered to be in C's best interests.

Permission to appeal has been granted to the secretary of state, so we would recommend taking a cautious approach and awaiting the outcome of the Court of Appeal's determination before implementing any care plan, which supports P accessing a sex worker.

What should statutory bodies be considering when preparing care plans that include facilitating access to a sex worker?

There are many practicalities to consider about how such a care plan may work and what it will involve, and legal advice may be needed to ensure that care planning does not give rise to other ancillary sexual offences ie keeping or procuring a brothel depending on P's living arrangements.

Initial considerations should include:

- Has an agency/sex worker been identified?
- Is the care provider willing to offer and implement a care plan, which includes supporting P to access a sex worker?
- Have the care provider/staff members been given the opportunity to take independent legal advice?
- Does P have the finances to pay for a sex worker?
- Section 53A – matters to consider:
  - Is there an agency involved?
  - What steps have been taken to ensure that a third party is not exploiting the sex worker, whether by force, threat or any other form of coercion?
  - Has or can a screening process take place to evidence the real identity of the sex worker?
  - Do they have previous experience of providing sexual services through their own website or an existing adult services platform?
- P's living arrangements
  - Does P live with somebody else who may wish to access a sex worker himself or herself?
  - Where can the sexual activity take place?

Should you require any assistance in respect of any similar cases you may have, please feel free to contact Leah Selkirk.

Leah Selkirk
Associate

Are you being pro-active enough when it comes to obstetric cases?

Despite Keehan J's helpful guidance (the Guidance) in *NHS Trust -v- FG* [2014] EWCOP 30 on the need for timely applications involving pregnant women to be made, the court continues to face late applications. These limit the time the court and the official solicitor have to consider the serious decisions that the court is asked to make and limit the time for them to adequately scrutinise and test the evidence available. This in turn puts NHS trusts and/or local authorities at risk of criticism. It also means that clinicians have the difficult task of managing the substantial work that a court application brings, alongside their clinical commitments within a shortened time frame.

There will of course be cases where a late application is unavoidable because an individual presents to a trust in the later stages of pregnancy. However, in our experience most applications late because the case has not been escalated to legal advisers (internal or external) early enough. We recommend that processes be put in place to ensure that this happens, as a timely application is preferable for everyone involved, especially the expectant mother.

By way of reminder, the Guidance applies in cases where a pregnant woman lacks, or may lack, the capacity to make decisions about her obstetric care resulting from a diagnosed psychiatric illness.

When to make an application

The Guidance suggests four categories of case where an application should be made to the Court of Protection:

Category 1: the interventions proposed by the trust probably amount to serious medical treatment within the meaning of COP Practice Direction 9E, irrespective of whether it is contemplated that the obstetric treatment would otherwise be provided under the Mental Capacity Act (MCA) or Mental Health Act (MHA).Delivery of a baby per se does not amount to serious medical treatment (SMT), but the interventions proposed might. For example, a caesarean section may constitute SMT where P faces a high risk of complications, or may cause P's psychiatric condition to deteriorate leading to restraint being required.

Importantly, Keehan J noted that when the treatment amounts to SMT: "an application should be made to the court irrespective of whether the treatment proposed could be provided pursuant to the provisions of s5 MCA or as medical treatment under s63 MHA." (para. 113).

Category 2: there is a real risk that P will be subject to more than transient forcible restraint.

Where it cannot be predicted whether active restraint will be required or not (but it is planned for just in case), this category will not apply; there has to be a greater degree of confidence that restraint will be required. Trusts therefore need to make early assessments about the possible use of restraint, including the type of restraint and how likely it is to be needed.

Category 3: there is a serious dispute as to what obstetric care is in P's best interests whether as between the clinicians caring for P, or between the clinicians and P and/or those whose views must be taken into account under s.4(7) of the MCA.

Attempts should of course be made to resolve any disputes before a court application is made, but this needs to be done urgently to ensure that if an application does become necessary, it is made in good time.

Category 4: there is a real risk that P will suffer a deprivation of her liberty which, absent a Court order that has the effect of authorising it, would otherwise be unlawful (ie not authorised under s4B of or Schedule A1 to the MCA).

As long as the restraint does not amount to a deprivation of P's liberty, and provided it is necessary to prevent harm to P and is a proportionate response to the likelihood of P suffering harm and the seriousness of that harm (as per s6 of the Mental Capacity Act 2005 (MCA)), then it can be used under s5 MCA. The difficulty is in distinguishing between restraint that will fall within s5 MCA, and restraint that will constitute a deprivation of liberty. Keehan J suggests that this is a "fact sensitive issue which must be determined in each individual case", and he points to the acid test set out in *P -v- Cheshire West and others [2014] UKSC 19* [see our article on depriving 16/17 year olds in hospital for a breakdown of this test].

The Guidance echoes the *Serious Medical Treatment Guidance [2020] EWCOP 2*, which is clear that those providing care should approach the court in any case in which they assess it is right to do so. There may therefore be obstetric cases that do not fall neatly into any of the above categories, but which should, nonetheless, be put before the Court.

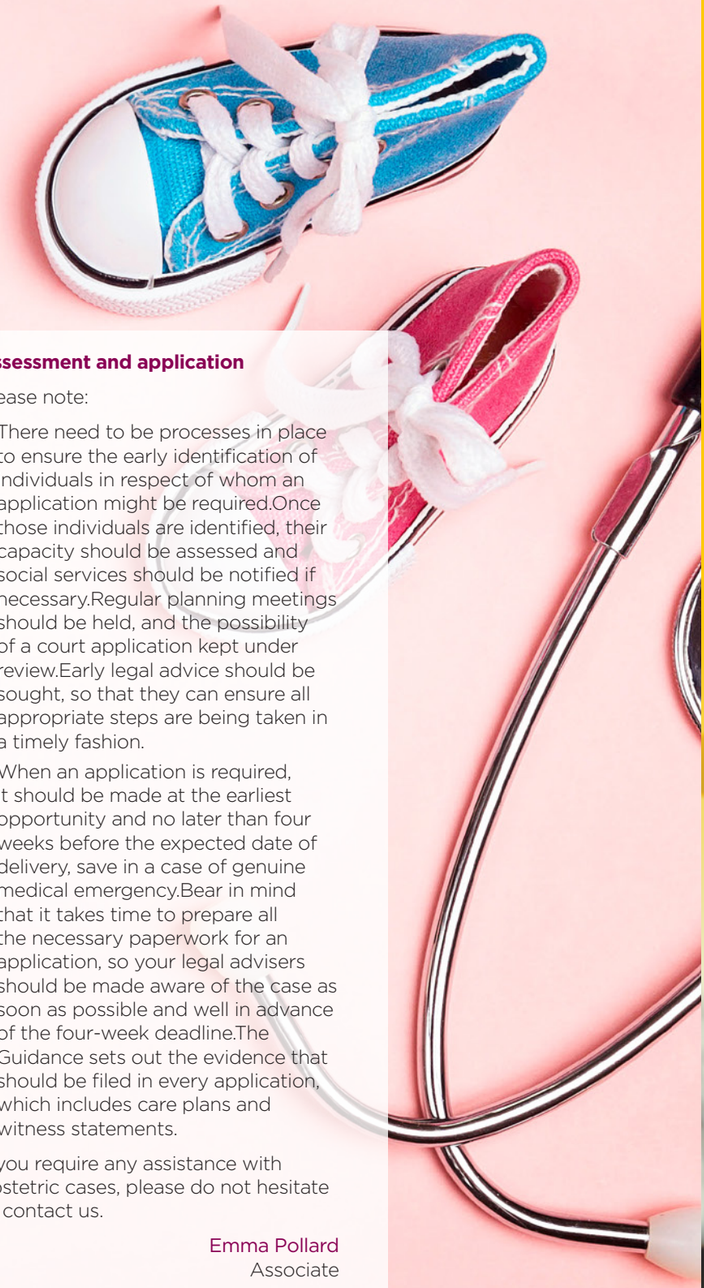
Assessment and application

Please note:

- There need to be processes in place to ensure the early identification of individuals in respect of whom an application might be required.Once those individuals are identified, their capacity should be assessed and social services should be notified if necessary.Regular planning meetings should be held, and the possibility of a court application kept under review.Early legal advice should be sought, so that they can ensure all appropriate steps are being taken in a timely fashion.
- When an application is required, it should be made at the earliest opportunity and no later than four weeks before the expected date of delivery, save in a case of genuine medical emergency.Bear in mind that it takes time to prepare all the necessary paperwork for an application, so your legal advisers should be made aware of the case as soon as possible and well in advance of the four-week deadline.The Guidance sets out the evidence that should be filed in every application, which includes care plans and witness statements.

If you require any assistance with obstetric cases, please do not hesitate to contact us.

Emma Pollard
Associate



Hybrid courts

Now that restrictions are easing, we are seeing a general movement towards hybrid courts, with some courts starting to require attendance in person. We hear on the grapevine that the judiciary is keen to maintain remote hearings for shorter case management hearings, in the interests of saving time and costs. We consider this a pragmatic approach (and agree cost savings will be achieved all around) and court guidance on when a remote hearing might be appropriate would helpful to ensure consistency of application across all courts. We will let you know as and when we hear more.

Kiran Bhogal
Partner and Head of Health Advisory
London

Top tips on working between in-house teams and external lawyers

I have recently joined Hill Dickinson's Health Advisory team following three years at a large acute NHS trust. During my time at the trust, we dealt with a whole host of Court of Protection (COP) cases, from urgent out of hours applications, to clinicians just seeking a sounding board.

In my experience of working in-house, COP cases are a bit like buses—nothing for ages and then two or more come at the same time. When one does land, it is typically at the end of the day or week, and the situation is now 'urgent'. This can be stressful for in-house teams as it can feel like you are always on the back foot. However having external lawyers on hand to discuss the case and support you can be extremely beneficial.

I have been fortunate that many of the external lawyers I have talked to or instructed to assist with COP cases have been great. However there are times, especially when you are juggling a COP case and everything else in your caseload, that things do not run as smoothly. I therefore wanted to share some of my tips on in-house teams and external lawyers working together. These are by no means an exhaustive list, but include some that I found helpful when I worked in-house.

1. Don't panic

While this is easier said than done—remember you are not going to know everything or in some cases anything about the COP. Working in-house means you often have to know a little bit about everything, so it is ok not to know the answer. This can be hard when everyone is looking at you for the legal framework.

2. Seek advice early

Even if this is just taking advantage of free initial advice, having the opportunity to discuss the case early can be beneficial.

Delay in bringing cases to court is a feature that is often criticised by judges in COP cases. While sometimes this cannot be helped, it is vital that a timely application is made (if needed), in keeping with the clinical urgency for the patient. Few cases improve with time and there is nothing worse than hearing that a patient has missed opportunities for a better outcome. You do not need to wait until you perfect your evidence before starting the court process. Sometimes, starting an application can provide the impetus to pulling the necessary evidence together. Remember: if in doubt, ask for help. And remember that an application can be withdrawn if agreement is reached before the final hearing.

3. Education

With COP cases, you are reliant on staff to raise the case with you as early as possible. However, some staff do not know when to do this or who to raise these with. Therefore, educating staff and having clear processes in place is key. Hill Dickinson can help provide in-house training for both the legal team and clinicians on getting the Mental Capacity Act 2005 right, and identifying when a case needs to be escalated and brought before the court.

4. Timings

When dealing with court timetables, and if time permits, make sure you check with the staff involved before you agree to any deadlines. A reasonable deadline for one staff member may be completely unworkable for another, so make sure that you are clear with your external lawyers about what is realistic. After learning the hard way, I know that setting realistic deadlines can help to avoid criticism by the court down the line.

5. Debrief

With some cases, the end can be a relief, especially if the case has been particularly difficult or emotive for those involved.

While it can be tempting to just move on to the next case, I have found the conclusion of a case to be a useful time to reflect, learn and educate staff to ensure that everyone is better prepared should it happen again (which I know it will). Therefore, a verbal debrief, newsletter or case summary can be a good way of learning from experiences, receiving and providing feedback, and helping staff understand the contextual and practical application of this complex area of law.

William Morris
Associate

Meet the team

Emma Pollard
Associate
Health Advisory London
+44 (0)20 7280 9268
emma.pollard@hilldickinson.com

Kiran Bhogal
Partner
Health Advisory London
+44 (0)20 7280 9344
kiran.bhogal@hilldickinson.com

Emma Galland
Partner
Health Advisory London
+44 (0)20 7280 9294
emma.galland@hilldickinson.com

Sharon Thomas
Partner
Health Advisory Liverpool
+44 (0)151 600 8249
sharon.thomas@hilldickinson.com

Joanna Trewin
Partner
Health Advisory Manchester
+44 (0)161 817 7373
joanna.trewin@hilldickinson.com

Ben Troke
Partner
Health Advisory Leeds
+44 (0)113 487 7963
ben.troke@hilldickinson.com

hilldickinson.com/health

About Hill Dickinson
The Hill Dickinson Group offers a comprehensive range of legal services from offices in Liverpool, Manchester, London, Leeds, Piraeus, Singapore, Monaco and Hong Kong. Collectively the firms have more than 850 people including 185 partners and legal directors.