Essex CHAMBERS

MENTAL CAPACITY REPORT: COMPENDIUM

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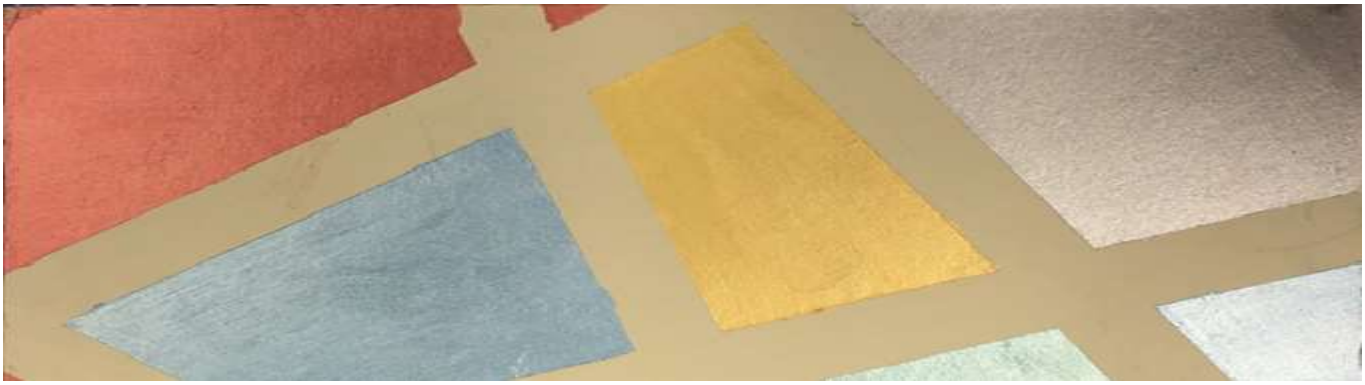

Welcome to the November 2021 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: the Sexual Offences Act, care workers, and paying for sex; and obligations that cannot be avoided in the context of decisions about serious medical treatment;

(2) In the Property and Affairs Report: an important consultation on a scheme to enable access to funds held by financial institutions; and guidance about disclosure of medical records to attorneys and deputies;

(3) In the Practice and Procedure Report: a new training video on communication and participation, the use of the inherent jurisdiction overseas, and a systemic approach to unblocking entrenched relationships;

(4) In the Wider Context Report: the CQC's State of Care report, vaccination and children, and a new research report on accessible legal information;

(5) In the Scotland Report: an important reversal of course by the OPG for Scotland in relation to remuneration of professional guardians.

We also say a – temporary – farewell to Annabel Lee as she goes on maternity leave, and welcome to Nyasha Weinberg as the newest member of the team.

You can find our past issues, our case summaries, and more on our dedicated sub-site here, where you can also find updated versions of both our capacity and best interests guides.

If you want more information on the Convention on the Rights of Persons with Disabilities, which we frequently refer to in this Report, we suggest you go to the Small Places website run by Lucy Series of Cardiff University.

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

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COP jurisdiction and powers – interaction with criminal proceedings

Summary[1]

The Court of Appeal has overturned the decision of Hayden J that care workers would not commit a criminal offence under s.39 Sexual Offences Act 2003 were they to make the practical arrangements for a 27 year old man ("C") to visit a sex worker in circumstances where he has capacity (within the meaning of the MCA 2005) to consent to sexual relations and decide to have contact with a sex worker but not to make the arrangements himself. Section 39 SOA 2003 provides (in essence) that it is a criminal offence for a care worker to cause or incite sexual activity by a person with a mental disorder.

As Lord Burnett identified:

> *23. The proceedings in the Court of Protection were unusual. Hayden J was not invited to make a best interests decision but was invited to express a view on the application of section 39 of the 2003 Act to a hypothetical set of facts. That view depended upon assumed facts of which there was detailed evidence. After giving judgment, the judge was invited to make a declaration but declined to do so. In the result, there is no "order" which is the subject of an appeal. The proceedings below were seen by all as a steppingstone. A further hearing considering a fully worked up care plan was envisaged. The judge himself recognised at more than one point in the judgment that the whole debate had a further hypothetical air. The characteristics of C raised a serious question about whether it would be appropriate to expose a sex worker to the risks of spending time alone with him.*

Whilst Lord Burnett noted that s.15 MCA appeared to give the Court of Protection the power to make declarations about the lawfulness of specific provisions in a care plan, he noted that the use of that power to declare lawful conduct which has the potential to be criminal should be confined to cases where the circumstances are exceptional and the reasons cogent (paragraph 30). Although such a declaration was not made, Lord Burnett considered that it applied with equal force in circumstances where the court made a decision reflected in its judgment that certain hypothetical conduct would not amount to a criminal offence. Lord Burnett was therefore "*doubtful that it was appropriate to entertain this application and determine it*." However, he considered that it was necessary to deal with the substance of the matter not least because in coming to his decision, Hayden J had taken a different view of the law from Keehan J in *Lincolnshire County Council v AB* [2019] EWCOP 43.

[1] Tor and Neil having been involved in the case, they have not contributed to this note.

For Lord Burnett, Hayden J had erred in seeking to give a definition of "causes or incites" for purposes of s.39 SOA 2003 that he had in order to enable him to find that the potential arrangements for C would not necessarily result in criminal liability. Rather, Lord Burnett considered (at paragraph 49) that:

> *the words "causes or incites" found in section 39 of the 2003 Act carry their ordinary meaning* […] *The litmus test for causation is that identified in the authorities. Do the acts in question create the circumstances in which something might happen, or do they cause it in a legal sense? Applying the approach of the Supreme Court in Hughes the care workers would clearly be at risk of committing a criminal offence contrary to section 39 of the 2003. By contrast care workers who arrange contact between a mentally disordered person and spouse or partner aware that sexual activity may take place would more naturally be creating the circumstances for that activity rather than causing it in a legal sense.*

A second question was whether a different reading of s.39 SOA 2003 was compelled by the European Convention on Human Rights. Lord Burnett observed that:

> *53.* […] *The argument advanced under article 8 with reference to section 39 entails the underlying proposition that there is a positive obligation on the state to allow care workers to make arrangements for sexual contact with prostitutes for those in its care over the age of consent (or at least over 18) who are unable to make the arrangements themselves, at least in circumstances where contact with prostitutes is not generally prohibited. There is no sign of such a positive obligation having been recognised by the Strasbourg Court, nor of that court having recognised that article 8 entails a positive obligation on the state to allow the purchase of sex without fear of criminal sanction.*

Noting that the Supreme Court had recently restated the correct approach where arguments under the Convention invited the domestic courts to march ahead of the European Court of Human Rights, Lord Burnett continued:

> *58. It is far from surprising that no case of the Strasbourg Court has been cited to us that recognises a human right to purchase the services of the prostitute or to be provided with such services by the state. The approach to prostitution across the Council of Europe states varies considerably. It ranges from closely regulated prostitution with neither prostitute nor client committing a criminal offence to outright illegality. Almost all Council of Europe states criminalise some aspects of the sex trade. The approach of both Sweden and Norway is notable. Prostitution is not an offence. An individual selling sexual services commits no offence but a person who purchases such services does. Similarly, since 2017 in Ireland it has been an offence to purchase sex: see part 4 of the Criminal Law (Sexual Offences) Act 2017 amending earlier legislation.*
>
> *59. The regulation, including criminalisation, of various aspects of the sex trade is a paradigm example of a sphere of activity redolent with complex and controversial moral judgments. It calls for generic risk assessments with the need for legislatures to strike difficult balances. The Strasbourg Court would allow a wide margin of appreciation to the parties to the Convention in this area. There is no sign in the Strasbourg case law of a recognition of positive obligations of the sort which underpin the argument that section 39, interpreted according to ordinary canons of statutory construction, would give rise to a violation of C's rights under article 8. That is sufficient to support the conclusion*

> *that article 8 of the Convention does not require these sections to be interpreted differently if that were possible using section 3 of the 1998 Act. Nonetheless the context of this argument is such that it must be regarded as unlikely in the highest degree that the Strasbourg Court would recognise a positive obligation of the type contended for in these proceedings.*

Lord Burnett was therefore clear that s.39 SOA 2003 did not even entail an interference with Article 8(1) rights, but that even if it did, it would be legitimate interference. He was equally dismissive of the arguments based upon discrimination:

> *64. Section 39 of the 2003 Act is concerned with sensitive moral and ethical issues in the field of penal policy. One of its purposes is to throw a general cloak of protection around a large number of vulnerable people in society with a view to reducing the risk of harm to them. To the extent that the provision discriminates against people in C's position by comparison with others in the care of the state (or more broadly) it represents the considered view of Parliament striking balances in these difficult areas. Such a view should ordinarily be respected. In my judgment, the discriminatory effect of section 39 cannot be stigmatised as being manifestly without reasonable foundation. The statutory provision is clearly justified.*

The Secretary of State had raised a wider argument, namely that any involvement by care workers in facilitating C's use of a prostitute would be contrary to public policy and on that basis should never be sanctioned by a court. However, in light of the conclusions that he had reached as to the interpretation of s.39 SOA 2003, Lord Burnett did not need to consider this wider argument – not fully argued before Hayden J – and therefore refused permission to the Secretary of State to amend his grounds of appeal to argue it.

Baker LJ gave a concurring judgment. He was equally troubled by the procedural approach adopted:

> *72.* […] *The powers invested in the Court of Protection under the Mental Capacity Act 2005 do not include the power to "decide" whether or not a proposed course of action is criminal and a declaration under s.15 of that Act that the course of action proposed in this case was lawful would be contrary to established authority and wrong in law. As the cases cited by my Lord demonstrate, the circumstances in which such a declaration would be justified must be exceptional and the reasons for making the declaration cogent. In this case I see no cogent reasons for making such a declaration and indeed every reason to refrain from doing so. The course of action proposed in this case would not only place the care workers at jeopardy of prosecution under s.39 of the Sexual Offences Act 2003 but would also expose C to the risk of prosecution under s.53A.*

Baker LJ considered that the same principles as he had identified in *Re JB* applied in the instant case:

> *74. The Court of Protection strives to promote the autonomy of incapacitated adults to enable them as far as possible to live with the same degree of freedom enjoyed by those who have capacity whilst having regard to their need for safety and protection. I agree with Hayden J that understanding about the importance of respecting the autonomy of adults with learning disabilities has evolved and is still evolving. But as part of the wider system for the administration of justice, the Court has to adhere to*

> *general principles of law. Alongside the growing awareness of the autonomy of people with learning disabilities there has been an evolution of thinking about the treatment of people who sell sexual services. Where Parliament has expressly decided that certain conduct should be a criminal offence, it is no part of the Court of Protection's role to declare that it is lawful.*

Baker LJ was, however, at pains to emphasise that the court was only concerned with Hayden J's decision in the case before him. At paragraph 75, he recognised that:

> *There are other situations where care workers are asked to assist people who have the capacity to consent to or engage in sexual relations but lack capacity in other respects, for example to make decisions about their care, treatment or contact with other people. One example is where a person with dementia living in a care home wishes to spend time with his or her partner at the family home. Another example is where a young person wishes to meet people of their own age and make friends. In both cases, one consequence may be that the incapacitated adult engages in sexual relations. I envisage that it might be appropriate in those circumstances for the Court of Protection to endorse a care plan under which care workers facilitate or support such contact and to make a declaration under s.15 of the Mental Capacity Act that the care plan is both lawful and in P's best interests. But in making these observations I emphasise three important points. First, the merits of making such a declaration will turn on a thorough analysis of the specific facts of the individual case. Secondly, in making such a declaration, the court may have to consider carefully whether the steps proposed under the care plan have the potential to amount to a criminal offence under s.39. Thirdly, as set out in the cases cited above, any declaration would not be binding on the prosecuting authorities, although no doubt it would be taken into consideration in the event of any subsequent criminal investigation.*

King LJ agreed with Lord Burnett, and also with the observations of Baker LJ: [2]

> *70. As Baker LJ explains, achieving autonomy for an incapacitated adult lies at the heart of the Mental Capacity Act 2005. It is not however the role of the Court of Protection to endorse an act which would be unlawful. Under the 2003 Act, the motive of the care worker, no matter how laudable, and the consent of the person with a mental disorder who wishes to engage in sexual activity are each irrelevant. In those circumstances, I cannot see how on any plain reading of the statute, the extensive arrangements necessary in order for C to engage in sexual relations with a sex worker, and without which sexual activity with a third party would be impossible for him, can be held to be outside the terms of section 39(1) of the 2003 Act.*
>
> *71. There are, however, many less extreme and benign situations which day in and day out touch on the lives of people up and down the country; Baker LJ gives the example of a care worker arranging private time for a long married couple which she knows is likely to include sexual activity in those circumstances. Such a case is wholly different from that of C and the question of whether it is appropriate to make a declaration under s15 of the 2005 Act in such cases is something to be left*

[2] As a judge senior to Baker LJ, her judgment comes before his in the formal record, but as she agrees with Baker LJ's observations, it makes clearer reading to address her judgment second: no disrespect to her is intended.

open for argument in the appropriate case.

Comment

Hayden J's judgment had been the subject of much (often ill-informed) comment, and it is perhaps forlornly to be hoped that this judgment will not be the subject of comments divorced from the issues actually considered. This is particularly so because, in many ways, the judgment of the Court of Appeal in this case bears much resemblance to that of the Court of Appeal in the *Tavistock* case (another case raising equally strong feelings): perhaps not surprisingly as both Lord Burnett and King LJ sat on both appeals. In both cases, a first instance court had, in effect, been lured onto procedurally dangerous ground by wider concerns. In the *Tavistock* case, it was a concern about the implications of the administration of puberty blockers; in this case, it might be seen as a concern as to how best to secure the ability of those with cognitive impairments to express themselves sexually. In both cases, however the Court of Appeal made clear that the courts had over-extended themselves, and took matters back to first principles: in the *Tavistock* case the concept of *Gillick* competence, in this case first principles of criminal law. Those first principles – and in particular the reading of the language of causation/incitement – made the answer clear for the Court of Appeal.

It is of note that Baker and King LJJ, both of whom had direct experience at first instance of having to navigate the troubled waters of sex and mental capacity, were both at pains to seek to find a way in which to limit the consequences of their conclusions so as not necessarily to implicate care workers in the situation where money is not going to change hands.[3] The boundaries between the MCA 2005 and the criminal law in relation to sex are, however, difficult, complex, and reflect difficult tensions which were highlighted very clearly in the early 2000s as requiring statutory resolution. They have not been so resolved, leaving complexities both for the Court of Appeal in this case, and – even more broadly – the Supreme Court in *JB* to address.

The practical implications of the judgment are going to require considerable resolution on the ground, and the team are working hard on a webinar to help people think them through.

Fighting ever increasing odds against a draconian intervention – and when is a without notice hearing acceptable?

Hull City Council v A & Ors [2021] EWCOP 60 (Poole J)

Best interests – contact – residence

[3] Where money will change hands then, as both Lord Burnett (at paragraph 34) and Baker LJ (at paragraph 72) identified, C – and potentially also his carers – would be at risk of prosecution for the strict liability offence under s.53A of paying for sexual services of a prostitute who had been exploited.

Summary

In this case, Poole J was concerned with – in effect – what was less bad: allowing a woman with dementia to remain at home in the care of a son about whom there were significant concerns, or authorising steps to remove her, even if temporarily, to enable assessment of her health and wellbeing. The case concerned a 76 year old woman, Mrs A, living her in her own home. She was a widow with four living sons, one of whom, B, lived with her.

When the local authority with responsibility for her initially approached the Court of Protection, contending that it was in her best interests to be transferred to a residential care home, it was initially rebuffed, it appears in large part on the basis of her consistent wish to remain at home, the court instead approving B's proposal that should be her primary carer at home, and assuring the court that he would seek professional support as needed. This position held for several months. However, consideration of whether Mrs A should be vaccinated against COVID-19 triggered a significant change in B's approach to engagement with carers, professionals and the court. He unilaterally and immediately cancelled all care and support for her within the home and he stopped his mother visiting the day centre. He stopped visitors coming into the house. He had become increasingly hostile to visits from social workers such that no professional was permitted by him to cross the threshold of Mrs A's home for at least a month. He had become abusive and agitated when social workers attempted to visit Mrs A, shouting at them from an upstairs window, threatening to call the police, and ordering them to leave. B also refused to meet with social workers outside the house. B's decisions also made it impossible for other members of the family to visit Mrs A at home.

The local authority's concerns were also heightened by evidence (not previously known to the court) showing that B had a long history of criminal activity including multiple convictions related to cannabis, including supply. He had multiple convictions for assault. Most seriously, he had received a ten year sentence of imprisonment in late 1994 for an offence of causing grievous bodily harm with intent. His most recent offence was for battery in 2010. In light of this, and its escalating concerns as to Mrs A's welfare, it came to court to seek orders bringing about her transfer to a care home – which was not at that point immediately available but would be so within a matter of weeks.

When the matter first came before Poole J it did so on a without notice to B, as he explained at paragraph 21:

> *The reason for applying without notice was the perceived danger that he would react to notice by putting A at risk of harm. That is not an unreasonable supposition given his recent behaviour, but the court should only proceed in exceptional circumstances to make orders of the kind sought without notice to those affected. Given B's history and conduct, given his stated rejection of the authority and his frank disengagement from the court process, it was my judgment on 29 October 2021 that it was likely that he would take steps to frustrate the order of the court if notice were given to him. Giving notice to B would increase the risk of harm to A. Balancing his Art 6 rights with his, and A's, Art 8 rights, the risk of B acting in a way that would be harmful to A if notice were given, and the risk that*

> *he would take action to frustrate the court's orders, I was satisfied the exceptional course of proceeding without notice to B was justified.*

At that point, however, Poole J was not satisfied that the matters had yet reached the point where immediate intervention, with the authorisation of restraint if necessary, was imperative. As an intermediate step, he made orders in Mrs A's best interests that B should allow a health and welfare check to be conducted at his mother's home for up to one hour on reasonable notice without B present in the same room, and that he was prohibited from obstructing or interfering with that meeting. A penal notice was attached to the injunctive orders made. Poole J adjourned the without application to removal and gave permission to the local authority not to inform B of the fact of the application. Poole J listed a closed and then an open hearing for the day after it was intended that the order requiring B to grant access to be served.

The order was served by social workers on behalf of the local authority, but did not produce the desired effect. B did, however, attend the open hearing, at least for part of it.

> *33. He told the court that A is well and that he ensures that she takes her daily medication. He told me that she was less paranoid and so was improving. Indeed, A has appeared well when seen briefly by others at the threshold to her home. He told me that he wants a second opinion on A's mental capacity, indicating that he does not accept that she lacks capacity to make decisions about her residence and care. The evidence from Dr Adebayo was, however, very clear and relatively recent. He is opposed to any visitors (including presumably someone who was instructed to assess capacity) entering the house because of the risk that they might spread the Covid-19 virus to him and A. He expressed the view that it was nobody else's business how he and A lived and that she was not isolated because he is with her 24 hours a day. I asked what protective measures could be taken by way of negative testing for Covid-19, mask wearing or otherwise for him to allow visitors into the home to see A for themselves in a proper manner. He became more agitated. He did not answer the question but refe3rred to "things I have seen". I asked him the question again and he left the hearing.*

It appeared that B might have left the hearing because of an internet problem, but he declined to rejoin. Poole J reached the view that:

> *36. From his participation at the hearing today and what he told Ms Bradley as reported to me, as well as all the previous evidence in the case that was before me on 29 October 2021, I conclude that B has become implacably antagonistic to the Local Authority, social workers, the Court, and the legal representatives for A. His avowed reason for not allowing visitors into the house appears to be a fig leaf – his real reason is distrust of all those involved in this case, apparently initially triggered by consideration of A being vaccinated, not protection from Covid-19. If, as he says, he would allow an independent person to enter the house, that shows that his objection to social workers from the Local Authority entering is not due to the risk of Covid-19 transmission.*

Poole J therefore had to grasp the nettle of what to do:

> *39. Firstly, I revisit the question of proceeding without notice to B. Although he knows that the court*

made orders on 29 October 2021 without notice to him, he still does not have notice of the application to remove A from the home and to convey her to Y. That application has continued to be heard in closed proceedings. I am satisfied following the hearing on 2 November 2021 that if he were to have notice there would be a substantial risk that he would use the time afforded to him to obstruct A's planned removal and conveyance. He would be likely to take steps to frustrate the purpose of the order. Those steps could put A at risk of harm. I am satisfied that the exceptional course of proceeding without notice to him is required in this case.

40. As to the substantive question of whether it is necessary now to take steps to remove A from B's care and to accommodate her at Y, I have to weigh all the circumstances when determining A's best interests, following the statutory provisions set out above. I have already referred to A's wishes and feelings and the views of others about her best interests. They have not changed since 29 October 2021. It is however now clear to me in the light of events since 29 October 2021, that it cannot be in A's interests to continue to be looked after by her son, given his current state of mind and his history, with no means of checking adequately on her safety, health and welfare, or her use of medication. It is also necessary to seek to ascertain her wishes and feelings which is not possible so long as B controls her contact with others in the way he has done. It is possible that B is keeping A safe and well. But it is also possible that his relationship with her and care for her is harmful to her. The court cannot know, because he has obstructed all reasonable attempts to check on A and for her Litigation Friend and legal representatives to be able to assess her wishes and feelings and interests.

41. It would not now be realistic to force entry to carry out checks on A with a view to her remaining in the home immediately afterwards. The circumstances would not be conducive to an effective assessment of her health and welfare within the home in the immediate aftermath of removing B for the purpose of checks being carried out. After assessment there would be no carers available to provide her with care within her own home. The earliest that carers might be available to provide 24 hour care in the home is 12 November and that is subject to risk assessments. In any event B has shown himself unwilling to allow any carers to have entry to the home, so he would have to be kept out of the home. Previously he has stayed next door to A's home. He could do so again and cause difficulties for A's care in her own home. The alternative of allowing B to continue to care for A in her own home after an assessment would be fraught with risk. He would be likely to be in a very agitated state. He might well be even more likely to take steps to obstruct future access to A. The health and welfare check might confirm that A is safe and well, but it might equally reveal that she has not been well looked after by B, has come to harm, and ought to be protected from him. B's conduct on 1 November 2021 and his appearance at the hearing today have confirmed that attempting to remove B from the house in order to assess A and then to leave her in the home afterwards to be cared for by B is not now a realistic option.
42. B has been given every opportunity to work with others and the court. He stubbornly refuses to do so. The only viable option that remains for checking on A's health and welfare is to remove her from her home for an interim period to be cared for at the Y residential care home.

43. The alternative is to leave A in the care of B in her own home. I have already referred to the risks of so doing. In addition I have to take into account the risk that the process of removing A and transferring her to the care home could well be harmful to her.

Poole J was clearly troubled by the position:

> *44. The situation is precarious and every option is laden with risk. The decision, balancing all the competing factors, is a difficult one, but it has to be made. My concern in leaving A in the sole care of B with his history of violence and drug use, his easily triggered agitation, his hostility to social workers and other visitors to the house, his intransigent determination to isolate A and to be the only one who has contact with her, his obstruction of attempts to assess her health and wellbeing, mean that the removal of her from the home for a short period is now necessary in her best interests. Taking into account all the matters which the court must balance when considering A's best interests, I am sure that it is now in her best interests to be moved from her home to the Y residential care home for an interim period. I shall list the case before me for a review hearing approximately one week after A's transfer to the Y care home which will now take place on 3 November 2021. I shall authorise the use of restraint to ensure that A is safely conveyed to the care home, in accordance with the measures set out in the Transition plan. I shall make injunctive orders against B to seek to ensure that the transfer is carried out as peaceably and safely as possible. I shall make provision for A to have contact with B and other family members in safe circumstances, in her best interests once she is at the care home.*

In an addendum to the judgment (rare in welfare judgments, even if relatively common in medical treatment cases), Poole J recorded that Ms A was safely transferred to the care home without the need for physical intervention or restraint.

Comment

Having just had the chance to have a first look at Beverley Clough's new, and very stimulating, work *The Spaces of Mental Capacity Law: Beyond the Binaries* (review forthcoming when he has a moment), what came to Alex's mind when reading this judgment was how to hold a (not literal – thankfully) inquest into what other possible courses of action, and by whom, could have led away from the point where Poole J found that he was constrained to require Mrs A's – temporary – removal from her own home. We would suggest that this would be a very useful exercise for any wanting to think – for instance – about the application of Articles 16 and 19 CRPD (the duty upon States to protect those with disabilities from violence and abuse and to secure their right to independent living respectively).

Into that 'inquest' would go the fact that – as happens more often than might appear from reported cases – the court was seeking in the face of considerable odds to secure Mrs A's continued residence at home. Those odds do, from the judgment, to have become increasingly insurmountable in light of the position adopted by B – but, notwithstanding the tantalising addendum, it would be fascinating (and important) to understand whether Poole J's clear intention that the transfer to the care home be on an interim basis ultimately leads to a permanent situation, or whether a solution enabling her return home can be crafted and/or tolerated by the local authority and the court. It will equally be fascinating, and important, to identify insofar as possible what Mrs A wants as part of that exercise.

Best interests decision-making, dignity and delay – obligations that cannot be avoided

North West London Clinical Commissioning Group v GU [2021] EWCOP 59 (Hayden J)

Best interests – contact – residence

Summary

In Hayden J made a series of very powerful observations about the obligations imposed upon treating bodies to ensure proper consideration of whether continuing treatment is in a person's best interests, and to take proper steps to secure timely resolution of any dispute. The case concerned a man in a prolonged disorder of consciousness who had been being cared for at the Royal Hospital for Neuro-disability (RHND) since 2014. By August 2018, and at the request of the man's brother, a best interests meeting was held, at which point it was clear his treating clinicians had come to the clear conclusion that there was no prospect of any change in his condition and that continued treatment was both futile and potentially burdensome. There was, however, a dispute between family members as in relation to whether treatment should be withdrawn. What did not happen were appropriate steps to resolve that dispute, or to make an application to the Court of Protection, for a very prolonged period. When the application was finally made, Hayden J had had little hesitation in concluding – not least on the basis of clear evidence as to GU's likely wishes and feelings that – it was not in his best interests to continue to receive CANH. At the hearing at which this decision was reached, the Official Solicitor had contended strongly that there had been "inordinate and inexcusable delay" on the part of RHND, in giving consideration to the issue of whether continued treatment was in GU's best interests, and in taking steps to enable the Court to determine that issue in the absence of family agreement. This was compounded by further delay on the part of the CCG. Hayden J gave the opportunity to the RNHD to explain the position, and in the judgment now delivered Hayden J made clear in no uncertain terms the extent to which he found the situation problematic.

In formal terms, it is an unusual judgment, because Hayden J did not, in fact, decide anything. He could have undertaken an exercise to enable him to make a declaration under s.15(1)(c) that the actions of the RHND in treating GU had been unlawful. However, he declined to do so on the basis that this was neither necessary or appropriate (paragraph 40). Rather, he considered it necessary:

> *to evaluate whether GU's dignity was properly protected and, if not, why not. The hearing on 15th July 2021, was specifically convened to afford the RHND an opportunity carefully to review their approach to GU's treatment and to assist this court in understanding what the Official Solicitor rightly, in my judgement, identifies as the 'inordinate and inexcusable delay' in determining GU's best interests.*

A striking feature of the judgment was the extensive review of passages from domestic and international cases and legal instruments, "*to signal and analyse the emphasis given to human dignity, in order to evaluate its application to this case and more widely to the many challenging decisions that the Court of Protection is required to take*." During the course of this, he set out his clear view that:

> *64. Thus, whilst there is and can be no defining characteristic of human dignity, it is clear that respect for personal autonomy is afforded pre-eminence. Each case will be both situational and person specific. In this respect there is a striking resonance both with the framework of the Mental Capacity*

Act 2005 and the jurisprudence which underpins it. The forensic approach is 'subjective', in the sense that it requires all involved, family members, treating clinicians, the Courts to conduct an intense focus on the individual at the centre of the process. Frequently, it will involve drilling down into the person's life, considering what he or she may have said or written and a more general evaluation of the code and values by which they have lived their life.

65. The case law of the Court of Protection reveals this exercise, in my judgement, to be receptive to a structured, investigative, non-adversarial enquiry which, as here, frequently establishes a secure evidential base, illuminating P's wishes and feelings. This investigation requires sensitivity, intellectual integrity and compassion on the part of all those involved. The beliefs and/or prejudices of others are entirely extraneous to the question of what P would want in the circumstances which he or she finds themselves in. Sometimes, where P has become isolated and alone the investigation may be inconclusive but experience shows and the case law reveals, that many of us leave a mark on those around us and closest to us which is clearer, stronger and more enduring than perhaps we might anticipate (See: N, Re [2015] EWCOP 76; Sheffield Teaching Hospitals NHS Foundation Trust v TH & Anor [2014] EWCOP 4). The outcome of this investigation will, of course, never achieve the same evidential weight as a strong, clearly expressed wish by a capacitous individual. But, the evidence of the code by which P has lived his life and the views he has expressed (which cast light on the decision to be taken) frequently provide powerful evidence when evaluated against the broad canvas of the other forensic material.

66. Although it is not an issue in this instant case, evaluating the codes and values by which an individual has lived his life will, in many cases, involve taking account of both religious and cultural beliefs. This is not to be equated with a superficial assumption that because a person is a member of an identified faith, he will inevitably have wanted a particular medical decision to be taken. It must be recognised that within any faith or culture there will exist a diversity of interpretation and practices, some of which will be extra-doctrinal and not easily reconcilable with the theological strictures of the faith. Thus, for example, some Roman Catholics whilst having a clear religious identity may nonetheless choose to practice birth control; some Jews may not adhere to prescribed dietary requirements; some Muslims may not observe Ramadan. Even those who do not regard themselves as having a faith may have grown up in countries or families where faith-based beliefs have migrated into more general cultural values. All this is in sharp focus when considering what is often referred to as the 'sanctity of life', a phrase which is rooted in religious lexicon, though it has developed a broader meaning in the law (e.g. sanctity of contract). When considering what P would want, it is his own religious views and practices that need to be focused upon and not the received doctrine of the faith to which he subscribes. The latter approach risks unintentionally subverting rather than promoting the autonomy that is integral to human dignity.

Further, and in a helpful reminder of contextual factors, Hayden J observed that:

87. When considering the likely wishes of an incapacitated adult, the religious codes and community values within which he or she has lived will be an important facet of the subjective evaluation of best interests. These are however, for the reasons considered at para 59 [this may be a typographical error for 66] *above, essentially extraneous and contextual factors which can never be permitted to occlude the far more rigorous exercise of identifying what P most likely believed and what he or she*

would have wanted in circumstances where medical treatment had become burdensome and futile.

Bringing his attention to bear upon the obligations imposed upon treating organisations, Hayden J emphasised that:

> *98.* […] *The judgment in the Supreme Court in re: Y* […] *and the available guidance make it pellucidly clear that the person responsible for making decisions in this sphere, where P lacks capacity, is the individual with overall responsibility for the patient's care, as part of their clinical responsibility to ensure that treatment provided is in the patient's best interests. This will usually be a consultant or general practitioner. This is reflected, almost verbatim within the Royal College's guidance* [i.e. the RCP guidelines on prolonged disorders of consciousness] *and it does not permit of any ambiguity.*

In relation to the RHND itself, Hayden J observed that:

> *99. After what I strongly suspect were years of real distress and concern, the pressure to convene a best interests meeting was, ultimately, generated by E (GU's brother). Even a moment's reflection will reveal that this puts a family member in a highly invidious position. The RHND's failure to act led to a situation in which E had to press for the discontinuance of treatment in order that his own brother (GU) might be permitted to die with dignity. Many in E's situation might have found themselves unable or unwilling to take this course. They should not have to do so.*
>
> *100. The* [RCP] *guidance emphasises that the central point to keep in mind is that the decision-making process is about the best interests of the individual patient not what is best for those who are close to, or around them. I was told by the CEO of RHND that the discontinuance of life sustaining treatment in the kind of circumstances arising here causes distress to staff, other patients and their families. It was clearly intended to signal that this was, in some way, a reason to delay the best interests decision-making process. I have no doubt that these cases cause deep distress to others in the hospital. Indeed, it would be concerning if they did not. I have equally no doubt that these considerations have no place at all in evaluating GU's best interests. Factoring these matters into the decision process is both poor practice and ethically misconceived.*

Hayden J was not attracted to the proposition that the guidance might need to be updated, tartly observing that he was not persuaded that there was a need for any further guidance:

> *102. I am not persuaded that there is a need for further guidance, beyond that which is folded into the analysis of this judgment. Indeed, I have come to the conclusion that the existing guidance must be restated and emphatically so. This Court's guidance* [Serious Medical Treatment [2020] EWCOP 2] *was released as recently as 17th January 2020 and is condensed into five pages. It is intended to be an easily accessible document. I am aware that it is widely consulted. It is, I hope, a convenient gateway to the wider case law and to the other available professional guidance.*
>
> *103. What does require to be spelt out, though it ought to be regarded as obvious, is that where the treating hospital is, for whatever reason, unable to bring an application to the court itself, it should recognise a clear and compelling duty to take timely and effective measures to bring the issue to the attention of the NHS commissioning body with overall responsibility for the patient.*

Finally, he observed that:

> *105.* […] *The Royal College has issued guidelines, they are to be treated as such and not regarded as set in stone. Consideration of a patient's best interests arises in response to clinically identified need. The need for an assessment is driven by what the patient requires and not confined to the structure of annual review* [as recommended as the minimum in the RCP Guidance]. *In simple terms, it requires to be kept in constant and unswerving focus. (see e.g.;* ***Cambridge University Hospitals NHS Foundation Trust v AH & Ors (Serious Medical Treatment) [2021] EWCOP 51****). Regular, sensitive consideration of P's ongoing needs, across the spectrum, is required and a recognition that treatment which may have enhanced the patient's quality of life or provided some relief from pain may gradually or indeed quite suddenly reach a pivoting point where it becomes futile, burdensome and inconsistent with human dignity. The obligation is to be vigilant to such an alteration in the balance.*

Comment

It is likely that advocates and others will regularly have recourse to Hayden J's review of the approach to dignity in the case-law.[4] For Alex's part, and having fought 'dignity wars' in different contexts, he does still require some persuasion that it is necessarily the answer to really difficult questions.[5] He would, however, entirely agree that the way in which the dignity of the individual in question is spoken about will be very revealing of the person doing the talking.

The judgment also stands as a clear restatement of both the procedural and substantive requirements in relation to decision-making. For our part, the four critical points to draw out would seem to be the following:

1. Proper best interests decision-making is a matter of good governance, requiring identification of who is responsible for coordinating the process and (if different) who is responsible for implementing any decision that is taken;

2. Best interests decision-making is an ongoing process, requiring review both on a regular basis and whenever a material factor emerges which might change the calculus;

3. Even if implementing a decision may challenge the conscience of those involved, they are still obliged to undertake the process of consideration of what course of action is in the best interests of the person (see also in this regard this case).

4. Where there is no consensus, action has to be taken by the public body responsible to obtain a timely resolution from the Court of Protection.

[4] Professor David Feldman's articles: "*Human dignity as a legal value - Parts I and II*" [1999] Public Law 682-702 and [2000] Public Law 61-71 make a good introduction to the – very extensive – academic literature about the concept.

[5] Similarly, 'autonomy' is also a term which can sometimes obscure more than it reveals. Some may find this podcast discussion between Dr Camillia Kong, Jane Richards and Alex of interest here.

It is understandable, at one level, why Hayden J did not wish to engage in an analysis of whether the actions of the RHND were unlawful. Had he done so, a number of very difficult questions would have arisen. If and when they arise again, it may be that assistance can be gained from a German Federal Court of Justice decision in 2019 in a very similar situation.

Winter is coming

The DHSC has published its Adult Social Care Winter Plan for 2021-22 (together with a review of its previous plan). For present purposes, of most relevance, given that this continues to be source of real concern, is what it says about visiting in care homes:

> *Visiting in care homes*
>
> *It is critical to support all people who receive care to safely meet with their loved ones, even in the most high-risk settings. Residents should have visiting opportunities throughout the winter, in line with current government and local guidance, as outlined below.*
>
> *National support*
>
> *We regularly update our guidance on care home visiting to outline how providers can take a dynamic risk-based approach to support safe visiting in and out of care settings, with the support of their local director of public health (DPH) where required.*
>
> *We have strengthened the recognition of the role of essential care givers to ensure residents can have visitors in most circumstances, including during an outbreak.*
>
> *Actions for local authorities*
>
> *Directors of public health (DPHs) and directors of adult social services (DASSs) have an important role to play in supporting visiting, and in supporting the care home to deliver safe visits into care homes. This may be through a dedicated care home outbreak management team or group, often in partnership with local social care commissioners. The DPH should work with the local DASS in developing and communicating their advice to care homes.*
>
> *Local authorities should support visiting, recognising its importance for resident welfare – any decision to take a more restrictive approach should be proportionate, targeted and time limited.*
> *In all cases, exemptions to any local restrictions should be made for visits to residents at the end of their lives.*
>
> *Local restrictions should also respect the role of essential caregivers, including allowing them to visit in most circumstances.*
>
> *Actions for providers*
>
> *Care home providers should:*

- *develop and update visiting policies that enable visiting, where it is possible to do so, while keeping residents safe – this should be done in line with published guidance on care home visiting (which covers testing, PPE and individual risk assessments)*

- *ensure that all residents can nominate an essential caregiver*
- *encourage visitors to get the COVID-19 vaccine and flu vaccine before visiting, if eligible*

- *advise visitors to stay away from care settings if they have any flu symptoms*

- *in the case of an outbreak, stop visits in and out of the care home, unless from an essential caregiver or for an end-of-life visit*

The Winter Plan also reiterates the importance of DNACPR decisions being applied in a blanket fashion to any group of people. The DHSC has established a Ministerial Oversight Group on DNACPR decisions that is responsible for the delivery and required changes of the recommendations in the CQC report: Protect, respect, connect – decisions about living and dying well during COVID-19 report. Public-facing information has now been published by NHSEI, which sets out what a DNACPR decision is, how it should be applied, who should be involved and what to do if an individual or their loved ones have concerns. This information can be found on the NHS England website. Alex has also done a shedinar on DNACPR recommendations and advance care planning.

Finally, and in a commitment which will be welcome, DHSC notes that (in response to a recommendation in the review of the last plan) that:

> *We are conducting a full review of all adult social care guidance to ensure that it is clear and consistent. The department is engaging with stakeholders as part of this review process to ensure that our guidance is tested with the end user before publishing and to ensure that the messaging is accessible for the sector. The department will also ensure that guidance is accompanied by a summary of changes table for each guidance update.*

PROPERTY AND AFFAIRS

Small Funds consultation

Families seeking access to small funds belonging to loved ones who lack mental capacity will benefit from a simpler and quicker system, under plans set out by the Ministry of Justice.

A new streamlined process would allow withdrawals and payments from cash-based accounts, up to a total value of £2,500 – without the need to get permission from the Court of Protection.

Currently, if a person lacks mental capacity and as a result cannot manage their finances, a family member or guardian must apply to the Court of Protection to manage these funds. This is to protect vulnerable people from fraud or abuse.

However, concerns have been raised that this can be a disproportionately costly and lengthy process to access relatively small amounts of money. The Government has therefore launched a consultation on a new system to ease the administrative burden on families.

The consultation can be found here.

By way of background, the impetus for this has come about in large part because of issues relating to accessing Child Trust Funds held by banks in the name of individuals who have now turned 18 and lack the capacity to make decisions about managing their property and affairs. This issue – and the legal complexities to which it gave rise – were discussed by Alex here.

Medical disclosure information to attorneys and deputies

The Office of the Public Guardian has published guidance around disclosure of medical and care information to attorneys and deputies to enable them to make best interest decisions on behalf of the donor. It is particularly helpful in tracking through the operation of data protection law, which is sometimes seen as a bar to disclosure of information. As the guidance explains, data protection law does not stand in the way of appropriate disclosure to enable attorneys/deputies.

Short note: deputies, ACC and the Care Act

In *Calderdale MBC v AB* [2021] EWCOP 56, Senior Judge Hilder gave judgment – or rather, gave permission to publish the order in the case, having reached determined the issues – that a property and affairs deputy is not the person authorised under the MCA to make decisions about the person's needs for care and support within the meaning of s.32(4)(a) of the Care Act 2014.

The case arose out of an application for authorisation of AB's community deprivation of liberty made by the local authority. This included an application by the local authority for a clarificatory declaration which in turn stemmed from a query or "concern" raised by the deputy, Mr Lumb.

AB had a local authority funded package of care which was provided by his siblings and paid for via direct payments made to his brother-in-law, DB. Mr Lumb queried whether in fact the management of AB's direct payments should instead fall to him and whether the carers used (ie AB's siblings) should be CQC-registered.

The local authority, in submissions which were apparently unopposed by any other party (the order records AnB and Mr Lumb agreeing with the local authority position; the Official Solicitor taking no position) submitted that where an adult lacks capacity to request their needs be met through direct payments, s.32 of the Care Act 2014 applies. The P&A deputy Mr Lumb, it submitted, was not the person authorised under the MCA to make decisions about P's needs for care and support within the meaning of s.32(4)(a)). It argued that the authority to be an "authorised person" under s.32 Care Act was not the authority to *"'apply P's funds to meet the costs of care arrangements,'* (as the decisions would not be in relation to P's funds at all, and the money would not become P's own assets); but rather authority to *'make decisions about the adult's needs for care and support*', which would appear to contain within it an inherent *'determination of P's care needs"'* [order para 5f].

As the deputy was not the authorised person, the decision about direct payments rested with the local authority whose role it was *"to determine whether the person seeking direct payments was a 'suitable person' who would act in the adult's best interests in arranging care and support and is capable of doing so, per s32(4)(c)and s32(7)*" [order para 5h]. There was no authorised person under the Care Act; the ultimate arbiter of suitability as to who might be an appropriate recipient of direct payments therefore rested with the local authority.

As a final coda to the order/judgment, HHJ Hilder drew the parties' attention to paragraphs 52-56 of her judgment in *ACC & Ors*, in which she set out (the limits upon) the powers of deputies.

This judgment should not, in principle, be 'news' to anyone. It is, however, important for clarifying the interaction between two different forms of statutory authority, granted to different people for different purposes.

PRACTICE AND PROCEDURE

Communication and participation in the Court of Protection - new training video

Researchers on the AHRC-funded project, *Judging Values and Participation in Mental Capacity Law*, based at the ICPR, Birkbeck School of Law, have pioneered a training film for specialist lawyers who work in the Court of Protection, "Communication and Participation in the Court of Protection," now available on YouTube. The video, developed in association with VoiceAbility, utilises role-plays and roundtables with lawyers (including our very own Tor) and people with learning disability and autism to demonstrate how to enhance communication and achieve better quality evidence for the court.

The video is now available on YouTube here. The Judging Values and Participation in Mental Capacity Law project involves a team of academics from Birkbeck College, University of Bristol, and University of Oxford and the project is funded by the Arts and Humanities Research Council.

Contingency planning and the Court of Protection – what, if any, threshold has to be crossed?

North Middlesex University Hospital NHS Trust v SR [2021] EWCOP 58 (Katie Gollop QC, sitting as a Deputy High Court Judge)

COP jurisdiction and powers – other

Summary

What (if any) threshold needs to be satisfied before the Court of Protection can exercise its (relatively) newly discovered 'contingency' jurisdiction? This important question was before Katie Gollop QC, sitting as a Deputy High Court judge, in this case. The question arose in the question of birth planning for a woman, SR, with a number of mental health difficulties. At the point that the application came before the court, she had capacity to make decisions about her birth arrangements and (perhaps unusually in these case) there was agreement between her and the professionals involved that the right method of delivery was by way of caesarean section. There was, however, a concern that she might lose capacity on or before the point she was to come to hospital for a surgical delivery.

The application came before the court on an urgent basis, which led Katie Gollop QC to add her voice to the consistent judicial chorus of concern as to timing. As she noted:

> *27. The Guidance given by Keehan J in Re FG [2014] EWCOP 30, [2015] 1 WLR 1984 is not limited to pregnant women who lack capacity to make obstetric decisions as a result of a diagnosed psychiatric illness: it also applies to those with fluctuating capacity (see paragraph 9). It requires that application is made "at the earliest opportunity". In this case it was, or should have been, clear in September* [i.e. at least a month before the application was made] *that an application would be necessary because SR fell within two of the four categories identified in the Guidance. Those were and are that there was a real risk that she would be subject to more than forcible restraint, and a real risk that she would*

suffer a deprivation of her liberty which, absent a Court order, would be unlawful. It is necessary to draw attention to the Guidance again because it is still not as widely observed as it should be.

28. Trusts and their advisors may be tempted to think that in a case where all concerned agree that P has capacity, and the medical treatment the clinicians propose to provide is in accordance with the patient's wishes and feelings, no harm is done by making a late application. That is not the case: the evidence may change, capacity may change requiring the involvement of the Official Solicitor who will struggle to assist if she has no time to prepare, points of complexity may emerge during the hearing, and a late application puts pressure on an already busy urgent applications list. Where, as here, an ongoing situation mandates an application, delay must be avoided.

The matter being before the court, Katie Gollop QC was concerned to understand what the correct test was in law for making an anticipatory declaration or order. She was not in a position, she considered, to determine whether a threshold test was necessary nor, should it, be what the test was. Counsel for the Trust was unable to identify any authority that would assist, and the Official Solicitor was not involved (presumably because SR was considered to have litigation capacity), such that no submissions were received from that corner. However, Katie Gollop QC ventured some observations, as follows:

41. […] *First, the making of contingent declarations will almost always be an interference with, or have the potential to interfere with, the Art 8 ECHR rights of the individual concerned to respect for their private and family life, including their autonomous decision making about what is done to them physically. That potential exists even where, as here, the contingent declaration made accords with, promotes, and facilitates the person's current, capacitous decisions, and thus their autonomy. It exists even in those circumstances because, whether capacitous or incapacitous, people have the right to reconsider their positions and change their minds. Indeed, in an evolving healthcare situation, the changing clinical picture may require reconsideration of previously made decisions. Ideally, everyone should have access to the full range of options when the time comes to put into effect a decision about their private and family life but a contingent declaration or order, restricts that full range. It is for this reason that such relief should only be granted where it is necessary, justified and proportionate, and why the power to grant relief should be used sparingly, or only in exceptional circumstances.*

42. In addition, I remind myself that before deciding whether to make any declaration or order, the court must, in accordance with s1(6) MCA, have regard to whether the purpose for which it is needed "can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action".

43. Given these safeguards, it is unclear whether an additional threshold test which must be crossed before an anticipatory order can been made is needed. It is possible that without one, a general requirement of "exceptional circumstances" or "sparing use", may risk the corrosion of rights that the Vice President warned against. Here, I bear in mind in his observations in Guy's and St Thomas's NHSFT that: "This factual situation i.e. a capacitous woman who is likely to become incapacitous, during the course of labour is relatively unusual but it is not unprecedented" (paragraph 3). It could be that the situations requiring anticipatory relief occur more commonly than the small number of

> *decided cases suggests. On the other hand, a threshold test may limit the court's power unnecessarily.*
>
> *44. If a threshold test is required, then it seems to me that a balance of probabilities would be unduly restrictive. (I do not read the Vice President's use of the word "likely" in Guys and St Thomas' NHSFT (see paragraph 34 above) as an indication that a contingent declaration should only be made where it is more likely than not that P will lose capacity.) I also agree with Ms Powell that an anticipatory order being final, the existence of a risk, and not merely the reasonable belief that there may be one, is required. I would suggest that "a real risk" that P may lose capacity is the appropriate threshold, and I note that that is the language used by Keehan J in Re: FG. "Real" means more than theoretical (or "technically possible" as Dr B put it), based on credible evidence rather than speculation, and the risk must, of course, be person specific and present at the time the relief is granted rather than historical.*

Applying this approach, Katie Gollop QC found that on the facts of the case there was a real risk that SR would lose capacity to make decisions about her labour and birth arrangements. She also found that it was necessary, justified and proportionate to make declarations which permit a caesarean section and restraint, and that SR's circumstances were exceptional. The decision in relation to the caesarean section itself was clear, not least because of SR's own (currently capacitous) wishes; the issue of restraint was more nuanced, but, ultimately, on the facts of the case, it was justified.

As a postscript, following judgment, the court was informed that despite some panic attacks during the process, SR's caesarean section delivery went ahead under a spinal anaesthetic, as planned on the morning of 25 October 2021. Mother and baby were both well.

Comment

Although the observations about whether – and if so – what test to apply in contingency planning cases were identified as obiter, they were undoubtedly more than just passing musings. A "real risk" of loss of capacity must, I would suggest, strike the right balance for the reasons identified, in a curious world in which the Court of Protection is being invited to wade into decision-making about a person who currently has capacity in the relevant domains.

Two further points arise for comment. The first was expressly – and importantly – identified by Katie Gollop QC, and relates to communication and information sharing between healthcare professionals. As she identified at paragraph 25: "[a] *pregnant woman who is under the care of psychiatric services, whether as an in-patient or in the community needs, and is entitled to, joined up care*." Helpfully, and no doubt alive as a practitioner to the misunderstandings that sometimes arise here, she then read into the judgment the relevant extract from the GMC's 2018 guidance *Confidentiality: good practice in handling patient information*:

> *"Sharing information for direct care*
> *26*
> *Appropriate information sharing is an essential part of the provision of safe and effective care.*

> *Patients may be put at risk if those who provide their care do not have access to relevant, accurate and up-to-date information about them.[9] Multidisciplinary and multi-agency teamwork is also placing increasing emphasis on integrated care and partnership working, and information sharing is central to this, but information must be shared within the framework provided by law and ethics."*

The second point arises out of the unusual fact-pattern of this case (unusual in the sense that 'non-dispute' cases in this context do not often come before the courts). This was a situation where there was alignment between the wishes of SR and the advice of the teams caring for her. Why, then, was a court application required? On one view, and with sufficiently robust advance planning, it might be thought that SR could have (in effect) bound herself to accept the interventions that she might require to give effect to her will, even if her preferences closer to the time were in conflict with this. This raises ethical questions as well as legal ones (see, here, this work from the Mental Health and Justice project). It is unclear, but likely, that it was the prospect of having to use restraint to bring about SR's safe transfer to and undertaking of any caesarean section, that triggered the application to court. If so, it is perhaps of some interest no-one seems to have thought that SR could in effect give advance consent to any restraint to which she might be subject. This is particularly so given that the Government has said[6] in the context of the White Paper on Mental Health Act reform that it thinks that the law already provides that it is possible to give advance consent to admission to psychiatric hospital so as to circumvent the need to consider the use of either the MHA 1983 or DOLS if at the point of admission the person is to be confined and lacks capacity to consent. It will be interesting to see whether this position is rolled forward into the draft Code of Practice to the MCA (including the LPS) when it finally makes its way out for consultation.

Systematically unlocking an entrenched problem

Re W (A Child) [2021] EWHC 2844 (Fam) (Family Division (Hayden J))

Other proceedings – family (public law)

This case, in public law proceedings concerning a disabled 12 year old boy, is nevertheless of interest to Court of Protection practitioners as it concerns the familiar situation in which the parents of a person with significant care needs find themselves in conflict with the professionals. W required 1:1 care at all times because of his disabilities,. The care agency threatened to withdraw their services, saying that the parents had:

(i) insisted on having oversight of the training of carers at all times;

(ii) required the removal of two of the carers from their position on unreasonable grounds;

(iii) alleged, without proper foundation, serious misconduct by the paediatric nurse with oversight of

[6] See Reforming the Mental Health Act (publishing.service.gov.uk) at page 64. The Independent Review of the MHA 1983 had considered whether or not to introduce such an idea, but could not agree.

W's care package and demanded her de-registration before their allegation had been investigated;

(iv) declined to co-operate with a review of W's care package despite having complained that he is not being adequately supported by trained health care staff; and

(v) refused to permit the emergency services to be called promptly even though W's oxygen saturation levels had dropped below 85% on a particular date.

As is common in public law proceedings involving children, the court ordered a psychological assessment of W's parents, focusing on their ability (or otherwise) to provide adequate parenting to him. The psychologist who prepared the report, Dr Hellin, found that neither parent had any mood disorder or other psychological problem, and, more importantly, that their emotional and strong responses to professionals were no more than to be expected given the circumstances:

> *12. Dr Hellin did not consider that either parent had any sign of mood related problems, personality disorder or serious mental illness. M was assessed as a "balanced, thoughtful woman with considerable psychological resilience". There was nothing to suggest that she has "health anxiety or abnormal illness behaviour" rather, her psychological state had deteriorated in consequence of W's health needs and the demands placed on her, particularly as those needs had become more complex. M's mental health had become acute when W had a crisis involving a bowel intussusception and brain haemorrhage, in December 2019. At that time Dr Hellin considered that M would have met the criteria for post-traumatic stress disorder, which she would no longer now meet. Nonetheless, this acute episode left a legacy of a "heightened level of resting anxiety". As Dr Hellin points out in clear and unambiguous terms, this anxiety is "rational" and based in the "cumulative reality of life-threatening medical events in [W's] life and the uncertainty of his condition and prognosis". M's response to the very challenging circumstances she faces are said to be "normal" and Dr Hellin would expect "a similar response in even the most psychologically robust person".*
>
> *…*
>
> *13.* […] *Dr Hellin goes on to describe how W's needs and extensive disabilities cast the parents own lives deep into the background:*
>
> > *"They live with ongoing intense chronic and acute stress, day-to-day anxiety about his survival, the uncertainty regarding his future and their limited sense of control, at times, in the face of complex commissioning and care/medical delivery systems."*

In the course of the judgment, Hayden J cited the following passage from *Re K and Ors (Children)* [2011] EWHC 4031 (Fam). an earlier case decided by Hedley J. Although again a case concerning children, the essential points about the role of the family in the care of a person with disabilities may be thought to apply to those children once they attain the age of 18.

> *"30. Cases of severely disabled children do not, as I have indicated, sit easily or conveniently within the scope of Part IV of the Children Act 1989... It seems to me that legal proceedings will often, at best, have a very limited contribution to make in cases like this. Whatever its deficits may be perceived*

> *to be, the family unit, if functional, is of central importance to the permanently disabled for it is the one fixed point in the constantly moving waters of state care provision. The welfare of such children over a lifetime is closely bound up with the ability of the family to remain a functioning and effective unit.*

In W's case, Hayden observed that similarly, "*the court would not be best assisted by evaluating the issues in terms of the parent's perceived failures or any mental health difficulties. It requires a recognition by the professionals that these are ordinary parents dealing with extraordinary circumstances. Dr Hellin considered that the entire aetiology of these challenging circumstances is better understood within 'a different paradigm' and should be considered from 'a systemic or organisational perspective'.*"

Hayden J summarised Dr Hellin's conclusions at paragraph 16:

> *"There are certain features of the system around W which make it more, rather than less, likely that problems will arise in it. First, it is a very complicated system.*
>
> *Second, the stakes are very high. Ultimately, this is about keeping a child alive and ensuring his best possible quality of life.*
>
> *Third, commissioners face what many would consider to be impossible decisions about resource allocation.*
>
> *Fourth, care work is intrinsically stressful, and the pressures on health professionals and care staff have been vastly increased by the Covid-19 pandemic.*
>
> *These factors all affect the emotional climate of the system around W and the relationships between those components of the system.*
>
> *The system around W has become sensitised and inflamed. Feelings have run high and perspectives have become polarised and entrenched.*
>
> *[M] and [F], individual professional staff and their organisations have become stuck in polarised beliefs about each other.*
>
> *It has become difficult for the parents and for professionals to respond moderately in ways that sooth rather than exacerbate the dynamic tensions between the different parts of the system.*
>
> *I hope it will be apparent that this analysis does not apportion blame.*
>
> *The family, commissioners and health and social care providers are all affected by the dynamic context in which they are trying to do their best.*
>
> ***Rather than looking to change the parents, I recommend a systemic intervention drawn from organisational psychology, psychodynamic psychotherapy, group analysis and systems theory.***

> *The intervention would assist all agencies and the parents to understand the dynamic processes that have led to the current difficulties, to step back from mutual blame and recrimination, to establish working practices which will contain and diminish sensitivities and optimise collaboration between the different parts of the system.* *(my emphasis)*
>
> *I recommend that an organisational or a systemic supervisor/consultant is employed to work with the system and facilitate systemic meetings within which the aims set out in the paragraph above would be addressed.*
>
> *The involvement of the Court has radically shifted the dynamics of this system.*
>
> *The involvement of their legal representatives and of the Court, a neutral authority, has diluted the emotional intensity of the polarised "them and us" dynamic which previously existed between the parents and the health/care providers."*

Comment

It will be interesting to see whether this judgment is relied on by CoP practitioners, either to seek an independent psychology report in cases where there is longstanding or entrenched conflict between families and professionals, or to seek the involvement of an '*organisational or a systemic supervisor/consultant'* either instead of or alongside court proceedings. Most practitioners will be able to think of at least one case where proceedings were hugely protracted without the underlying problems being properly resolved, and this judgment may provide a template for alternative ways of approaching such cases.

Going with or against the grain of the MCA – the inherent jurisdiction overseas

AB v XS [2021] EWCOP 57 (Lieven J)

COP jurisdiction and powers – other

Summary

This case concerned XS – a 76 year old UK-Lebanese dual national – then resident in Lebanon. The applicant was her cousin AB, who wished XS to return to the UK. Lieven J had to decide whether it was in the best interests of XS, who had been diagnosed with Alzheimer's disease in 2013, to return to the UK six years after she had moved abroad to Lebanon. The application was opposed by XS's nephews in the UK.

Habitual Residence

Lieven J firstly had to decide whether she had jurisdiction on the basis that XS was based abroad. She directed herself by reference to s.63 MCA 2005 which states:

> *"63. International protection of adults*

> *Schedule 3 –*
> *(a) gives effect in England and Wales to the Convention on the International Protection of Adults signed at the Hague on 13th January 2000 (Cm. 5881) (in so far as this Act does not otherwise do so), and*
> *(b) makes related provisions as to the private international law of England and Wales.*

Relevant provisions for the determination of jurisdiction in this case from Schedule 3 include:

> *7.*
> *(1) The court may exercise its function under this Act (in so far as it cannot otherwise do so) in relation to –*
> *(a) an adult habitually resident in England and Wales,*
> *(b) an adult's property in England and Wales,*
> *(c) an adult present in England and Wales or who has property there, if the matter is urgent, or*
> *(d) an adult present in England and Wales, if a protective measure which is temporary and limited in its effect to England and Wales is proposed in relation to him.* (emphasis added)

Lieven J reviewed the case-law on habitual residence (at paragraphs 22-5), and considered that the critical question was XS was now integrated into society in Lebanon (see paragraph 29). Lieven J considered that XS was habitually resident there on the basis of the evidence that:

> *28.* […] *she has now stayed for 7 years and is physically integrated into the nursing home and with the staff there. Her medical and therapeutic needs are being met in Beirut, and it has undoubtedly become her home. It is of some relevance that XS was born in Lebanon and has Lebanese citizenship, although on the facts of the case these are probably less weighty factors.*

Lieven J found that it followed that XS was habitually resident in Lebanon and, as a Court of Protection judge, she had no power under the MCA to make a return order.

The Inherent Jurisdiction

The second issue that the Lieven J had to consider in light of her conclusion above was whether she had could or should exercise her powers as a High Court judge under the inherent jurisdiction to order XS's return to the UK. In determining whether it would be appropriate to exercise the inherent jurisdiction Lieven J reviewed the case law, and in particular the decision in *Re QD (Jurisdiction: Habitual Residence)* [2019] EWCOP 56 where Cobb J declined to exercise the inherent jurisdiction in somewhat similar circumstances.

At paragraph 35, Lieven J concluded that it would be:

> *plainly inappropriate to exercise the inherent jurisdiction to make an order to return XS to England because it would cut across the statutory scheme for no principled reason. I have found that she is habitually resident in Lebanon, and therefore I cannot make an order for return under the MCA. However, the MCA has provisions in Schedule 3 for making welfare decisions in respect of*

> *incapacitated adults with an international dimension. To make such a welfare order under the inherent jurisdiction would be to cut across the carefully crafted statutory scheme applicable to precisely people in XS's situation, and as such would be a misuse of the inherent jurisdiction.*

Lieven J accepted that the nature of the inherent jurisdiction that meant that each case always needed to be considered on its own particular facts, and the court must always retain a element of flexibility. However, in this instance, she was clear that "*this case falls quite clearly on the wrong side of the line in relation to cutting across a statutory scheme"* (paragraph 37).

Best Interests

Although, strictly, she did not need to do so in light of her conclusions above, Lieven J analysed, separately, whether it would be in XS's best interests to return to England and Wales. She noted that the evidence from the specialist geriatric psychiatrist showed that XS was very frail, was in the advanced stages of dementia and could die at any time. She also considered (paragraph 39) that XS was familiar with her environment and carers in Lebanon with the resulting risk that to bring her to the UK would be "*extremely disruptive"*. The limits of the benefits of any such move were set out at paragraph 40 – with the evidence suggesting that "*she will be wholly unaware of the fact that she has moved to England and will not know either the Applicant or any of the other people she knew in England."*

In conclusion, and in finding it would not be in XS's best interests to return to the UK, Lieven J stated as follows:

> *Taking all these factors together, my view is that XS's best interests are served by her remaining in Lebanon and spending her days there. In reaching this conclusion I fully take into account the strong views of the Applicant and GH that XS would have wished to return to the UK. However, I have to judge the situation as it is now, and what is in XS's interests now.*

Comment

The case shows that a clear justification is required for cutting across the statutory regime of the Mental Capacity Act 2005 by invoking the inherent jurisdiction. It is perhaps of note that Lieven J felt it necessary to give specific – independent – consideration to XS's best interests notwithstanding the fact that she had reached a conclusion that she would not intervene on jurisdictional grounds. Even though not referred to the judgment, Lieven J was no doubt aware that Peter Jackson J (as he was then was) had accepted in *Re Clarke* [2016] EWCOP 46 that the High Court's nationality-based inherent jurisdiction existed in relation to those lacking the relevant decision-making capacity. Further, given her conclusions as to XR's habitual residence, it must logically have been the position that all of the previous directions in the case (for instance the instruction of the geriatric psychiatrist) were made under the High Court's inherent jurisdiction. There is, perhaps, no disconnect, though: directions made to enable examination of the position and informing the court of the position were not cutting across the grain of the MCA; in XR's case, Lieven J considered that granting substantive relief requiring her return would be a step too far. The position might have been different, however, if Lieven J had been

persuaded that XR's best interests in fact dictated a return home – at that point, it would be logical to see the use of the inherent jurisdiction as plugging a protection gap.

Experts in the Family Court

The President of the Family Division has published a brief memorandum that it is likely to be of assistance by analogy in the context of proceedings before the Court of Protection, given the alignment between the statutory tests applied in the two jurisdictions.

It repeats the reminder that experts should only be instructed when to do so is 'necessary' to assist the court in resolving issues justly. In summary, the memorandum provides as follows.

Admissibility: The court will consider whether the expert evidence is admissible, following the guidance of Lord Reed PSC in the Supreme Court in *Kennedy v Cordia (Services) LLP (Scotland)* [2016] UKSC 6.

Scope of expert evidence: Experts may offer evidence of both opinion and fact, including 'drawing on the work of others, such as the findings of published research or the pooled knowledge of a team of people with whom they work.'

Governing criteria: 'There are four criteria which govern the admissibility of opinion evidence of an expert'….:

(i) whether the proposed expert evidence will assist the court in its task;
(ii) whether the witness has the necessary knowledge and experience;
(iii) whether the witness is impartial in his or her presentation and assessment of the evidence; and
(iv) whether there is a reliable body of knowledge or experience to underpin the expert's evidence.

Assisting the court: 'If scientific, technical or other specialised knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise.'

The expert's knowledge and expertise: 'The expert must demonstrate to the court that he or she has the relevant knowledge and experience to give either opinion evidence, or factual evidence which is not based exclusively on personal observation or sensation.'

Impartiality: 'If a party adduces a report which on its face does not comply with the recognised duties of an expert witness to be independent and impartial, the court may exclude the evidence as inadmissible.'

Reliable body of knowledge or experience: The court will be easily satisfied of the reliability of the relevant body of knowledge where the expert is providing evidence in a recognised scientific discipline; *'[t]here is more difficulty where the science or body of knowledge is not widely recognised. The court will refuse to authorise or admit the evidence of an expert whose methodology is not based on any established body of knowledge.*'

Necessity: Expert evidence 'will only be "necessary" where it is demanded by the contested issues rather than being merely reasonable, desirable or of assistance…This requirement sets a higher threshold than the standard of "assisting the court" set out above.

It should be noted that this requirement does not extend to proceedings under the High Court's inherent jurisdiction concerning a vulnerable but capacitous adult.'

To avoid delay, 'courts should continue to consider each application for expert instruction with care so that an application is granted only when it is necessary to do so.'

Duties to the Court and Professional Standards: The duties of an expert to a court 'include requirements to have been active in the area of work; to have sufficient experience of the issues; to have familiarity with the breadth of current practice or opinion; and if their professional practice is regulated by a UK statutory body…that they are in possession of a current licence, are up to date with CPD and have received appropriate training on the role of an expert in the family courts.'

Separate guidance exists for psychologists acting as experts.

THE WIDER CONTEXT

Revocation of Schedule 21 to the Coronavirus Act

The DHSC has now revoked the operation of the powers granted to public health consultants in England under Schedule 21 to the Coronavirus Act to address potentially infectious persons, including by way of requiring them to self-isolate. This does not mean that there are no such powers available, but where required the provisions of the Public Health Act 1984 will be required. It should be noted that the powers under Schedule 21 (and those under the 1984 Act) were/are always of questionable use in relation to those with impaired decision-making capacity, relying as they did/do primarily upon the threat of criminal sanction: in reality an empty threat for a person who cannot understand that they are doing anything wrong.

CQC State of Care report

The Care Quality Commission's report 'The state of health care and adult social care in England 2020/21' was printed on 21 October 2021 and can be found here.

The data used in the report came primarily from the CQC inspections and the information obtained during that process from people who use services, their families and carers. The report examines people's experience of care and draw some depressing but not unexpected conclusions including that:

- The impact of the pandemic on many who use health and social care services has been intensely damaging.
- The pandemic has further exposed and exacerbated already existing inequalities for some groups in accessing high quality care.
- People with a learning disability have faced increased challenges as a result of the pandemic.
- The need for mental health care has increased, with children and young people particularly badly affected.
- The strain on carers has intensified.
- Health and social care staff are exhausted and the workforce is depleted, leading to serious consequences for providers and those they care for.

Of particular interest is the conclusion that while services have largely maintained levels of Deprivation of Liberty Safeguards during 2020/21, the CQC continues to have concerns about delays in authorisations, resulting in individuals being deprived of their liberty longer than necessary, or without the appropriate legal authority and safeguards in place.

There are of course no easy answers, but the forward to the report identifies a need for accelerated

funding to be made available to target areas, a need for long term funding, and the development of new models for urgent and emergency care.

BPS guide to best interests decision-making

The British Psychological Society has published a helpful guide to best interests decision-making.

Alice in Wonderland, or using the Human Rights Act to extend the coercive powers of the MHA into the community

Cumbria, Northumberland Tyne & Wear NHS Foundation Trust & Anor v EG [2021] EWHC 2990 (Fam) (Lieven J)

Article 5 ECHR – deprivation of liberty

Summary[7]

When can a mental health patient lawfully remain in the community, rather than in hospital, but be deprived of their liberty in the community? In 2018, the Supreme Court in *MM* held that a restricted patient cannot be discharged from hospital under the MHA 1983 on conditions that amounted to a deprivation of liberty. The – sometimes odd – consequences of this decision continue to be felt, and have fallen again to be considered by Lieven J. As identified at the outset of her decision, the issues she had to consider were:

1. Whether s.72 MHA can be construed to allow the detention of a restricted patient in a community setting pursuant to s.17(3) MHA where that person has not resided in, or been treated by, a hospital for a considerable period of time; and

2. If it cannot, either by purely domestic statutory construction, or by recourse to the HRA 1998, can the same result be achieved by operation of the High Court's inherent jurisdiction?

As is the case in a number of the post-*MM* cases, EG's case concerned someone who had been conditionally discharged from hospital, whom it was considered by the clinical team and the Secretary of State (1) should remain in the community; (2) subject to conditions amounting to a deprivation of liberty; and (3) who had capacity in the relevant domains. He was therefore subject to a 'technical' recall by the Secretary of State – i.e. he was not actually required to return to hospital, but was immediately placed on s.17(3) MHA 1983 leave. He was automatically referred to the Mental Health Tribunal in consequence of his recall. The Tribunal found that there was no element of treatment in hospital at all, and, indeed, his team were actively avoiding a readmission to hospital because they thought it would bring about a deterioration in his mental state. It therefore felt it had no choice but to discharge EG because the criteria under s.72(1)(b)(i) were not met, even though this did not serve the interests of any party (including, it considered, EG) or the public. The Trust and the Secretary of

[7] Nb, Tor having been involved in this case, she has not contributed to this note.

State were granted permission to appeal, and Lieven J heard the appeal both as a judge of the Upper Tribunal (to consider the MHA construction point) and of the High Court (to consider the potential use of the inherent jurisdiction).

Lieven J held that it was not possible to conclude, applying domestic principles of construction absent s.3 of the Human Rights Act 1998, that the Tribunal erred in law:

> *52. In EG's case he does not need to be detained in hospital for treatment. He has been receiving treatment with no connection whatsoever to a hospital for 7 years. The evidence shows that being in hospital, even as an out-patient, is positively counter-therapeutic for EG. As such, it is not merely that his treatment has no significant connection with hospital, rather it had and has, no connection at all. It is true that since his technical recall, his treatment has been supervised from hospital. But that is not because it is appropriate for him to be liable to be detained in a hospital for medical treatment, it is because that is the only way he can be deprived of his liberty after the Supreme Court's decision in MM. Therefore, the liability that is being created is not because his mental disorder makes it appropriate for him to be detained in hospital for treatment.*
>
> *53. In my view, the FTT applied the caselaw impeccably. They did not confuse the tests under s.20 and s.72. They applied that caselaw to the facts of EG's case and the evidence that not merely did he not need to be in hospital for treatment, but that it was actually harmful for him to receive treatment in hospital. It is noteworthy that in all the cases where the s.72 test was met, the patient was receiving some treatment in hospital, including some visits to hospital. For these reasons, in my view there was no error of law in the Tribunal's analysis of s.72, absent applying s.3 of the Human Rights Act.*

Lieven J therefore turned to consider whether the HRA came to the rescue, in circumstances where everyone before her agreed that she should seek to avoid the outcome by which EG would be forced to return to hospital. On the specific facts of his case, she was satisfied that there would be a breach of Article 5(1)(e) ECHR if EG was forced to return to hospital:

> *64.* […] *The evidence is entirely clear that it is strongly against his therapeutic interests for him to be treated in hospital, even by going there as an outpatient. As the FTT record at paragraph 32 of its decision, the clinical team have been actively avoiding readmitting EG because it would bring about a deterioration of his mental health. This is not a situation where the State cannot meet EG's therapeutic needs because of lack of resources, or the way services are organised. An appropriate therapeutic milieu is available, but the law, as construed above, does not allow EG to be detained there.*
> *65. I accept Ms Butler-Cole's broad proposition that Rooman does not require a person to be detained in the least intrusive way. The focus of paragraph 208 is on the situation where a person's detention is being justified under Article 5(1)(e), but they are not receiving suitable therapy. Here, the evidence shows that in hospital EG would not be being given suitable therapy, however broadly one interprets that phrase. The situation EG would find himself in if he was returned to hospital would fall within the terms of [208] of Rooman.*
>
> *66. Ms Paterson now seeks to rely on Article 5(1)(a)* [i.e. on the basis that any deprivation of liberty followed a conviction of a competent court. Therefore, the detention would be justified on the

> basis of risk to the public, not therapeutic benefit.] *That reliance does not in my view work in law. The detention of EG is under s.72 of the Mental Health Act. He was made subject to a s.37/41 MHA order in January 1994 and was conditionally discharged to The Care Home by the FTT in April 2004. It is not now open to the Secretary of State to say that the tests in the MHA do not apply and the Court should consider the matter under Article 5(1)(a) instead.*

Lieven J therefore asked herself whether she could interpret s.72 MHA 1983 so as to prevent a breach of EG's Article 5 ECHR rights, and found that she could:

> *69. A Convention compliant outcome on the present case is one that allows EG (and others in his position) to be made lawfully liable to a deprivation of their liberty when they are in the community, so that there is no breach of Article 5(1)(e) as construed above. Mr Mant argues that to allow a restricted patient to be deprived of their liberty in the community on long term s.17 leave, without any part of their care plan involving treatment in hospital, is possible without straining the legislation beyond that permitted in Gilham.*
>
> *70. In my view it is possible here to adopt the same logical approach that was taken in Gilham. The natural construction of s.72(1(b)(i) is that set out above. However, that leads to a Convention non-compliant outcome as I have explained. It is therefore possible to read the sub-section that makes "liable to be detained" mean liable in law to be detained for treatment, even where that treatment is being provided in the community, so long as it could lawfully be provided in hospital.*
>
> *71. In my view, such a construction would not go against the grain of the legislation. The grain of this part of the statute might be said to be two-fold. Firstly, to allow the patient to be detained in a less restrictive setting, and secondly, to ensure that the protection of the public and an appropriate level of detention can be met. By construing the sub-section in this way, both purposes are met.*
>
> *72. It is important to bear in mind that the very nature of the s.3 exercise is that the court is reaching an interpretation which does not accord with the meaning of the statute applying normal domestic canons of construction. The caselaw makes clear that is a broad power which allows something very close to re-writing as long it does not cut across "the grain".*
> *73. It is therefore possible to construe s.72 as to not require the Tribunal to discharge, even where the link to the hospital is tenuous (as here), where such a construction is necessary in order to avoid a breach of Article 5. I will leave the parties to formulate a declaration that achieves this effect.*

Having reached this conclusion, Lieven J did not strictly need then to consider the question of whether (as a High Court judge) she could or should use the inherent jurisdiction. However, as she had been addressed fully upon it, and the issue was an important one, she set out her (obiter) conclusions. After a detailed review of the (contradictory) authorities, she expressed the very clear view that the jurisdiction does not extend to depriving a person with capacity of their liberty for two fundamental reasons.

> *90.* [….] *Firstly, whether under Article 5 or the common law, the right to liberty is jealously protected and should only be removed in carefully understood and constrained circumstances. This has*

recently been reflected by the Grand Chamber in Ilnseher v Germany (Application No 10211/12) [2019] MHLR 278, drawing together dicta from earlier decisions of the court, stated (at para 129):

> *"the permissible grounds for deprivation of liberty listed in article 5(1) are to be interpreted narrowly. A mental condition has to be of a certain severity in order to be considered as a 'true' mental disorder for the purposes of sub-paragraph (e)"*

91. Although the legal issue being considered in Ilsenher at [129] concerned the scope of the grounds for lawful deprivation of liberty under Article 5, the underlying point that Article 5 rights have to be carefully protected, and any interference with those rights must be strictly construed, are relevant to the issue before me. The problems outlined by the Grand Chamber in HL v United Kingdom in respect of the lack of clear principles and appropriate legal safeguards to the use of the inherent jurisdiction continues to be the case. If anything, the breadth of the use of the inherent jurisdiction in the light of Re SA and the wide and potentially unlimited categorisation of a "vulnerable adult" serves to increase the concern about the unprincipled extension of the inherent jurisdiction into the area of deprivation of liberty. This analysis is not undermined by Re T, both because that case concerned children, and because of the role of the positive obligations under Articles 2 and 3.

92. A further reason for rejecting the argument that EG can be deprived of his liberty under the inherent jurisdiction is that the domestic caselaw, principally stemming from DL, shows that the use of the inherent jurisdiction in respect of vulnerable adults is a facilitative rather than a dictatorial one. It is to be used to allow the vulnerable person to have the space, away from the factor which is overbearing their capacitous will, to make a fully free decision. An order which deprives that person of their liberty is a dictatorial order which severely constrains their freedom, however well meant, rather than allowing them the space to reach a freely made decision.

Interestingly, and helpfully, the judgment then includes the order actually made.

Comment

The Supreme Court in *MM* (and, relatedly in *PJ*) made very clear that they considered that, if Parliament wanted to extend the coercive powers of the MHA 1983 into the community, it should make this clear. We are currently in the distinctly unsatisfactory situation where increasingly heroic and complicated hoops are being jumped through to address the situation of those in the position of EG (and/or those who would be in their position but for a finding that they lack capacity, at which point a parallel and arguably equally unsatisfactory set of provisions are being deployed). It is laudable, at one level, that all concerned are seeking to find ways in which to secure that those in the position of EG are not being recalled to hospital, but are being maintained in the community. But a real problem with judicial fire-fighting of the nature that Lieven J was being invited to undertake here is that it raises the potential for yet further unanticipated consequences arising out of the solution crafted to meet the particular problem before the court. In the circumstances, it is to be hoped that Parliamentary time will allow for measures to be brought forward as part of the reform of the MHA 1983 to allow (1) a proper debate about how far the coercive powers of the MHA 1983 should actually extend into the community; and (2) what safeguards are required in consequence.

Short note COVID-19, vaccination and children

In C (Looked After Child) (Covid-19 Vaccination) [2021] EWHC 2993 (Fam), Poole J started to approach some of the difficult questions that may be posed in relation to vaccination in respect of children. The case concerned a 12 year old boy, C, who was looked after by the Applicant Local Authority following a care order made in 2015. He wanted to be vaccinated with the Covid-19 and winter flu vaccines. He was supported by his Guardian and Local Authority who both considered it to be in C's best interests to have the vaccinations. His father had given his support for C's decisions. However, C's mother was strongly opposed to her son being vaccinated.

Poole J declined to embark upon an investigation of any competing theses as to whether national programmes of vaccination in relation to this age group were justified. He identified at paragraph 19 that:

> *In cases that concern vaccines that are part of national programmes, the question of whether expert evidence is necessary will only arise if there is an identifiable, well-evidenced, concern about whether, due to their individual circumstances, a vaccine is contraindicated for a particular child, or if there is, as MacDonald J put it in M v H, "new peer-reviewed research evidence indicating significant concern for the efficacy and/or safety" of one or more of the vaccines that is the subject of the application…". Even if such new research were available, I have serious reservations about whether an individual expert or individual judge could or should engage in a wholesale review of the evidence behind an established and continuing national vaccination programme. However, perhaps an expert could assist the court as to the quality and relevance of such new research. In the present case the issue does not arise - mere assertion that a vaccine is unsafe, however strongly expressed, does not meet either of the conditions under which expert evidence might be considered necessary to assist the court.*

Applying the decision of the Court of Appeal in *Re H (A Child) (Parental Responsibility: Vaccination)* [2020] EWCA Civ 664, Poole J observed that

> *21. In the absence of any factors of substance that might realistically call into question whether the vaccinations are in an individual child's best interests, decisions for the child to undergo standard or routine vaccinations that are part of national vaccination programmes are not to be regarded as "grave" decisions having profound or enduring consequences for the child.*

Poole J gave one important qualification to this concerning the role of *Gillick* competence (which he had previously recalled was child- and decision- specific: see paragraph 13):

> *22. There is one qualification that I would make to the general principles stated above. The Court of Appeal in Re H was concerned with vaccinations for infants or very young children. In this case, C may well be Gillick competent to make the decisions to be vaccinated. I have not undertaken an assessment of his Gillick competence because I consider it unnecessary to do so to answer the primary question raised in this case. The view of a Gillick competent, looked after child of C's age deserves due respect when considering any question of their best interests. Given that C consents to*

> *the vaccinations, there is no conflict between him and the Local Authority. If, however, such a child refused vaccination, that would raise different questions, namely whether the local authority with parental responsibility could override the child's decision and whether the issue should be brought before the court. As I noted in the brief review of the law above, it is established that the court may override a Gillick competent child's decision. Those questions do not arise in this case. There is advantage in this being a short and clear judgment and so I shall not indulge in an academic exercise.*

Poole J therefore confirmed that a local authority did not need to make any application to court in circumstances where: (i) such vaccinations are part of an ongoing national programme approved by the UK Health Security Agency, (ii) the child is either not Gillick competent or is Gillick competent and consents, and (iii) the local authority is satisfied that it is necessary to do so in order to safeguard or promote the individual child's welfare. There is no requirement for any application to be made for the court to authorise such a decision before it is acted upon. In the great majority of cases, therefore, even those involving parental objection, cases would not need to come to court. Poole J did, however, reiterate that s.33(3) CA 1989 does not give local authority carte blanche to proceed to arrange and consent to vaccinations in every case:

> *25.* […] *Firstly, it is acknowledged that local authorities should not rely on s.33(3)(b) in relation to grave decisions with enduring or profound consequences for the child. I cannot discount the possibility that an individual child's circumstances might make such a decision "grave". Secondly, pursuant to s.33(4) a local authority must make what has been termed "an 'individualised' welfare decision in relation to the child in question prior to arranging his or her vaccination." (per King LJ, Re H at [33]). Thirdly, as King LJ observed in Re H at [99] in the event that a local authority proposes to have a child vaccinated against the wishes of the parents, those parents can make an application to invoke the inherent jurisdiction and may, if necessary, apply for an injunction under section 8 Human Rights Act 1998 to prevent the child being vaccinated before the matter comes before a court for adjudication.*

Short note: deprivation of liberty and children in unregulated placements – the saga continues

It was previously decided in *Tameside MBC v AM & Ors (DOL Orders for Children Under 16*) [2021] EWHC 2472 (Fam) that it is open to the High Court to authorise, under its inherent jurisdiction, the deprivation of liberty of a child under 16 in an unregistered placement, subject always to the rigorous application of the President's Practice Guidance. The Court of Appeal is due to hear an appeal on 16-17 November 2021. This case before MacDonald J concerns a further question: whether it is still open to authorise such placements where a placement either will not or cannot comply with the Practice Guidance. The answer is:

> *"62. Having regard to the comprehensive submissions made by leading and junior counsel, and the legal provisions set out above, I am satisfied that an unwillingness or inability to comply with the terms of the President's Practice Guidance does not act per se to oust the inherent jurisdiction of the High Court to authorise the deprivation of a child's liberty in an unregistered placement confirmed in Re T.*

> 63. However, I am equally satisfied that compliance with the Practice Guidance is central to the safe deployment of that jurisdiction and to its deployment in a manner consistent with the imperatives of Art 5. Within this context, whilst accepting that an unwillingness or inability on the part of a placement to comply with the terms of the President's Practice Guidance is a factor that informs the overall best interests evaluation on an application under the inherent jurisdiction, and that each case will turn on its own facts, I am satisfied that the court should not *ordinarily* countenance the exercise the inherent jurisdiction where an unregistered placement makes clear that it will not or cannot comply with the requirement of the Practice Guidance to apply for registration …" (emphasis in original)

The continuing fallout of *Cheshire West* coupled with an acute shortage of secure accommodation in relation to under 16s continues unabated. Care providers are often unwilling to register holiday parks, private Air B&B properties, caravans and canal boats as children's homes with Ofsted. As a result, children are exposed to sub-optimal placements that are beyond the statutory regulatory regime designed to safeguard them. But the squeeze may now be on regarding the litany of cases coming before the courts. The combination of (i) the Care Planning, Placement and Case Review (England) (Amendment) Regulations 2021 (which prohibits the placement of looked after under 16s in arrangements other than a children's home or foster care placement), and (ii) the High Court not ordinarily countenancing its exercise of the inherent jurisdiction should, you would expect, reduce the number of children falling into this vulnerable situation. Whether it will do remains to be seen. It is also far from obvious how parallel problems in relation to those over 16 are going to be solved.

Short note: psychiatric detention, psychiatric treatment and medical evidence

R.D. and I.M.D. v. Romania (Application no. 35402/14) saw the European Court of Human Rights looking sceptically at compulsory psychiatric confinement in the Romanian context, but with observations with a wider resonance.

Two people were arrested after allegedly striking a police officer. The prosecution obtained psychiatric reports in 2011 which stated they were both suffering from persistent delusional disorders and outpatient treatment was recommended. Given their lack of criminal responsibility there was no case to answer.

In 2013, a court ordered compulsory treatment based on those reports and when the individuals did not attend, in 2014 the court made a compulsory confinement order to a psychiatric hospital based on the 2011 reports. Sedatives and antipsychotic medication were administered (and still are). In 2017, both were also placed under guardianship; for IMD it was her mother, and for RD it was the deputy mayor. Although subsequent medical reports in 2018 verified that the mental disorders persisted, they did not indicate that an assessment had effectively been made of the level of danger they potentially posed to themselves or to others.

The European Court held that their compulsory confinement was based on a lack of recent medical

evidence contrary to Article 5 ECHR. Their forced administration of medication breached Article 8 ECHR because the legal provisions did not adequately regulate the provision of treatment. They did not, for example, provide patients with a right to appeal against a doctor's decision to administer medication against their will. Nor did the guardianship procedures provide sufficient safeguards in this regard. The Strasbourg court found that there was a serious interference with private life inherent in administration of medication against their will, and that it was not "in accordance with the law" as required by Article 8(2). Romania was to pay them EUR 16,300 for nonpecuniary damage and EUR 5,150 in respect of costs and expenses.

This case may be of interest to both MHA and MCA reformers. Concerns remain as to whether compulsory treatment under MHA s.63 provides adequate safeguards for Article 8(2) purposes, hence the proposals in the White Paper seeking to tighten these up. Conversely, the court did not hold that medication absent informed consent would always be unlawful, as at least some would read the Convention of the Rights of Persons with Disabilities as requiring.

LPS-ers will be interested to see that medical evidence more than 3 years old was not sufficiently recent to justify confinement. The second LPS renewal can last for 3 years so "sufficiently recent" will be something to look out for in due course, particularly perhaps in relation to the necessity and proportionality assessment. For now, the European Court's view as to what is "sufficiently recent" is that this will depend on the specific circumstances of the case.

Research corner

We highlight here recent research work of interest to practitioners. If you want your article highlighted in a future edition, do please let us know – the only criterion is that it must be open access, both because many readers will not have access to material hidden behind paywalls, and on principle. This month, we highlight the publication of the CLARiTY Project report 'Making Legal Information Accessible: Lessons from the CLARiTY Project,' available from the website of the Everda Capacity project. An easy read report is also available to download.

The CLARiTY Project was a public legal education initiative for people with learning disabilities and family carers that Professor Rosie Harding ran in 2020/21 with Sophie O'Connell (Wolferstans Solicitors) and Philipa Bragman OBE, in collaboration with Bringing Us Together. The project was funded by the ESRC Impact Acceleration Account at the University of Birmingham and supported by Wolferstans Solicitors and the Leverhulme Trust.

The aim of the CLARiTY project was to increase access to justice and address areas of unmet legal need relating to mental capacity and health and social care law during the coronavirus pandemic. The CLARiTY Project hosted six free, interactive, online sessions for people with learning disabilities and family carers about legal topics including understanding the coronavirus lockdown rules; visiting friends and family in hospitals and care settings; supported decision-making; best interests under the Mental Capacity Act 2005; Lasting Powers of Attorney and Deputyship; challenging Care

Act decisions, and using the Ombudsman service. Plain language and easy read summaries of the topics covered in the sessions were published on the project website.

Through delivering these CLARiTY sessions, we discovered a high level of unmet need for introductory, accessible legal information. In our report, the authors make recommendations for legal service providers and regulators about the need to increase the availability of high-quality accessible legal information, and suggestions of how to achieve this.

Alex talked to Rosie about her work from the shed in a video available here.

SCOTLAND

Reduction in guardians' remuneration "off the table"

A predictable furore followed the publication in the October 2021 Journal of the Law Society of Scotland, under the "OPG: Update" item, of an immediate reduction in remuneration of professional guardians obliged to charge VAT ontheir rates of remuneration, by an amount equivalent to the VAT chargeable. The intimation was in the following terms:

> *"Professional guardians are asked to note that VAT should not be added to remuneration. Remuneration is calculated by OPG on the approval of an account and the amount set is the total amount that can be taken from the adult's estate.*
>
> *For accounts submitted from 1 November 2021 onwards, professional guardians charging VAT on their goods and services must take VAT from the total amount awarded."*

That intimation appeared without consultation or warning, and notwithstanding the existence of the professional guardians scheme was not intimated to professional guardians. Remarkably, it would have applied retrospectively to work already done from the beginning of the current accounting year onwards, and indeed would have applied to remuneration for appointments already accepted on the basis of the previous arrangements for remuneration. Several financial guardians have reported that before accepting current appointments, and indeed in many cases long before, they had been explicitly advised by OPG that they should charge VAT on top of the allowed remuneration, and hitherto had always done so. Remuneration is allowed by OPG on a scale related to the value of the estate. Reducing remuneration by the amount of VAT would have reduced guardians' annual remuneration on first accounts by up to £4,167 and on subsequent accounts up to £3,750. Any professional guardians not registered for VAT would not have been affected, but for all others their remuneration would not only have been reduced as stated, but it would by those amounts have been less than the remuneration for lay guardians doing the same work.

Many professional guardians have already reported that they were already considering whether it was economical for them to continue providing the service that they offered even at the previous rates, and because they already felt that the service that they provided was not valued, the latter impression having of course been greatly exacerbated by the proposed imposition of these reductions in remuneration without either consultation or direct intimation and explanation to the professional guardians affected.

The consternation resulting from this move appears to have been even greater among some local authorities than among professional guardians themselves. Professional guardians can opt to do other work. Local authorities, however, effectively have no practicable option but to engage professional guardians in the cases where they are obliged under section 57(2) of the Adults with Incapacity (Scotland) Act 2000 to apply for an appointment with financial powers (whether or not

welfare powers are also required). It is reported that their only source of suitable financial guardians for this purpose is known and trusted guardians operating under the professional guardians scheme.

Following upon representations made direct to the Public Guardian, she reported (by email to this writer) on 12th November 16.42 that she had that afternoon received formal legal advice which she stated to be lengthy and requiring her further consideration, but she intimated that: "I am however happy to concede that the proposed changes are now off the table".

Meantime, so far as this writer can see, whether to change rates of remuneration or to introduce differential effective remuneration on the basis of VAT status or otherwise is a matter of policy for the Public Guardian, not a matter of law, except for the constraints expressed in the leading case on relevant matters reported in GWD as *X's Guardian, Applicant*, 2010 GWD 32-654 and identified in the judgment available here by the case references of two conjoined cases (from different sheriffdoms) and the title "Remuneration of a financial guardian under section 68 of the Adults with Incapacity (Scotland) Act 2000". The report at the link is the scotcourts report, which lacks the paragraph numbering which appeared in the original judgment and which is included in the replication of the judgment on Westlaw. At paragraph 41 of the judgment (for those who have access to the numbering) Sheriff Baird said that:

> *"No professional person would be willing to take on such an appointment unless he or she would be adequately remunerated for so doing, but it is vital that there exists a pool of suitably qualified people who are available to act in these cases."*

In paragraph 47, in the context of the facts of that case, he commented that:

> *"… the Public Guardian is demonstrating a willingness to remunerate financial guardians appropriately, and the benefit to the adult's estate is that an appropriately qualified person continues in office as guardian."*

Of principal relevance to the proposal to reduce remuneration even in relation to appointments as guardian already accepted are the comments of Sheriff Baird in relation to legitimate expectation. He narrated that it had been submitted to him that:

> *"… if a guardian did not have a legitimate expectation that he would be properly remunerated for doing this required work, appropriate persons would not be prepared to do it at all." (paragraph 58)*

He concluded that:

> *"As to the reasonable expectation argument, it is clear that this applies to the principal way in which a financial guardian is remunerated, because such a person knows that payment will be made on the basis of a percentage commission, and will therefore know the probable amount actually to be paid."*

If the Public Guardian had opted to continue with her original proposal, reducing the effective

remuneration of VAT registered professional guardians not only in relation to future appointments, but in relation to existing appointments, she would have to have been aware that on the basis of existing case law her action would be likely to have been challengeable by judicial review by any guardians holding existing appointments on the basis of the remuneration applicable when they accepted those appointments.

If "off the table" means that there will be no further repetitions of similar incidents, the task will still remain of retrieving the damage done, and if possible preventing or mitigating any substantial reduction in the pool of trusted and experienced professional guardians available to meet needs for their services, particularly where responsibility to meet those needs rests with local authorities, and to avoid an outcome which would appear effectively to amount to disability discrimination.

The last word on this can rest with the initial reaction of an experienced professional guardian to finding the original announcement:

> *"I am totally shocked at the way this has been done without any warning. We take on guardianships on the basis of the published rates. I really feel I go above and beyond for clients. A couple I deal with pro bono as they have no money to spare. During lockdown I've arranged funerals, taken adult's relatives to funerals, delivered groceries, sat with a dying client, collected prescriptions, sorted GP appointments etc. The reason most have a professional guardian is they have no one else other than a few committed social workers. We wait months and months for remuneration as the OPG are so slow – their own fees are often disproportionate to the work involved. It seems the only way to run these now is an absolute bare minimum approach?"*

Adrian D Ward

World Congress on Adult Capacity reminder

A reminder that the abstract submission deadline for the 7th World Congress on Adult Capacity is fast approaching and if you would like to submit an abstract, you have until Tuesday 7th December 2021 to do so. The Congress is to be held from Tuesday 7th to Thursday 9th June 2022 in Edinburgh. Prospective authors for both papers and posters are invited to submit a title and a maximum 200 word abstract under the following topics:

- Achieving respect for the adult's rights, will and preferences
- Monitoring, regulation, remedies and enforcement
- Law, policy and practice review and reform
- Rights, ethics and the law during national emergencies
- The adult and research

Further information about each of the topics listed can be viewed on the Congress website.

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Conferences

Members of the Court of Protection team are regularly presenting at 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.

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 December. 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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