



Welcome to the June 2020 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: the Court of Appeal presses the reset button in relation to capacity and sexual relations, and three difficult medical treatment decisions;

(2) In the Property and Affairs Report: the impact of grief on testamentary capacity;

(3) In the Practice and Procedure Report: a remote hearings update, and a pragmatic solution to questions of litigation capacity arising during the course of a case;

(4) In the Wider Context Report: DoLS and the obligations of the state under Article 2 ECHR, the Parole Board and impaired capacity, and recent relevant case-law from the European Court of Human Rights;

(5) In the Scotland Report: the interim report of the Scott Review critiqued.

You can find our past issues, our case summaries, and more on our dedicated sub-site [here](#). We have taken a deliberate decision not to cover COVID-19 related matters which might have a tangential impact upon mental capacity in the Report, not least because the picture continues to change relatively rapidly. Chambers has created a dedicated COVID-19 page with resources, seminars, and more, [here](#); Alex maintains a resources page for MCA and COVID-19 [here](#).

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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## HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

### The Court of Appeal, decision-making and sex: have we been getting it all wrong?

*A Local Authority v JB* [2020] EWCA Civ 735 (Court of Appeal (Sir Andrew McFarlane P, Baker and Singh LJ))

#### *Mental capacity – sexual relations*

[Note, Tor and Nicola Kohn have recorded a half-hour web conversation summarising and commenting upon this decision, available [here](#)].

#### Summary

The Court of Appeal has made clear that we have been asking the wrong question in relation to sexual relations. The issue arose in the context of proceedings concerning a 36-year-old man with a complex diagnosis of autistic spectrum disorder combined with impaired cognition. The question before the judge at first instance, and in written submissions presented to this court before the hearing, was couched in different terms, namely whether a person, in order to have capacity to *consent* to such relations, must understand that the other person must consent. The first instance judge, Roberts J, had held the fact that the man in question, JB, could not

understand that fact, did not mean that he lacked capacity to consent.

The local authority appealed, and sought to persuade the Court of Appeal that Roberts J had been wrong to exclude this information from the information relevant to the test. The Court of Appeal, however, took a different course, steered by Baker LJ (giving the sole judgment of the court).

Baker LJ started by observing that the issue – of great importance to people with learning disabilities or acquired disorders of the brain or mind – required the court to balance three fundamental principles of public interest.

*4. The first is the principle of autonomy. This principle lies the heart of the Mental Capacity Act 2005 and the case law under that Act. It underpins the purpose of the UN Convention on the Rights of Persons with Disabilities 2006, as defined in article 1:*

*“to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.”*

*5. The second is the principle that vulnerable people in society must be protected. As this court observed in B v A Local Authority [2019] EWCA Civ 913 (at para 35):*

*“ ... there is a need to protect individuals and safeguard their interests where their individual qualities or situation place them in a particularly vulnerable situation.”*

*Striking a balance between the first and second principles is often the most important aspect of decision-making in the Court of Protection. The Mental Capacity Act Code of Practice expresses this in simple terms (at para 2.4):*

*“It is important to balance people’s right to make a decision with their right to safety and protection when they can’t make decisions to protect themselves.”*

*6. There is, however, a third principle that arises in this case. The Mental Capacity Act and the Court of Protection do not exist in a vacuum. They are part of a wider system of law and justice. Sexual relations between two people can only take place with the full and ongoing consent of both parties. This principle has acquired greater recognition in recent years within society at large and within the justice system. The greater recognition has occurred principally in the criminal and family courts, but it must extend across the whole justice system. The Court of Protection is concerned first and foremost with the individual who is the subject of proceedings, “P”. But as part of the wider system for the administration of justice, it must adhere to general principles of law. Furthermore, as a public authority, the Court of Protection has an obligation under s.6 of the Human Rights Act 1998 not to act in a way which is incompatible with a right under the European Convention of Human Rights, as set out in Sch.1 to the Act. Within the court, that obligation usually arises when considering the human rights of P. But it also extends to the rights of others.*

To resolve the appeal, Baker LJ had to consider

both the Act and the development of the case-law. As he noted, there is only reference to sexual relations in s.27(1) of the MCA which provides that nothing in the Act permits a decision to be made on behalf of a person with regard to a number of matters listed in the subsection including "consenting to have sexual relations." He then conducted a very extensive review of the "somewhat confusing" (paragraph 24) case-law, which will no doubt be pored over by those who have been involved (whether directly or indirectly) in the messy evolution of how the courts have grappled with capacity and sexual relations.

Having set out the rival submissions of the local authority as appellant and the Official Solicitor on behalf of JB, Baker LJ then turned (at paragraph 91) to his analysis of the position. He started by recalling the decision-specificity of the test under the MCA 2005 which means that the "information relevant to the decision" depends first and foremost on the decision in question" (paragraph 91). As he then noted:

*92. The analysis of capacity with regard to sexual relations in the case law has hitherto been framed almost exclusively in terms of the capacity to consent to sexual relations. But as this case illustrates, giving consent to sexual relations is only part of the decision-making process. The fundamental decision is whether to engage in sexual relations. The focus on the capacity to consent derives, in part, from the judgments delivered by Munby J prior to the implementation of the MCA, which unsurprisingly influenced the analysis in subsequent cases after the Act came into force. In addition, as pointed out above, the only reference to sexual relations in*

*the MCA is in s.27 where the list of "excluded decisions" which cannot be made on behalf of a person lacking capacity includes "consenting to have sexual relations". But the list in s.27 does not purport to be a comprehensive list of the decisions in respect of which issues as to capacity will arise.*

As Baker LJ noted, the earliest caselaw decided by Munby J had framed the analysis by reference both to the question whether someone has the capacity to consent to sexual relations and also by reference to the question whether someone has the ability to choose whether or not to engage in sexual activity. However, in subsequent cases, the focus had been on the first question to the exclusion of the second. As Baker LJ noted:

*92. [...] The word "consent" implies agreeing to sexual relations proposed by someone else. But in the present case, it is JB who wishes to initiate sexual relations with women. The capacity in issue in the present case is therefore JB's capacity to decide to engage in sexual relations.*

Importantly, Baker LJ did not just limit himself to JB's specific situation, but rather emphasised that "[i]n my judgment, this is how the question of capacity with regard to sexual relations should normally be assessed in most cases" (paragraph 92).

As Baker LJ then held:

*94. When the "decision" is expressed in those terms, it becomes clear that the "information relevant to the decision" inevitably includes the fact that any person with whom P engages in sexual*

*activity must be able to consent to such activity and does in fact consent to it. Sexual relations between human beings are mutually consensual. It is one of the many features that makes us unique. A person who does not understand that sexual relations must only take place when, and only for as long as, the other person is consenting is unable to understand a fundamental part of the information relevant to the decision whether or not to engage in such relations.*

The Official Solicitor had argued that, even if the decision was expressed in those terms, the relevant information should not include an understanding of the consensuality of sexual relations. However, Baker LJ held that none of the reasons stood up to scrutiny:

*95. [...] The inclusion of an understanding of the other person's consent as part of the relevant information does not, as he asserted, recast the test as "person-specific" but, rather, ensures that the information is firmly anchored to the decision in question, as required by statute and confirmed by this court in the York case. I accept that it is important for the test for capacity with regard to sexual relations to be as simple and straightforward as possible but that cannot justify excluding information which is manifestly relevant to the decision. And if the consensuality of sexual relations is part of the relevant information, it plainly relates to capacity itself rather than the exercise of capacity.*

*96. Mr Patel understandably relies on earlier judicial observations that sexual activity, and decisions made about such activity, are "largely visceral rather than cerebral, owing more to instinct and*

*emotion than to analysis". But it has never been suggested that decisions are exclusively visceral or instinctive. It is, of course, true that sexual desire is emotional rather than intellectual, but for human beings the decision whether or not to engage in sexual relations obviously includes a cerebral element. It involves thought as well as instinct. And amongst the matters which every person engaging in sexual relations must think about is whether the other person is consenting.*

*97. Mr Patel also relies on the point made in earlier judgments that the focus of the MCA is different from that of the criminal law. It would, however, be wrong and unprincipled to exclude an understanding of the consensuality of sexual relations from the relevant information on the grounds that non-consensual sexual acts should be dealt with by the criminal justice system. As illustrated by the background history to this application, which includes an incident of alleged sexual abuse in respect of which the police decided to take no action, the criminal justice system does not necessarily deal with such cases and there may well be good reason for this, because the police and the prosecution authorities have a discretion whether or not to pursue every potentially available criminal charge and exercise that discretion in the public interest. But even if it could be guaranteed that such incidents were dealt with by the criminal courts, to leave such matters to the criminal justice system would be an abdication of the fundamental responsibilities of the Court of Protection, which include the duty to protect P from harm.*

Baker LJ returned to the importance of striking a

balance between the principle that vulnerable people in society must be protected and the principle of autonomy is often the most important aspect of decision-making in the Court of Protection. However, he did:

*98. [...] not accept the argument that including an understanding of the consensuality of sexual relations as part of the information relevant to the decision about the capacity regarding sexual relations amounts to an unwarranted infringement of JB's personal autonomy or of his rights. Insofar as it is a restriction of his autonomy and his rights, it cannot be described as discriminatory because it is a restriction which applies to everybody, regardless of capacity. As social beings, we all accept restrictions on our autonomy that are necessary for the protection of others. No man is an island. This principle is well recognised in the European Convention on Human Rights. For example, the rights in Article 8 are not absolute and must be balanced against other interests, including the rights of others. Although the Court of Protection's principal responsibility is towards P, it is part of the wider system of justice which exists to protect society as a whole. As I said at the outset of this judgment, the Mental Capacity Act and the Court of Protection do not exist in a vacuum. They are part of a system of law and justice in which it is recognised that sexual relations between two people can only take place with the full and ongoing consent of both parties.*

Baker LJ recognised that by recasting the decision as the decision to engage in sexual relations, and by including an understanding of the consensuality of sexual relations as part of

the information relevant to the decision, the Court of Appeal was "moving on from the previous case-law" (paragraph 99). However, he made clear:

*99. [...] But that is because the issues arising in this case and the arguments presented to us have not been considered by this Court before. In my judgment, however, it is not inconsistent with the earlier authorities of this Court. As recognised by this Court in B v A Local Authority, "what comprises relevant information for determining an individual's capacity to consent to sexual relations has developed and become more comprehensive over time." That development has continued in this case. The Court in IM v LM stressed that "the notional process of using and weighing information attributed to the protected person should not involve a refined analysis of the sort which does not typically inform the decision to consent to sexual relations made by a person of full capacity". But as already stated, the information which a capacitous individual must take into account in deciding whether to engage in sexual relations includes whether or not the other person is consenting. My decision in this case is therefore not inconsistent with earlier decisions of this Court. As for the decisions at first instance, I respectfully disagree with the contrary observations of Parker J in London Borough of Southwark v KA and Mostyn J in D Borough Council v B.*

In summary, therefore:

*100. [...], when considering whether, as a result of an impairment of, or disturbance in the functioning of, the mind or brain, a person is unable to understand, retain, or*

*use or weigh information relevant to a decision whether to engage in sexual relations, the information relevant to the decision may include the following:*

*(1) the sexual nature and character of the act of sexual intercourse, including the mechanics of the act;*

*(2) the fact that the other person must have the capacity to consent to the sexual activity and must in fact consent before and throughout the sexual activity;*

*(3) the fact that P can say yes or no to having sexual relations and is able to decide whether to give or withhold consent;*

*(4) that a reasonably foreseeable consequence of sexual intercourse between a man and woman is that the woman will become pregnant;*

*(5) that there are health risks involved, particularly the acquisition of sexually transmitted and transmissible infections, and that the risk of sexually transmitted infection can be reduced by the taking of precautions such as the use of a condom.*

Baker LJ noted that there remained the question whether the information relevant to the decision whether to engage in sexual relations must always include all of the matters identified in the previous paragraph. Whilst he recognised that this was a matter of considerable importance, it did not arise on the appeal before the court, and the summary of the case-law that he had set out *"illustrates that on several occasions judicial obiter dicta in this difficult area of the law have been initially followed by other judges, only to be rejected in later cases after hearing further argument. For that reason, it would be prudent for this Court to*

*refrain from commenting until it has an opportunity to hear full argument on the point in a case where the issue arises on the appeal"* (paragraph 103).

On the facts of the case before the court, and whilst commending the judge's "strong commitment to the principle of autonomy, and the right of disabled people to enjoy life's experiences to the full," Baker LJ found "with considerable regret" that he had to part company from her:

*106. First, I do not consider it appropriate to view these issues through "the prism of the criminal law". In fairness to the judge, I think she was understandably led into this approach by dicta in previous reported cases and by submissions given to her by counsel, who in turn were influenced by the earlier cases. But in my view it is unnecessary and inappropriate to consider whether "a full and complete understanding of consent in terms recognised by the criminal law" (my emphasis) is an essential component of capacity to have sexual relations. What is needed, in my view, is an understanding that you should only have sex with someone who is able to consent and gives and maintains consent throughout. The protection given by such a requirement is not confined to the criminal legal consequences. It protects both participants from serious harm.*

*107. Secondly, although some capacitous people might struggle to articulate the precise terms of the criminal law in this regard, I do not agree that capacitous people have difficulty understanding that you should only have sex with someone who is able to consent and who gives and maintains consent. I respectfully disagree with the judge that*

*this is "a refined or nuanced analysis which would not typically inform any decision to consent to such relations made by a fully capacitous individual". Nor is it "a burden which a capacitous individual may not share and may well be unlikely to discharge". It is something which any person engaging in sexual relations has to consider at all times. This is not altered by the fact that some capacitous people choose to ignore the absence of the other person's consent and proceed with sexual activity anyway (thus probably committing a criminal offence such as sexual assault or even rape).*

*107. Thirdly, I do not think it right to reject the requirement of an understanding as to the necessity of mutual consent to sex on the grounds that there are "mistakes which all human beings can, and do, making the course of a lifetime". There may be occasions, I suppose, where someone genuinely makes a mistake about whether their sexual partner is giving or maintaining consent. But that circumstance, if it ever arises, is very different from the situation where one person does not understand that the other person has to give and maintain consent.*

The Court of Appeal therefore set aside the declaration that JB had capacity to consent to sexual relations. However, whilst it could have made its own declaration, Baker LJ held that it was wrong to do on the specific facts of the case, and, in particular, the way in which the issue had been analysed before Roberts J. He therefore held that the right course was to remit it to her to reconsider in light of the judgment and such further evidence as she would wish to seek. The court therefore remitted the case, making an

interim declaration under s.48 of the MCA that there is reason to believe that JB lacks capacity to decide whether to engage in sexual relations.

### Comment

This is an extremely significant judgment, and it is very likely that the matter will not stop there (and is likely to be by considered by the Supreme Court together with the case of *Re B*). By both recasting the question in JB's case and suggesting that this is the way in which capacity with regard to sexual relations should normally be assessed in most cases, the Court of Appeal has essentially pressed the reset button on what has become an intensely tangled – and frankly unsatisfactory – series of cases. It responds to the fact that individuals with impaired decision-making capacity are not always (as some of the previous cases could be read as suggesting) purely passive recipients of sexual activity initiated by others, but can also be sexual beings wishing to express themselves by initiating sexual activity.

Alex's view (not one necessarily shared by his fellow editors!) is that a very important consequence of this decision is that – in principle – it opens the way for a court to take the view that it is not bound by s.27 MCA 2005, which provides that nothing in the MCA permits a decision to be made on behalf of a person to consent to having sexual relations. Would it be possible to say a court (and I very specifically say court here, as it would be **very** challenging for anyone to take steps here without judicial imprimatur) can make a best interests decision behalf of someone to engage in sexual relations? And, if so, would this be the way in which to resolve the pragmatic but (to purists, problematic) compromise hammered out in the



TZ cases (decided by Baker himself) to the situation where the person is undoubtedly at risk in some sexual encounters, but not in others? That compromise is to find that the person **has** capacity to consent to sexual relations but does not have capacity to make decisions as to contact, thereby enabling best interests decisions to be made in relation to contact where it is clear that the contact is for purposes of sex.

Another important consequence is that it clears the way to resolving what was otherwise a very odd potential outcome. By framing the test by reference to consent, it would be possible to find that a person could not consent **solely** because they did not understand that their partner needed to consent. But – as we pointed out in our note upon the first instance decision<sup>1</sup> – that could mean that a partner who freely initiated sexual activity with them could face criminal consequences even if there was no suggestion that the partner had any impairment in their decision-making. The interaction between the MCA and the Sexual Offences Act 2003 remains complex and difficult, but this judgment may at least have helped clear the path of some of the more tangled undergrowth.

Finally, for a perspective from a social worker, we commend the article in Community Care by Lorraine Currie, Acting Principal Social Worker and professional lead for the MCA at Shropshire County Council.

### **‘True’ best interests, advance decisions and the subjective approach**

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<sup>1</sup> Which Alex cannot help but note did question whether the right question was being asked at first instance.

*Barnsley Hospitals NHS Foundation Trust v MSP* [2020] EWCOP 26 (Hayden J)

#### *Best interests – medical treatment*

In this case, Hayden J considered an application, initially made to him as the Out of Hours judge, for determination of the question of whether a Trust should continue to provide ITU support to a 34 year old man, or withdraw treatment other than palliative care. For more than a decade, the man – identified as MSP – had painful and complex abdominal problems. In October 2019, he underwent surgery where an ileostomy was formed (in other words, his small intestine was diverted through an opening in his abdomen). There was a significant prolapse in February 2020, which it is clear MSP found to be very distressing. At MSP’s request the stoma was reversed on 14 May 2020. The evidence before the court was, as Hayden J recorded, that MSP “utterly loathed life with a stoma.”

On 4 February 2020, MSP drafted a carefully crafted ‘Advance Directive’ (as he called it), which he copied to his parents and to his step-sister. Outside the hospital setting these were the only three people who knew MSP had a stoma. The advance decision to refuse treatment was detailed and comprehensive, and also included (although, technically, as advance statements) making provision for music to be played in the event that he fell into coma and at his funeral (the former reflecting the violent and frightening dreams he had when ventilated on ICU previously in 2013). It included, amongst the treatments that he refused “[t]he formation of a stoma, through an ileostomy, colostomy,

*urostomy or similar, that is expected to be permanent or with likelihood of reversal of 50% of under".* Unfortunately: (1) the advance decision was not witnessed, as required by the provisions of s.25 MCA 2005; and (2) no-one outside those people identified above were aware of it.

In mid-May 2020, MSP returned to hospital with very significant abdominal pain and sepsis. Mr M, who was the consultant gastroenterological surgeon on duty, responsible for MSP's care at this admission, impressed upon his patient that his condition was life threatening and that he required a stoma to be formed immediately. Unfortunately, and for reasons which were not entirely clear, the advance decision was not brought to the hospital's attention until after Mr M had operated. Crucially, at the time of MSP's admission nobody had any reason to doubt his capacity, indeed he did not lack capacity at that stage. There was no doubt that MSP expressed his consent to the stoma being inserted, although when the application came to court, it was clearly a surprise to the two other doctors who gave evidence, and who had known MSP for some time.

The stoma was formed on 27 May 2020, and, in fact, MSP's clinical situation was such that it would have to be irreversible. It is not entirely clear what prompted the application to court, but it appears that it may well have been the bringing to the Trust's attention of the advance decision that MSP had sought to create.

At the point that the application came before Hayden J, MSP was sedated and ventilated in ITU. He was breathing spontaneously with only a small amount of support. In the circumstances, as Hayden J identified (at paragraph 19): "*if MSP's wishes are to be given*

*effect, what requires to be identified is whether it is in his best interests for artificial nutrition and hydration to be withdrawn."*

As Hayden J noted at paragraph 13:

*This application revolves around MSP's own expressed wishes. It requires them to be scrutinised, not only in the context of what he has said and written but by reference to the way he has lived his life, his personality and his beliefs. His parents have been the conduits through which this information has been placed before the Court.*

Hayden J set out in considerable detail the evidence from MSP's family, in particular his mother, which led him to say (at paragraph 17) that:

*There is no doubt, in my mind, that he had come to a clear and entirely settled decision that he was not prepared to contemplate life with a stoma or indeed any significant life changing disability. It is not for me, or indeed anybody else, to critique those views or beliefs, but merely to identify them. They are a facet of MSP's broader personality, the expression of which is integral to his own personal autonomy.*

Hayden J then reviewed the legal framework, observing that:

*24. When applying the best interests tests at, s.4(6) MCA, the focus must always be on identifying the views and feelings of P, the incapacitated individual. The objective is to reassert P's autonomy and thus restore his right to take his own decisions in the way that he would have done had he not lost capacity.*

25. *The weight to be attributed to P's wishes and feelings will of course differ depending on a variety of matters such as, for example, how clearly the wishes and feelings are expressed, how frequently they are (or were previously) expressed, how consistent P's views are (or have been), the complexity of the decision and how close to the borderline of capacity the person is (or was when they expressed their relevant views). In this context it is important not to conflate the concept of wishes with feelings. The two are distinct. Sometimes that which a person does not say can, in context, be every bit as articulate as wishes stated explicitly.*

Having outlined the relevant authorities, he agreed (at paragraph 33) with the submission on behalf of the Trust that their import was clear:

*the judge must seek to arrive at his objective assessment of whether continuation of life sustaining treatment is in **this** patient's best interests. However, those interests must be seen through the prism of the subjective position of the patient.*

Hayden J also took the opportunity to reiterate (as he had previously done in *NHS Cumbria CCG v Rushton* [2018] EWCOP 41) the importance of compliance both with the statutory provisions and the codes of practice when preparing an Advance Decision. As he noted at paragraph 36, *"the combination of statute and code intends to strike a balance between the respect for adult autonomy and the risk that a person might find himself locked into and advance refusal which he or she might wish to resile from but can no longer do so."*

Hayden J then held that:

41. *It is in the context of this framework that I must evaluate what now truly are MSP's 'best interests'. The preponderant evidence points strongly to MSP not wishing to live with a stoma or, as he puts it, with any "ongoing medical treatment that will prevent me from living independently, either long term or indefinitely". Whilst this document is not binding as an Advance Decision, it nonetheless represents a clear and eloquent expression of MSP's wishes and feelings. Nor, as I have stated above, does it stand alone. It is reinforced by the choate and consistent evidence of MSP's parents, his step-sister (communicated via the parents) and the clear evidence of three consultants, each of whom was left with no doubt at all that MSP would not want to live either with the stoma or TPN and that the combination of both would be unbearable for him. MSP's father told me that if his son was permitted to recover consciousness and discover his own plight, he thought he would "kill himself". This is something his father fears most of all. It was at this point, in his evidence, that this strong and determined father faltered and was momentarily unable to maintain his emotional composure.*

Hayden J had, though, to evaluate the relevance of the conversation between MSP and the surgeon, Mr M, during the course of which he had consented to the formation of the stoma. He agreed with the submission on behalf of the Trust that the "conversation with Mr M and the authorisation by MSP of the stoma was predicated on Mr M's optimism that the stoma could, potentially, be reversed":

43. *The conversation between MSP and Mr M requires to be set in its context,*

having regard to the evidence holistically. Mr M knew nothing of the 'Advance Directive', he agreed that his conversation would have been of a different complexion if he had been aware of this. I emphasise this was nobody's fault; the document had not been produced. At the time of the conversation, MSP is described as very unwell and septic, he was also receiving a high grade and level of analgesia. I also factor in Mr M's optimism concerning the potential reversibility of the stoma, the force of which will undoubtedly have been communicated to MSP. I agree with Ms Dolan that in these circumstances MSP's consent is not necessarily inconsistent with all he has said, nor with the document that has been the focus of scrutiny. What MSP did not want was to find himself in the position he now is. Whether the history of the case justified Mr M's optimism is logically irrelevant. MSP rejects life with an **irreversible** stoma and in terms which are unambiguous and consistent. In these circumstances he has made it clear that he rejects all medical treatment or procedures or interventions that artificially sustain his life. Manifestly, this extends to parenteral feeding.

What, then, to do?

44. As Ms Castle [the Official Solicitor] submits, and I accept, the issue in this case is respect for MSP's autonomy. His expressed wishes and feelings, she analyses, weigh most heavily in the balance, to the extent that they are determinative here. In other words, the presumption of preservation of life is rebutted by the countervailing weight to be afforded to MSP's autonomy. Ms Dolan has, as her arguments set out above illustrate, concentrated on the

consistency and cogency of MSP's clear views. Logically her arguments lead to the same conclusion advanced by the Official Solicitor. However, Ms Dolan stops short of reaching a conclusion and, though this is her application, on behalf of the Trust, she adopts what she articulates as a position of neutrality. She advances no other course, nor has she suggested that the sanctity of life or the presumption of promoting life has not been displaced. Her careful and skilful arguments, properly analysed, lead only to the conclusion reached by the Official Solicitor.

Hayden J emphasised that it was important to break the issues down analytically, in particular to disentangle the question of whether or not the stoma should have been created from the question of whether it was now in MSP's best interests for ITU treatment to be continued, especially parenteral feeding:

46. [...] Whilst I have highlighted the less than optimal circumstances in which MSP gave his consent to Mr M for the stoma, I do not consider that the evidence rebuts the presumption that MSP was capacitous at the time. If MSP has yielded to an overly optimistic prognosis of reversal which, as we know, proved to be unfounded, he may have means of legal redress. I am not in a position, on the evidence available to me, to know whether or not Mr M should have been more circumspect in his advice. Had he been pessimistic, as to the prospects of a reversal, there is little doubt in my mind that MSP would have rejected the procedure and have chosen to die. This does not mean that this court should correct the error by bringing about the death which MSP would prefer to life with an irreversible stoma. This is, in my

*judgement, runs contrary to s4 (5) MCA which prohibits an evaluation of "best interests" which is motivated by a desire to bring about death. The intensity of the focus on MSP's rejection of life with the stoma occludes the fact that he has been equally clear in rejecting anything which artificially prolongs his life. He would unhesitatingly reject the striking artificiality of parenteral feeding. This is clear both from his Advance Directive document and in his mother's evidence. In the exercise of his personal autonomy he is entitled to take that decision which this court is required to and does respect. Accordingly, and for these reasons, I consider that the plan advanced by Dr W is in MSP's best interests [i.e. withdrawal of artificial nutrition and hydration with continued sedation which, ultimately, will compromise respiration and lead to MSP's death]. It is important that I make it entirely clear that Dr W puts forward this plan only in the event that I conclude that it reflects what MSP would have wanted. Having heard all the evidence, which I regard as compelling and cogent, I am satisfied that the plan accords with MSP wishes and feelings.*

*47. MSP has endured a decade of serious ill health. The quality of his life and his mobility has desperately reduced. His confidence and self-esteem has been adversely impacted. His capacity to forge and maintain interpersonal relationships has been significantly eroded. He has made a practical, utilitarian calculation that life in these circumstances is not what he wants. In a real sense this is not a case about choosing to die, it is about an adult's capacity to shape and control the end of his life. This is an important facet of personal autonomy which requires to be guarded every bit as jealously for the incapacitous as for the*

*capacitous.*

Hayden J, finally, held that the anonymity of MSP should be protected for the remainder of his life and for a period of three months following his death, noting, in particular, the extent to which MSP wanted to conceal his stoma from the world.

### Comment

Hayden J was, rightly, at pains to emphasise that the case was not about the creation of stomas per se. As he noted (at paragraph 7): "[m]any people require a stoma to be fitted and I have no doubt that the vast majority make the necessary accommodations to ensure that it does not unnecessarily inhibit their enjoyment of life or become an impediment to their personal and sexual relationships." However, this was simply not the case with MSP.

The case is also of note for the way in which Hayden J had to navigate:

- (1) the mismatch between the consent to the procedure and the purported advance decision; and
- (2) the fact that – as a matter of law – he could not take a decision on behalf of MSP, now, to refuse continued life-saving treatment **simply** so as to seek to turn back time and undo what would have been MSP's very likely refusal of treatment at the point of the critical conversation with the surgeon.

The way in which Hayden J undertook this exercise could properly be described as respecting MSP's rights, will and preferences: i.e. complying with the provisions of Article 12 of the

Convention on the Rights of Persons with Disabilities.

That having been said, one matter that the judgment does not address in terms is the fact that – on the face of it – it does not appear that MSP was clinically in a situation in which it would have been impossible to rouse him so as to be able to ask him what he wanted. It is unlikely that this was not considered by those present, but it is perhaps to be regretted that this was not addressed expressly, not least so that Hayden J could have answered the question of whether the requirement in s.1(3) “all practicable steps” to support the person to take their own decision before having recourse to best interests decision-making has to be judged by reference to what the person themselves would have wished. In other words, would it have been legitimate for the court to consider as part of its consideration of MSP’s decision-making capacity whether MSP would have wished to have been brought out of sedation to be confronted with the true position?

It is, separately, perhaps of some importance to understand what this case has to do with advance decisions. Even had it been procedurally compliant by being witnessed, it would not have been applicable at the point of the discussion with Mr M, as MSP **had** capacity at that point. It is also not entirely obvious that it would have meant (for instance) that clinically assisted nutrition and hydration would have to have been stopped when the Trust became aware of it, because it is not, on its face, obvious that it covered precisely the circumstances in which MSP now found himself. Rather, the advance decision in this case served as very powerful evidence of MSP’s wishes and feelings

as regards **the sort of** treatment to which the court was now being asked to consent to or refuse on his behalf. The case therefore reinforces the importance that advance decisions – wherever possible – contain statements which enable decision-makers to understand the values and priorities of the person concerned. An example of how to create such an advance decision can be found [here](#). For more on the mechanics of advance decisions, see Alex’s (updated) discussion paper [here](#).

Finally, on a procedural point, Hayden J took the opportunity to note, and (rightly) to credit the Official Solicitor with being able to re-establish an out of hours service – it had been a very troubling state of affairs for several years that in very urgent medical treatment applications brought out of hours, the court was frequently not in a position to be able to look to the Official Solicitor to be able to represent P.

### Navigating the silos

*A Local Authority v AW* [2020] EWCOP 24 (Cobb J)

*Mental capacity – assessing capacity – contact – residence – sexual relations*

### Summary

Characteristically, Cobb J delineated the issue to be decided in this case at the very outset:

*This judgment does not establish any great or new point of legal principle. It sets out my reasoning in reaching conclusions in a case which has the characteristics of many which come before the Court of Protection: namely, where the subject of the application is believed to have capacity in making*

*decisions in relation to certain aspects of their life, but not in others; where there are, in such cases, inevitably 'grey areas' in between. It recognises the importance of treating each capacity issue as decision-specific and time-specific, as the judicial guidance in PC v City of York Council [2014] 2 WLR 1<sup>[1]</sup> and B v A Local Authority [2019] EWCA Civ 913; [2019] 3 WLR 685<sup>[2]</sup> makes clear. Where there are true 'grey areas', it illustrates the value of giving the parties and the court the chance, while at all times maintaining an eye on the key objectives laid out in the Court of Protection Rules 2017, to examine the evidence forensically, test the assessments and expert views, and achieve, where possible, a degree of clarity in the best interests of the subject. In cases such as this, the "right of every individual to dignity and self-determination" compete hard with the "need to protect individuals and safeguard their interests where their individual qualities or situation place them in a particularly vulnerable situation" (B v A Local Authority at [35]).*

The case concerned AW, a 35-year old man with a diagnosis of mild learning disability and autistic spectrum disorder. He had lived at a residential care placement, Windmill House, for 7 years. He was described as having "many skills", and was assessed as someone who:

*... can appear very able and without further examination would commonly appear more able than he is. This is due to his keenness to engage with others, relatively good self-presentation skills, verbal skills, and ability to learn phrases. He is a very likeable man. It is easy to underestimate his vulnerability and difficulty to apply abstract concepts of safety in relationships due to his autism.*

As an adult, AW pursued gay relationships, spending much time and deriving pleasure from accessing gay websites, gay chat rooms and dating sites; he enjoyed watching others performing sexual acts in the chat rooms, which he found sexually arousing. While his mother was accepting of this when he was living at home, it nonetheless raised concerns for her and those caring for him, particularly given his social vulnerability. Those concerns became all too real in 2009 when AW was seriously sexually assaulted by a man who he had met on the internet; the police became involved, although no prosecution followed. A further safeguarding referral followed in 2012, when he moved in with another man who he had met on the internet. More recently he had engaged in inappropriate behaviour with a minor, which unsurprisingly led to police involvement. Numerous incidents were detailed before the court in which AW had placed himself at very considerable risk in the company of men whom he had met through dating sites on the internet. When these relationships had run into difficulties, or had soured (as inevitably had been the case), AW often responded aggressively, and verbally and physically assaulted those around him (including his mother), sometimes indiscriminately. He had also run up significant debt through his excessive phone and internet use.

When AW moved to Windmill House in 2013, and routinely since, his care needs had been assessed; he was considered to be unable without support and supervision to maintain a habitable home environment, unable to manage and maintain nutrition, maintain his personal hygiene, be appropriately clothed, develop and maintain family or personal relationships, make use of necessary facilities or services in the

community. Such was his level of need that he had forty hours of one-to-one support per week, including specifically times when he was accessing the community. He was said generally to be very happy at Windmill Lodge, though because he spent many hours at night on the internet and on his phone, he tended to sleep all day, missing activities; this had caused him to become somewhat socially isolated.

AW's access to, and use of, the internet and social media was limited and restricted by the care staff at the care home. He was subject to 1:1 supervision when accessing the internet (which was permitted once per day) and at all other times, he had not had access to internet enabled devices. The Local Authority maintained that, due to the risks associated with AW's behaviour when using the internet, it was in his best interests to be supervised to access websites, including dating websites.

The Local Authority accepted that AW was able to engage with men on dating sites and should he wish to take the step of meeting someone in person, then (subject to the restrictions in place as a result of the COVID-19 pandemic) the care plan would be followed, and that individual would be risk assessed. Subject to the outcome of any such assessment, arrangements for direct contact would be made. Care staff had accompanied AW to clubs and events which would enable him to engage with other men. They wanted to continue to discuss his need for a relationship with him in an open manner, whilst at the same balancing his needs for safety and protection from exploitation.

In late 2019 (and until the end of February 2020), AW had become fixated on a man who lived at a separate residential placement. At the time of

his assessment by the psychiatrist directed to report to the court, Dr Rippon, AW was intent on moving to the placement to take that relationship further. However, subsequently, AW made clear that, as the man no longer wanted to progress the relationship, he did not want to move.

In February 2020, Cobb J had – by agreement – made declarations that AW lacked capacity to conduct the proceedings; to make decisions about contact with others; to use social media and the internet; to make decisions about disclosure of personal information to others; but that he **had** capacity to consent to sexual relations. As Cobb J noted:

*This suite of conclusions reflects a potential anomaly (as Hayden J reflected in Manchester City Council Legal Services v LC & Anor [2018] EWCOP 30 at [10]) namely the "decision making facility to embark on sexual relations whilst, at the same time, he is not able to judge with whom it is safe to have those relations".*

As he noted, later in the judgment, the fact that AW had capacity to consent to, and enter into, sexual relations:

*42. [...] creates potentially difficult challenges for the Local Authority, and the court, in balancing the positive obligations to ensure that AW is supported in having a sexual relationship should he wish to do so, while also ensuring, as far as possible, that he is kept safe from harm.*

*43. A detailed 'best interests' care package has been drawn up which defines the support which AW will receive so that he can safely meet in person*



*(when able to do so) those 'friends' who he has 'met' online; this care package seeks to strike a balance between offering AW protection, while affording him privacy and a degree of autonomy. The Local Authority clearly understands that it is not its role to vet AW's partners, or to deny him time with proposed sexual partners simply because the local authority considers them to be unsuitable. A person-specific contact assessment will be undertaken to establish whether AW has the capacity to have contact with an individual, and a specific support plan drawn up as appropriate, in line with the decision in *A Local Authority v TZ [2014] EWHC 973 (COP)*. The staff at Windmill House have been prepared to accommodate AW in entertaining visitors provided that his request has been properly risk assessed; provision has also been made in the care plan for an overnight stay with a partner albeit away from Windmill House.*

At the hearing in February 2020, Cobb J adjourned consideration of the issues of whether AW lacked capacity to make decisions regarding (a) where to reside and (b) his care and support arrangements, as these were to a greater or lesser extent contentious.

At the time of the hearing in May 2020, given that AW did not wish to leave Windmill House, the issue of capacity to decide upon residence had become academic, but Cobb J agreed to determine the issue on the basis that this would avoid another return to court in the future if AW met another man and wished to move again. Cobb J identified that:

*45. [...] On these facts, I have particularly focused on the difficulties which AW has in considering "the difference between*

*living somewhere and visiting it", and "what sort of care he would receive in each placement in broad terms" (see [32] above). Dr. Rippon is of the view that while AW has some understanding of such information, he is not able to use or weigh it (he did not understand "the implications", "the consequences of moving"), and that his decision-making about residence is and has been wholly driven by other factors, most notably at the time of her assessment, his fixation to pursue a relationship with Trevor.*

*46. Nor, in Dr. Rippon's view, was AW able to understand, use or weigh, with what areas of his life he needs support, and what sort of support he needs ("he did not think he needed [support staff] twenty-four hours a day, although could not describe what level of staffing he believed he would require"; he "struggled to answer open questions about the support he requires" [32] above). AW was unable, on assessment, to understand that those who would be providing him with support at Thornley House (should he move there) would not be familiar with him, and he was unable to predict what would happen if he did not have any support or he refused it. It is noted that is a degree of overlap in the information relevant to the two questions, and I am conscious that they should not be considered in separate 'silos' (Re B).*

*47. I accept the evidence of Dr. Rippon that AW struggles to understand abstracts, and this is secondary to his autism disorder. In relation to both residence and care, this particularly means that AW is unable to see the risks attendant in any situation; he can see the positives but not the negatives. I am further satisfied, from what I have read and heard, that no practicable steps can*

*be offered to AW to assist him to change this way of functioning, and assist him to attain capacity.*

Importantly, on a proper analysis, and contrary to the position that at one stage had suggested itself:

*48. Although the written material may have suggested otherwise, having heard the oral evidence and submissions I have reached the conclusion that this is not a case in which AW fluctuates in his capacity to decide on the issues under consideration. I accept that there is a basic and profound lack of understanding, and that, by reason of the deficits in his executive functioning, he has a pervasive inability to use or weigh the information. I accept Miss Thomas' submission that his levels of understanding and engagement with relevant issues do vary from time to time, but never to a point where it could be said that he is capacitous. When he is engaged, and not distracted by his obsessions, particular care should be taken by those who care for him to permit and encourage him to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him and must (as Miss Thomas accepts: see [36] above) attach particular weight to AW's "past and present wishes and feelings".*

Cobb J also held both that AW was deprived of his liberty at Windmill House, and that this was lawful for purposes of Article 5 ECHR.

Interestingly, Cobb J took care to note that:

*I am satisfied from all that I have read that AW is becoming adversely affected by the proceedings. He has expressed a*

*wish not to see his solicitor or social worker, and he has had little contact with his advocate. His mother agrees with this, expressing her concern (see [7] above) that the proceedings are causing him to become 'shut down'. It is patently in his interests that the proceedings come to an end, and the orders I shall make shall therefore be final orders.*

### Comment

Although Cobb J modestly suggested that the judgment did not establish any or new great legal principle, it is – as Sherlock Holmes would have said – not without points of interest. Some of those points arise out of the careful recitation and analysis of the evidence going to capacity, serving as a model of the resolution of a complex – finely-balanced – case. Others arise out of the fact that this is another in a small (but slowly growing) body of case-law relating to executive functioning, described (at paragraph 39) as “*the ability to think, act, and solve problems, including the functions of the brain which help us learn new information, remember and retrieve the information we've learned in the past, and use this information to solve problems of everyday life*” – crucially, and properly, linked to one of the MCA criterion (in this case, his problems with executive functioning being such as to prevent AW being able to understand the information relevant to residence and care).

Finally, the case now needs to be read in light of the subsequent decision of the Court of Appeal in JB that capacity in the context of sexual relations should be normally, in most cases, be assessed on the basis that the decision is whether the person has capacity to engage in sexual relations not – as Cobb J was loyally

considering here<sup>2</sup> – capacity to consent to sexual relations. AW's case is a paradigm case in which, as a person who was not merely a passive recipient, but an actual initiator of sexual activity, it becomes very clear in light of *JB* that talking about 'consent' was simply asking the wrong question. If this case had been decided after *JB*, it is likely that the court would (1) have been concerned as to whether AW could process the information that any prospective sexual partner had to consent before and throughout the relevant activity; and (2) explored whether it was necessary to undertake the *TZ* 'workaround' to secure his ability to express himself sexually without putting himself at risk. It could, potentially, have approached the question that, on a proper analysis, AW did not have capacity to decide to engage in sexual relations, and that best interests decisions could be made on his behalf as to when to engage in such relations, taking into account the potential risks that he might be at and might pose in so doing.

## Dental treatment and the Court of Protection

*United Lincolnshire NHS Foundation Trust v Q* [2020] EWCOP 27 (Gwynneth Knowles J)

*Best interests – medical treatment*

### Summary<sup>3</sup>

Q was 57-year-old woman, with profound and lifelong learning disabilities together with epilepsy. She also had impaired eyesight and was registered blind. She had mobility difficulties

which necessitated the use of a wheelchair. Those who cared for her believed her to suffer from some form of autistic spectrum disorder and it is clear that, from time to time, she displayed what was described as extremely challenging behaviour to her carers. She had lived for about 14 years in a supported living placement with two other residents and had 24-hour care and supervision. She was highly resistant to changes in the very rigid structure of her daily life and she could reject attempts to provide her with personal care. For many years, she had resisted any proper or thorough dental hygiene.

Throughout 2018, increasing concerns were expressed about Q's teeth, and about the pain that she appeared to be experiencing. By September 2019, a full dental clearance under general anaesthetic was planned, but on the day of the operation, it was cancelled as Q had a prolonged seizure of around six minutes whilst getting ready to come to the hospital.

Best interests meetings were held on 20 November 2019 and 11 February 2020 and it was agreed by everyone present that it would be in Q's best interests to undergo the proposed dental surgery and to receive intramuscular sedation to facilitate her transfer to and from hospital. Although not clear from the judgment, it appears that it must have been the consideration of sedation which triggered the application to the Court of Protection (there is nothing to indicate why the previous intention to carry out the full dental clearance had not been

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<sup>2</sup> Although it should perhaps be noted that Cobb J himself, referred at paragraph 42, to AW's capacity to consent to, "and enter into" sexual relations, even though the declaration made was (as was conventional

at the time) framed solely as "capacity to consent to sexual relations."

<sup>3</sup> Note, Nicola having been involved in the case, she has not been involved in writing this report.

thought to merit an application).

The NHS Trust made an application to the court for an order and declarations that Q lacked the capacity to make decisions about her dental treatment, in particular, whether she should undergo a full dental clearance under general anaesthetic. It was submitted that it was in her best interests to undergo full dental clearance under general anaesthetic to relieve the pain and discomfort caused by periodontal disease and to receive sedation to facilitate her transfer to hospital to undergo such surgery. The applicant Trust was particularly concerned that the deterioration in Q's oral health was compromising her health generally, causing her pain, and complicating her enjoyment of food which was identified as being one of her great pleasures in life.

Gwynneth Knowles J identified that there was "a wealth of evidence before the court that Q lacks the capacity to conduct these proceedings and to make decisions about her dental treatment," it being "plainly evident that Q has no ability to understand the most basic of discussions about oral hygiene or dental treatment. She cannot, in my determination, understand, retain, use, or weigh any of the information relevant to the decision whether or not to have such treatment, specifically full dental clearance, or the sedation and transport necessary to carry out such treatment" (paragraph 16).

Turning to best interests, there was clear medical evidence before the court outlining the risks and benefits. On the basis of the evidence before the court, Gwynneth Knowles J considered it reasonable to infer that Q continued to experience dental pain. She noted that the Official Solicitor was:

*22 [...] anxious to ascertain whether alternative and less invasive treatment options had been considered by the Trust. On receipt of answers to her questions from Dr A [the associate specialist in oral surgery], the Official Solicitor is reassured that a comprehensive assessment of Q's dental health will be carried out once she has been conveyed to hospital and, if there are any teeth which are sound and firm and likely to remain so for a reasonable period, that Dr A will exercise her clinical judgment to decide whether these teeth should be retained rather than extracted. Though as a result of the COVID-19 crisis the Official Solicitor has been unable to instruct an independent expert in special care dentistry, it is accepted by her that the evidence filed in support of Q's dental care plan is comprehensive and thoughtful.*

Of some note is that:

*22. [...] Again, by reason of the COVID-19 crisis, the Official Solicitor has been unable to visit Q to ascertain her wishes and feelings. She does however accept, having read the minutes of the meeting undertaken by Ms B with Q on 30 April 2020, that Q's ability to communicate is very limited indeed due to her severe learning disability. It is thus difficult to ascertain with any certainty what Q's wishes and feelings are about the proposed dental treatment. I agree.*

The plan for the transfer involved the covert administration of ketamine because, it was said:

*24. [...] when anxious, Q becomes extremely aggressive, damaging her wheelchair and injuring staff and she is likely to become anxious and distressed*

*if any attempt is made to take her to hospital voluntarily. The administration of ketamine covertly before departure allows for Q to be sedated when travelling to and fro from hospital by ambulance. Two previous occasions, as I have already indicated, to bring Q to hospital have been unsuccessful as no chemical restraint was used. Q became upset and had a prolonged fit. I accept that Q needs to be sedated to be safely transferred to and from the hospital. The use of a sedative administered covertly and safely, as happens with her annual flu injection, is proportionate and the least restrictive measure in the circumstances of this case.*

Gwynneth Knowles J was satisfied, that “standing back and looking at matters in the round”:

*25. [...] the proposed plan for medical and dental treatment is in Q's best interests. The plan is supported by all those who know Q well including her own sister. Though there is, of course, inherent risk in the administration of a general anaesthetic, the evidence of a consultant neurologist with a special interest in epilepsy indicates that the risk to Q is small and can be appropriately managed.*

*26. I have also considered that after surgery, Q's recovery is likely to be both painful and upsetting for her because she lacks the understanding to recognise what has happened to her and why it has happened. However, this will be transient discomfort after which she should be able to enjoy her food and derive pleasure from eating without pain. That transient discomfort has also to be balanced against the significant risk of, if untreated, Q experiencing worsening pain where she refuses food, becomes*

*malnourished, and is at risk of developing sepsis. In my view, the course of action proposed by the applicant trust is necessary and the least restrictive possible course in order to carry out the dental treatment that Q urgently needs and has needed for some time on the evidence before me. I am satisfied that it is in her best interests to make the order sought in respect of dental treatment and I approve the contents of the draft order which has been placed before me.*

### Comment

By the time that matters had come to court, it appears clear that there really was only one outcome that could enable Q's ability to eat without pain and enjoy her food which, as Gwynneth Knowles J identified, would vastly improve her quality and enjoyment of life. However, as with so many cases, the judgment is only the tip of the iceberg, and this reader at least is left wondering (1) whether Q had always been as resistant to support with dental hygiene as she had become in later years; (2) if she had, how had she reached her 50s without more serious problems; (3) if she had not, what had changed in her life and/or the way in which those around her supported her to make her more resistant; (4) what triggered the change in thinking from the relevant professionals to make them think that an application to court was now required in circumstances where (it appears) they had previously been content to administer a general anaesthetic to Q and carry out a full dental clearance on the basis of the 'general authority' in s.5 MCA 2005.

### Where the buck stops – medical treatment decisions and the Court of Protection

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*Re GTI [2020] EWCOP 28 (Williams J)*

*Best interests – medical treatment*

### Summary

GTI was a 45 year old man, with an established history of schizoaffective disorder. It had been controlled with psychotropic medication and he has lived in supported accommodation in the community. His daily routine included preparing meals, shopping, socialising in the pub, cooking and watching television. However in January 2020, during what appears to have been a paranoid episode, he appears to have stabbed himself in the neck causing significant damage to his recurrent laryngeal nerve. The neurological damage had affected his swallowing reflex and he was now unable to take food or drink orally without significant risks of aspiration, with food and drink passing into the lung. That carried with it the risk of recurrent aspiration pneumonia and physical asphyxia leading to respiratory arrest.

GTI had been taken to hospital after he had stabbed himself, where he had initially agreed to the insertion of a percutaneous endoscopic gastrostomy ('PEG'). However, his position then changed (after he had been detained for assessment under s.2 MHA 1983), and the operation did not go ahead as there were concerns about its legality. He was then transferred to a mental health unit with a nasogastric ('NG') tube in place. He pulled this out within 24-hours of admission and was given leave under s.17 MHA 1983 to go to another (physical health) hospital. Numerous attempts had been made to encourage GTI not to interfere with his total parenteral nutrition ('TPN') lines and to agree to the PEG insertion but without

success. He had been able on two occasions to drink water from a tap whilst having a shower and obtained a piece of chocolate. He was now supervised permanently by two mental health staff which is plainly highly intrusive.

GTI did not accept that he was unable to eat or drink normally. These seem to be perhaps two of the significant pleasures in his life but he is unable to accept the risks of aspiration or asphyxia. Since the injury he has been fed either by NG tube or directly into his bloodstream by TPN but GTI is resistant to these measures which are in any event only ever contemplated as temporary measures. He has removed several NG tubes and TPN lines inserted to feed him.

By the time of the application to the Court of Protection in May 2020, he had lost some 30% of his body weight. Further, his clozapine medication which the evidence suggested had kept his schizoaffective disorder well-controlled has had to be stopped because he had begun to develop agranulocytosis, a well-recognised adverse side effect of clozapine. The development of this side-effect was caused by his deteriorating physical condition associated with the lack of nutrition.

At a clinical decision-making meeting which took place on 20 May 2020 the conclusion was reached that the insertion of a PEG was in GTI's best interests. The decision was then taken to issue proceedings in the Court of Protection in order to seek the court's authorisation for that operation on the basis that GTI lacked capacity to take the decision himself and that the consensus of all present was that it was in GTI's best interests to urgently undergo the insertion of a PEG. The clinical team hoped to carry out the

procedure on the afternoon of 22 May.

The Official Solicitor was notified of the application on 21 May, and the application came before Williams J on 22 May, who heard it remotely by Zoom. GTI had told the Official Solicitor that he did not want to participate in the hearing. The same was also true of GTI's mother. It was clear that GTI did not want a PEG, making clear to the solicitor instructed by the Official Solicitor that he viewed it as intrusive and holding "a strong belief that he could if given the opportunity eat and drink normally. He expressed the view that imposing the procedure on him was reminiscent of the behaviour of dictators and was not the sort of thing that was acceptable" (paragraph 22). GTI's mother did not want to take a position which set her against GTI's wishes. She hoped that ultimately the court would take responsibility.

As to capacity, Williams J declared himself satisfied that:

*45 [...] GTI currently lacks capacity to take a decision for himself. The overwhelming weight of the evidence supports the conclusion that GTI is either unable to understand the information about the risks or his inability to take food or drink by mouth or that he is unable to use or weigh that information. These functional deficits are a consequence of his schizoaffective disorder; perhaps in part because the persecutory nature of the disorder leads him to question the reliability of the medical advice or perhaps in part is because of concrete thinking which prevents him considering alternatives to his own formulation of his situation.*

Importantly, Williams J did not stop there, but

considered (as is not always the case) whether any practicable steps could be taken to support GTI to make his own decision, but concluded that:

*45 [...] There is no means by which he could currently be enabled to make a decision save perhaps by authorising the treatment in order to restore proper nutrition and thus enable the resumption of the administration of enteral clozapine. On the evidence currently available it is possible to say that the current lack of capacity is likely to endure for some months if not years if his previous history of adapting to necessary change is an indicator.*

Turning to best interests, Williams J set out in some detail the medical evidence, and also GTI's wishes, before:

*Drawing all of the various threads together in relation to whether it is in his best interests I conclude that it is. I say that because*

- a. The medical evidence makes it clear that GTI cannot receive adequate nutrition through eating or drinking nor by any alternative means.*
- b. If he does not receive adequate nutrition his decline will continue his malnutrition will worsen and he is at risk of dying from starvation.*
- c. The evidence demonstrates that GTI does not wish to die but that he derives pleasure from his life; not just eating and drinking but various aspects including socialising and his interests in cars and music.*
- d. In order to restore his mental health he needs to be able to resume taking clozapine which he will only be able to do if his physical health recovers*

*such that his body is able to handle its administration without the risk of agranulocytosis.*

- e. *Although his mother does not wish to oppose GTI's expressed wishes I feel confident that she wishes him to improve his physical and mental health and that the idea of him dying of malnutrition / starvation would be profoundly distressing for her which he would not want her to suffer.*

Williams J was clearly troubled by the fact that he was making a decision that was going against GTI's expressed wishes, noting at paragraph 60 that he was:

*particularly conscious of the insult to GTI's personal autonomy of imposing a medical procedure on him against his wishes. Although I am satisfied that he lacks capacity to make the decision it is he who has to live with it not I. I take seriously what he said to Mr Edwards, not only the fact of the PEG being intrusive, but more importantly, that the state overriding his wishes and imposing a medical procedure on him would be experienced by him as a gross insult to his personal autonomy and dictatorial. How would I feel were that to be done to me I ask rhetorically. Of course, it is almost impossible to provide an answer given that the situation GTI finds himself in is beyond my ability to truly understand. If I were to suggest that I might feel angry and violated I doubt that it does justice to GTI's position. However there is another side to this from GTI's perspective I think. I do note though that GTI said his mother means the world to him. I also see that he speaks positively about his life prior to his injury. He enjoyed socialising and would like to expand his circle of friends. He aspired to*

*meeting a partner. He emerges as an intelligent and articulate man who has much to live for. I do not believe that he wishes to continue on a slow decline towards malnutrition, starvation and death. I do not believe he would dream of putting his mother through that appalling process. I believe he would wish to resume as good a life as was possible given the cards life has dealt him. That appears to have been his attitude before and the evidence of those who have been involved with him for some years appears to support the likelihood of him adapting and making the best of his situation again. Thus, whilst I accept that in approving the carrying out of this procedure I am overriding his wishes, I believe that in the short, medium and long term it is the best course for him and I hope that at some point in the future he might (even if only to himself) see that was so.*

Finally, and in a helpful reminder of where the buck stops, Williams J noted that:

*61. The Court of Protection exists to take decisions such as this. It not the decision of the hospital or any of the members of staff, nor that of GTI or his family or of the Official Solicitor. Ultimately the state has delegated the making of decisions such as this to the judges of the Court of Protection and it is we who bear responsibility for these decisions.*

### Comment

Over and above the (enormous) significance to GTI himself, the case provides a useful illustration of how judges are striving in a way frankly inconceivable when the MCA came into force to seek to construct decisions around the starting point of P's wishes and feelings. As



Lieven J had done in *PW*, another case in which the person expressed a clear wish not to die, but was refusing the one treatment that could keep them alive, Williams J did not simply proceed on the basis that the medical evidence gave the answer, but rather sought to recognise (to **respect**, using the language of the CRPD) both GTI's rights, will and preferences, and that those did not all line up neatly.

The reminder that the buck does stop with the Court of Protection was crisply and neatly put – and of no little importance. It was not a failure on the part of the medical team that the decision came to be taken by Williams J (although one might ask why it did not come somewhat earlier) but a necessary consequence of the fact that the magnitude of the interference with GTI's Article 8 rights took this out of the scope of those decisions it was appropriate for the clinicians alone to be responsible for.<sup>4</sup>

### Advance Decisions to Refuse Treatment – the backstory to a tragic case

We reported in 2018 upon the judgment of Hayden J in *NHS CCG v Rushton* [2018] EWCOP 41, a deeply sobering case in which Mrs Rushton's attempts to ensure that her decisions regarding future treatment were respected by making an ADRT were stymied until – belatedly – the Court of Protection was able to step into her shoes.

A Safeguarding Adults Review report (and – short – learning brief) has now been published by Cumbria Safeguarding Adults Board into her

case.<sup>5</sup> The report provides a significant backstory to the circumstances under which Mrs Rushton suffered the traumatic head injury which brought into hospital, as well as rather more detail than is provided in the judgment of Hayden J about the various clinical decisions that were taken resulting in the insertion of a PEG which was (he found) contrary to her ADRT. The story told in the SAR about Mrs Rushton's situation, and, in particular, the role of her youngest son in her life, is a complex and disturbing one; for present purposes, we limit ourselves to the SAR's conclusions in relation to the ADRT, which were as follows:

*7.20 The core purpose of adult care and support is to help people to achieve the outcomes that matter to them in their life (12). The outcome desired by Robyn and articulated in her Advance Decision was not achieved. A number of factors contributed to this. Firstly, there appears to have been only one copy of the Advance Decision and this was placed in Robyn's GP records. There should be a system in place, subject to the consent of the person making the Advance Decision, to ensure that Advance Decisions are shared with other parts of the healthcare system which may have a need to view the Advance Decision at some stage. It would also be helpful for the person making the Advance Decision and her family to retain a copy. In this case Robyn's family were not in possession of a copy of the Advance Decision which could have assisted them in their discussions with hospital staff following their mother's admission in December*

<sup>4</sup> For ways in which this can be framed in ECHR terms, see this article [here](#).

<sup>5</sup> Oddly, and probably reflecting the fact that SARs are required to be anonymised, the report refers to her as

"Robyn," when it is clear – and in the public domain in the form of the judgment of Hayden J – that her first name was Jillian.

2015.

7.21 Professionals may also need guidance on how to advise people who wish to make Advanced Decisions to ensure that they state their wishes as clearly and comprehensively as possible. Professionals may also need guidance on how to interpret and apply what is written in Advance Decisions to the circumstances which subsequently arise for the maker of the Advance Decision. In this case the GP, to whom Robyn was very well known, interpreted the Advance Decision more narrowly than did the Court of Protection.

7.22 In this case there is disagreement between the family and the hospital over whether the former mentioned Robyn's Advance Decision to the latter. The family are adamant that they notified the hospital of the Advance Decision on three separate occasions. There is no record of these notifications in the hospital records shared with this review. Professionals need to be advised to record any reference to an Advance Decision and then make enquiries to locate the document.

7.23 When the hospital decided to investigate Robyn's Advance Decision, they relied on the GP's interpretation of the contents of the document rather than requesting a copy to consider, although the now retired GP has advised this review that he sent the hospital a copy but this is not confirmed by the GP or hospital records. This is an insufficiently robust approach to considering such an important document. Professionals need to be advised to obtain a copy of any Advance Decision and to seek advice on the interpretation of the content of the document where necessary.

7.24 Cumbria Safeguarding Adults Board may wish to arrange for the learning arising from the handling of Robyn's Advance Decision to inform national guidance, specifically in respect of the need for professionals to advise people who wish to make Advanced Decisions to ensure that they state their wishes as clearly and comprehensively as possible, the need for a system, subject to the consent of the person making the Advance Decision, to ensure that Advance Decisions are shared with other parts of the healthcare system which may have a need to view the Advance Decision, the need for professionals to record all references to the existence of Advance Decisions and the need to obtain a copy of any Advance Decision and to seek advice on the interpretation of the content of the document where necessary.

The case of MSP discussed elsewhere in this Report stands as a further reminder, if reminder is needed, of the importance of the matters set out here in the SAR. Some relate to individual responsibilities, but others relate to how systems do (or do not) respond to the attempts made by individuals to plan for their future.

### **MCA/DOLS: DHSC additional guidance**

On 29 May 2020 DHSC provided some additional guidance to that given in April 2020 on the MCA and the DOLS safeguards during the pandemic, as well as updating the April guidance slightly, and providing a Welsh translation and an Easy Read version.

The additional guidance touches on the following issues.

First it addresses the question of testing someone for Covid-19 where they lack capacity to consent to this themselves. The guidance reminds decision makers to apply the MCA when making best interests decisions on this issue. It also provides that *'For many people, a best interests decision to test for COVID-19 will align with the decision that we could have expected the person to have taken themselves if they had capacity.'* A very strong nudge as to what decision that may be is given in the following sentence where it states that *'it is reasonable to conclude that most people leaving hospital for a care home, with the relevant mental capacity to take the decision, would have agreed to testing, for the protection of their own health, and others around them.'* [We cover the question of testing in more detail in our Rapid Response guidance note [here](#)].<sup>6</sup>

Secondly, the guidance addresses again the question of life saving treatment for Covid patients. This is defined in the guidance as treatment to prevent the deterioration of their condition (given the fact there is no cure for Covid). The guidance reminds us that that where life saving treatment is given to a person who lacks capacity to consent to it, that is materially the same as would normally be given to those without a mental disorder, then this will not amount to a deprivation of liberty. This is in line with the Court of Appeal decision in *R (Ferreira) v HM Senior Coroner for Inner South London and*

*others* [2017] EWCA Civ 31. As with the April guidance, the May additional guidance goes further than *Ferreira* by extending the logic to care homes as well as hospitals, and (potentially) the definition of 'life-saving' treatment from the category of "life-saving emergency medical treatment" that Lady Arden at least had in mind as being encompassed by *Ferreira* (see paragraph 120 of *Re D*, when, now as a Supreme Court judge, Lady Arden outlined what she considered she and other members of the Court of Appeal had decided).

Thirdly it reminds us that life-saving treatment cannot be given if it is contrary to a valid and applicable advance decision to refuse treatment made by the person.

The guidance then goes on in Q&A format to address the question of DOLS and how this is to operate during the pandemic. The guidance provides as follows:

- IMCAs and RPRs need to continue to represent and support those subject to DOLS, keeping in touch with them with remote techniques. Face to face visits should only be made if absolutely essential due to someone's communication needs, if it is urgent, or where there is a concern about their human rights. Presumably this means a concern over and above the fact that they are being deprived of their liberty (which is of course an interference with the person's

*capacity to make a decision about their own testing. If the person lacks the relevant mental capacity to consent to the test, and they are aged 16 or over, you should consider if the principles of the Mental Capacity Act 2005 allow you to make a 'best interests decision' to swab and receive results, on their behalf."* The same also appears in the [guidance](#) in relation to non-Radox test kits.

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<sup>6</sup> Note also in relation to testing the [guidance](#) given to care homes when they apply for the relevant Radox test kits (at page 8): "[y]ou should obtain consent to conduct the test from the resident, consulting family members and their GP as appropriate and in line with your usual policies and procedures. Some residents, for example some people with dementia, learning disabilities or mental health conditions, may lack the relevant mental

article 5 rights).

- Where changes to the arrangements to a person's care and support are made during the pandemic, these do not need to be reviewed or notified to the Supervisory Body unless they are 'much more restrictive' than the previous arrangements. The example given is that if a person is not able to have face to face contact with family but is able to have remote contact, then this would not call for a review as this is not a much more restrictive arrangement.
- That in light of what is likely to be a reduced pool of available options on discharge from hospital to a care home, it is likely to be in the person's best interests to be discharged to the 'first appropriate care home'.
- In community settings where a best interest decision is made that a person should socially isolate and this amounts to a DOL, then a Court application should be made.

Lastly the guidance addresses the emergency public health powers. It emphasises the importance of supporting those who lack capacity, and who are exhibiting Covid symptoms, to understand what is being asked of them in terms of following public health guidance. The first step is to assist the person to make the decision to isolate themselves.

Where restrictions are required, whether these can be imposed using the MHA and the MCA must be explored first. Only where these regimes are not available (presumably either because the person does not meet the criteria for detention - MHA – or the restriction in question cannot be said to be in the person's best interests but is required instead to protect public - health –

MCA), should the public health powers be considered. In such cases the Local Health Protection Team must be contacted. The guidance sets out the procedure that must be invoked in such cases, to ensure P's participation. The guidance also provides the mechanism for appealing such a decision – to the magistrates court, and makes clear that it is possible for an application to be brought on behalf of the person where they lack the capacity to do so, and that this may in some cases, be necessary even if the person is not objecting or does not appear to understand that they can make a challenge.

### The CQC, MCA and DoLS

The CQC has published [guidance](#) on working within the MCA during the pandemic. This makes the very important point that there have been no changes to the MCA and DOLS legislation as a result of the pandemic. It goes on to say as follows:

- Imposing social distancing, restrictions on movement, or isolation in response to coronavirus (for example confining a person to a room) may not in itself amount to a deprivation of liberty.
- Where life-saving treatment is being provided in a care home or hospital, including for the treatment of coronavirus, then the person will not be deprived of liberty as long as the treatment is the same as would normally be given to any person without a mental disorder. (as noted above this is consistent with the Court of Appeal decision in *Ferrerira*, although extending its logic).
- Most changes to a person's care or

treatment during the pandemic period will be covered by the existing standard authorisation, however, a review may be necessary in order to decide if a new authorisation is needed to replace the existing one.

- If a person is reasonably suspected as being “potentially infectious” (as defined in the Coronavirus Act) it is crucial to contact the NHS to ensure the individual receives the right care at the right time.
- When deciding whether to use the MCA or the Public Health Powers to lawfully restrict a person’s movements, consideration should be given to the person, family and carers wishes and feelings; whether a best interests decision applies; and whether there is an existing DoLS authorisation in place – these factors point towards using the MCA.
- Providers should continue to notify CQC of the outcome of a standard DoLS application once it is known. There is no need to tell the CQC at the application stage or about urgent self-granted authorisations.

The CQC has also published some information setting out how it is dealing with DoLS during the pandemic.

The CQC have ‘paused’ their routine inspections of services, instead using the emergency support framework [ESF] which is to apply to all health and social care settings registered with them. This is a flexible approach involving the following elements:

- using and sharing information to target support where it’s needed most

- having open and honest conversations
- taking action to keep people safe and to protect people’s human rights
- capturing and sharing what the CQC do.

Where however there are serious concerns which cannot be addressed through monitoring and discussion the CQC will inspect, provided these visits can be undertaken safely. The question of whether there are risks related to deprivation of liberty remains an important one to consider when determining whether to inspect and visit a service.

It remains to be seen whether the CQC will alter the approach set out here in light of the recommendations of the Joint Committee on Human Rights in its report upon the impact of COVID-19 crisis upon young people with learning disability and/or autism detained in psychiatric settings (covered in the Wider Context report).

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## PROPERTY AND AFFAIRS

### Short note: a very sad case about a will

In *Clitheroe v Bond* [2020] EWHC 1185 (Ch) Deputy Master Linwood had to decide on whether either of two wills should be admitted to probate. He described the dispute as a bitter family dispute that involved the surviving son and daughter of the deceased.

The wills cut the daughter out of the estate and made the son the principal beneficiary.

The daughter contested the wills on the grounds that her late mother had been suffering from a complex grief reaction or other affective disorder as a result of another daughter's death and that had led to her having insane delusions about the surviving daughter's character and behaviour which resulted in her being cut out of the will.

In the result, the court decided in the daughter's favour and the wills were not admitted to proof. On the way, the court rejected the daughter's alternative claim that the wills had been the result of the son's calumny. The court also made a ruling about the nature of the delusions required. The son had argued that the proper definition was that in *Williams on Wills*, 10<sup>th</sup> Edition at [4.15] namely:

*A delusion is a belief in the existence of something which no rational person could believe and, at the same time, it must be shown to be impossible to reason the patient out of the belief.*

The daughter argued that the second requirement was unnecessary, not supported by authority and impractical and argued that it was

not part of the law. The judge agreed with the daughter, see paragraph 160.

The court approached the matter on traditional *Banks v Goodfellow* lines. In particular, the burden of proof was on the son to show that the deceased was not suffering from a mental disorder, was not suffering from insane delusions and that any such delusions had not affected the will.

Under the MCA, of course, there is a presumption of capacity that recognises a very important human right, namely the right not to be deprived of the liberty to make decisions about your affairs without evidence that shows on the balance of probabilities that you are, by reason of a mental disorder, unable to make such decisions.

Should the fact that the testator is dead make a difference? The court is retrospectively depriving a testator of their right to make a will in the terms of their choice so logic and reason suggests that the burden should be on the person opposing the will. With the state of the law as it is, however, primary legislation will probably be needed to effect this reform.

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## PRACTICE AND PROCEDURE

### Remote hearings update

#### *The Civil Justice Council Rapid Review*

The Civil Justice Council, at the request of its Chairman the Master of the Rolls, Sir Terence Etherton, has undertaken a [rapid review](#) entitled “The impact of COVID-19 measures on the civil justice system” designed to: (i) understand the impact of the arrangements necessitated by COVID-19 on court users; (ii) make practical recommendations to address any issues over the short to medium term; (iii) to inform thinking about a longer-term review.

Of particular relevance to CoP practitioners is that, whilst the response rate to the consultation was excellent, especially given the short timescales, the report identified as a serious omission the failure to gather data from lay users (only 11 complete responses were received), including vulnerable and disabled court users. The need for urgent further research in this area was identified.

In terms of recommendations, respondents recommended maximising the use of remote hearings in preliminary matters, interlocutory hearings and trials without evidence, particularly where both sides were represented. The majority of costs disputes were also felt to be suitable for remote determination. Practical suggestions to improve the conduct of hearings included improving the equipment provided to judges and developing the functionality of platforms used to conduct remote hearings to enable better document sharing.

Particular concerns were noted in respect of the backlog of housing possession claims which will

require a comprehensive strategy for effective management going forwards. This was identified as a matter of priority by Sir Terence in his comments on the publication of the report.

#### *Observing remote hearings in the Court of Protection – practical assistance.*

Celia Kitzinger, an academic based at Cardiff University, has published an [article](#) which highlights the importance of Court of Protection hearings remaining open to the public in the age of remote justice. In this regard, she observes the importance of ensuring that the court’s recent work on improving transparency is not undermined by measures necessitated by COVID-19.

Based on her experience of observing 19 hearings during May 2020, she concludes that while it is certainly the intention of the Court of Protection to maintain transparency, “that is more aspiration than reality”, with a series of practical barriers making it difficult, but not impossible to observe hearings in practice.

She ends by encouraging members of the public to engage with the administration of justice in the Court of Protection and provides a step-by-step guide for doing so.

Professor Kitzinger, together with Gillian Loomes-Quinn, has subsequently established the [Open Justice Court of Protection Project](#), providing practical assistance for those wishing to observe hearings before the court.

#### *Remote hearings guidance from the Transparency Project*

The Transparency Project has published a [practical guide](#) to remote hearings in the Family

Court. Its focus is practical, covering matters such as “What will happen at the remote hearing”, “What if I am worried I won’t be able to work the technology?”, “What if I need to speak privately with my lawyer or supporter during the hearing?” The guide will be especially valuable for litigants in person, but should also prove helpful to all lay users of the Family Court who are unfamiliar with remote hearings. It is also largely applicable by analogy to proceedings before the Court of Protection.

*Guidance from Sir Andrew McFarlane – “The Family Court and COVID 19: The Road Ahead”*

The President of the Family Division has provided guidance “which seeks to establish a broad framework for the Family Court [...] over the next six months of more” in light of COVID-19. This is in the context of the challenge he describes as follows: “The reality to be faced is that the Family Court must now, for a sustained period, seek to achieve the fair, just and timely determination of a high volume of cases with radically reduced resources in sub-optimal court settings.”

The key message is that unacceptable delay in the administration of justice can only be avoided if hearings are significantly shorter, which in turn requires impeccable time management facilitated by “clear, focussed and very robust” case management by judges.

Many of the pressures on the family courts are different to those on the Court of Protection (for instance, there are very many fewer cases in which considerations of the credibility of a witness are going to be key). However, the guidance provides the following “COVID Case Management Checklist,” many of whose

principles may well be equally applicable before the Court of Protection:

*A Narrowing the Issues:*

- i. What issues are or can be agreed?*
- ii. Which of the remaining issues in the case is it necessary for the court to determine?*
- iii. Can those issues be determined without an oral hearing?*
- iv. If not, for which issues is an oral hearing necessary?*
- v. What oral evidence is necessary to determine those issues?*
- vi. The time estimate for each witness (including cross-examination) is to be reduced to the likely minimum necessary for the court to determine the issues to which it relates.*

*B Hearing Format:*

- i. Can the issues be determined fairly and justly at a fully remote hearing (having regard to the measures set out at C below)?*
- ii. Is it necessary to conduct all or part of the hearing with some of the parties in attendance at court [a hybrid hearing]?*
- iii. Where a remote or hybrid hearing is to be held, it should be undertaken by video link, unless the court determines that a telephone hearing will be sufficient or a video link is not available;*
- iv. Where a telephone hearing is to take place, it should be undertaken via BT MeetMe Dolby Plug-in, if available;*
- v. Consideration should be given to access to the hearing by media or legal bloggers [FPR 2010, r 27.11, PD27B and PD36J];*
- vi. Where in ordinary circumstances arrangements would be made for a child to meet the judge, the court should strive to establish a means by which the judge and the child may ‘meet’, albeit that this may, in some circumstances, have to be via a video link rather face-to-face;*



vii. The court should give at least 3 days notice of the platform that is to be used for any remote or hybrid hearing.

*C Optimising fairness of remote hearings:*

i. The court should consider what options are available to support lay parties and enhance their ability to engage in a remote hearing. The options may include:

a. Attendance at a venue away from the party's home (for example a room at court, solicitor's office, counsel's chambers or a local authority facility);

b. Arranging for at least one of the party's legal team to accompany them (whilst observing the need for social distancing);

c. Establishing a second channel of communication between the lay party and their lawyers (for example by email, communication app or telephone during the hearing);

ii. Cases should be clearly timetabled with a start and planned finish time - where a witness template has been completed by the advocates and approved by the judge, it must be complied with save in exceptional circumstances;

iii. Regular short breaks should be provided in a hearing of any length;

iv. The overall length of the hearing should be reasonable, taking account of the need for breaks and of the acknowledged additional pressure of engaging in a remote court process;

v. Prior to the start of the hearing, all advocates should have communicated with their clients and with each other in an advocates meeting;

vi. All participants should be logged in and ready to start at the appointed hearing time;

vii. Advocates should ensure that they are available not only for the proposed length of the hearing but also for a reasonable period thereafter to de-brief their client and

communicate with other advocates over the drafting of the order and any ancillary matters;

viii. At the start of each hearing the judge should make a short statement explaining the ground rules for the remote hearing;

ix. The judge should ensure that there is a means for a party to give instructions to their advocate during the hearing;

x. Where the hearing involves a litigant in person the judge should 'check in' regularly with any litigant in person to ensure that they are hearing, understanding and following the proceedings;

xi. At all times a remote hearing should be conducted with the degree of seriousness and respect that is evident at a fully attended hearing;

xii. The court should consider how best to arrange for the involvement of any interpreter or intermediary in the hearing;

xiii. The court should ensure that lay parties have access to the electronic bundle (unless this is not necessary, for example by reason of the hearing being an interim hearing where a party is represented and not required to give evidence).

The impact of the guidance is already possible to see in family case management decisions, including *Lancashire CC v M & Ors (COVID-19 Adjournment Application)* [2020] EWFC 43, reflecting also the Court of Appeal decision in *C (Children: Covid-19: Representation)* [2020] EWCA Civ 734, in which the Court of Appeal noted that:

[25], the means by which an individual case may be heard is a case management decision over which the first instance court will have a wide discretion based on the ordinary principles of fairness, justice and the need to promote the welfare of the subject child or children. For specialist judges, these are becoming routine

*decisions, and as time goes on a careful evaluation of the kind made in this case is no more likely to be the stuff of a successful appeal than any other case management decision.*

### Short note: pragmatism and litigation capacity

In *CS v FB* [2020] EWHC 1474 (Fam), Mostyn J was confronted by what to do where it appeared that one of the parties to proceedings between parents concerning a child lacked capacity to conduct those proceedings. The Official Solicitor had been contacted, and in light of the matters put to her office noted that the court might wish to direct that the capacity of the party – the mother – to conduct the proceedings be assessed by an independent psychiatrist. However, the Official Solicitor's letter continued:

*there is the question of how this assessment can be funded. Whilst I understand that FB should be financially eligible for legal aid, FB is not willing to instruct a solicitor, and so an application for legal aid cannot be made at this time. So, this does not provide a route for funding the assessment. I have asked the local authority if it is able to provide funding, but it has said that this is not possible. The assessment is for the purpose of these proceedings and they are not a party to them. The Official Solicitor is not in a position to meet the capacity assessment. I do not know if it is possible for the assessment to be funded by the applicant's legal aid. I have raised this with Dawson Cornwall, who represent the father, and they were going to look into whether this was possible. I hope that Dawson Cornwall will be able to inform the court of the outcome of their*

*enquiries. If funding can be secured by this route or if another means of funding is identified the Official Solicitor is willing to assist by identifying an expert, drafting the letter of instruction, and liaising with the local authority about arranging for FB to meet with the expert.*

*Possible further steps: should the experts assess FB as lacking capacity to conduct the proceedings and the court determines that FB is a protected party, the Official Solicitor would propose instructing Brethertons to apply for legal aid to be able to represent FB, and if legal aid is granted the Official Solicitor should be in a position to consent to act as FB's litigation friend'.*

Dawson Cornwall representing the father made the enquiries suggested by the Official Solicitor. The answer from the Legal Aid Agency was "a flat categorical no." As Mostyn J identified:

*13. [...] The court is, therefore, left in a curious Catch-22 situation. It is suggested that the court cannot determine that the mother lacks capacity to conduct these proceedings unless there has been expert evidence to that effect. However, that expert evidence cannot be funded until she has been declared to lack capacity. One can, therefore, see that the argument is entirely circular.*

If FB did, indeed, lack capacity to conduct the proceedings, then the operation of FPR Part 15 meant that, effectively, there was a complete bar to any steps taking place until she had a litigation friend. As Mostyn J noted:

*15. Therefore, to declare on a final basis that a party does not have capacity to*

*conduct the proceedings is unquestionably a very serious matter, intruding into the freedom of a person to conduct litigation in the manner in which they think fit. It is for this reason that the threshold of incapacity is set relatively high.*

[...]

*16. In the case of Baker Tilly v Makar [2013] EWHC 759 (QB) Sir Raymond Jack emphasised how momentous it was for a court, without the benefit of expert evidence, to make a final determination of incapacity.*

Luckily, however, there was a solution proposed by Counsel for the applicant (not considered in *Baker Tilly*), namely that:

*this court should on the available evidence make an interim declaration of lack of capacity thereby enabling for the Official Solicitor to be appointed as the mother's litigation friend and legal aid secured. Once that has happened it would then be possible and appropriate for the Official Solicitor, with the benefit of legal aid, to investigate for final determination the mother's capacity to conduct these proceedings. Under FPR 20.2(1)(b) the court has power to make an interim declaration; and, indeed, under its general powers the High Court has power to make final declarations, but that latter power is not necessary in this case at the present time.*

Mostyn J gave a 'clear yes' to the question whether an interim declaration was justified on the evidence before him, and did so.

The solution adopted by Mostyn J is a pragmatic one, equally applicable in proceedings before the

Court of Protection, the COPR giving the court the power to make an interim declaration (r.10.10(b)), and proceedings under the CPR, which also gives the court the power to make interim declarations (CPR r.25.1(b)). In the context of proceedings before the Court of Protection the issue is likely to arise not in relation to P, but rather another party: in relation to P, the structure of the Rules is such that P can only be joined as a party if they either (1) have capacity to conduct the proceedings; or (2) an accredited legal representative or litigation friend is in place (see COPR 2017, r.1.2(4)).

## THE WIDER CONTEXT

### ENGLAND AND WALES

#### The Joint Committee on Human Rights – detained young people with learning disability and/or autism

In a hard-hitting [report](#)<sup>7</sup> published on 12 June 2000, the JCHR provided a follow-up report to that published in 2019 on the detention of young people with learning disabilities and/or autism in Assessment and Treatment Units (ATUs) and other mental health hospitals. That earlier [report](#) had concluded that young people's human rights are being abused; they were detained unlawfully contrary to their right to liberty, subjected to solitary confinement, more prone to self-harm and abuse and deprived of the right to family life. As the JCHR noted in the introduction to its new report:

*Now that institutions are closed to the outside world as a result of the Covid-19 pandemic, the risk of human rights abuses are even greater. Unlawful blanket bans on visits, the suspension of routine inspections, the increased use of restraint and solitary confinement, and the vulnerability of those in detention to infection with Covid-19 (due to underlying health conditions and the infeasibility of social distancing) mean that the situation is now a severe crisis.*

The JCHR made a series of recommendations, including that:

*NHS England must write immediately to*

*all hospitals, including private ones in which it commissions placements, stating that they must allow families to visit their loved ones, unless a risk assessment has been carried out relating to the individual's circumstances which demonstrates that there are clear reasons specific to the individual's circumstances why it would not be safe to do so.*

*Figures on the use of restrictive practices, including physical and medical restraint and any form of segregation, detailing any incidences which go beyond 22 hours per day and amount to solitary confinement, must be published weekly by the institutions. These figures must be provided to the Secretary of State for Health and Social Care and reported to Parliament.*

*The Care Quality Commission (CQC) should carry out all their inspections unannounced; this is particularly important where any allegation of abuse is reported by a young person, parent, or whistle-blower.*

*The CQC must prioritise in-person inspections at institutions with a history of abuse/malpractice, and those which have been rated inadequate/requires improvement.*

*The CQC should set up a telephone hotline to enable all patients, families, and staff to report concerns or complaints during this period.*

*The CQC must report on reasons for geographical variation in practice with*

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<sup>7</sup> Note, Alex is now a special advisor to the Committee for its inquiry into Human Rights and the Government's response to COVID-19, and had input into this report.

*resultant harmful consequences.*

*Now, more than ever, rapidly progressing the discharge of young people to safe homes in the community must be a top priority for the Government. The recommendations from the Committee's 2019 report must be implemented in full.*

*Comprehensive and accessible data about the number of those who are autistic and/or learning disabled who have contracted and died of Covid-19 must be made available and include a focus on those in detention, for whom the state has heightened responsibility for their right to life.*

### **Not all deprivations of liberty are equal: the limits of the state's operational duty to protect the right to life**

*R(Maguire) v HM Senior Coroner for Blackpool & Fylde [2020] EWCA Civ 738 (Court of Appeal (Lord Burnett, LCJ, Sir Ernest Ryder and Nicola Davies LJ))*

*Article 5 – deprivation of liberty – other proceedings – inquests*

#### **Summary<sup>8</sup>**

The Court of Appeal has held that there are (perhaps surprising) limits to the obligation upon the state under Article 2 ECHR to investigate the death of those subject to the Deprivation of Liberty Safeguards.

#### *Background*

The case concerned an inquest into the death of

a 52 year old woman, Jacqueline (Jackie) Maguire that Article 2 ECHR was not engaged. Ms Maguire had a diagnosis of Down's syndrome and moderate learning difficulties. She required one-to-one support and had severely compromised cognitive and communication abilities. By the time of her death, she suffered limited mobility, needing a wheelchair to move around outside. She had lived for more than 20 years in a care home in Blackpool where she was deprived of her liberty pursuant to a standard authorisation.

In the week prior to her death, Ms Maguire had complained of a sore throat and had a limited appetite. For about two days before she died, she had suffered from a raised temperature, diarrhoea and vomiting. On 20 February 2017, Ms Maguire asked to see a GP. Staff at the care home did not act on that request. There then followed a chain of events which included a failure on the part of a GP to respond to calls and make a home visit; a further failure on the part of the out of hours GP to triage Ms Maguire properly or to elicit a full history from carers; and poor advice being given to the carers from NHS111. In fact the first medically trained personnel to attend Ms Maguire were an ambulance crew after 8pm on the 21 February 2017, however they had not been notified that Ms Maguire had Down's syndrome and they found themselves unable to take her to hospital as she simply refused to go.

Ms Maguire therefore remained at the care home overnight. She was found collapsed the following day. She was admitted to hospital by ambulance and died that evening. A post-

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<sup>8</sup> Note, as Tor and Nicola were involved in the case, they have not been involved in the drafting of this note.

mortem examination concluded that her death was as a result of a perforated gastric ulcer with peritonitis and pneumonia.

The coroner at a Pre Inquest Hearing determined that Article 2 ECHR was engaged and therefore conducted the inquest on this basis. However, at the conclusion of the evidence, the coroner reconsidered the position in light of the decision of *R (Parkinson) v Kent Senior Coroner* [2018] EWHC 1501 (Admin) which had been handed down shortly before the hearing had begun. Relying on this decision, the Coroner ruled that the allegations against Ms Maguire's carers and healthcare providers amounted to allegations of individual negligence, which *Parkinson* had clarified as falling outside the state's obligations under Article 2.

#### *The application for judicial review*

The application for judicial review contended that the Coroner was wrong to conclude that Article 2 did not apply. It was argued that the law had developed so that the court should now recognise the state's positive obligations under article 2 towards those who may be described as "particularly vulnerable persons under the care of the state". Alternatively, it was argued that the Coroner ought to have concluded that there was sufficient evidence of systemic problems in events leading to Jackie's death that article 2 ought to have been left to the jury. There had been no effective communication system between those authorities charged with protecting Jackie (GP services, NHS111, the ambulance service and the hospital) and no individual with oversight of Jackie's healthcare who could convey an accurate account of her symptoms in circumstances where she was unable to do so. These were regulatory and

structural failures. Together with the failure to sedate Jackie on the evening of 21 February, they were capable of amounting to systemic dysfunction.

The second ground of challenge was that the Coroner had erred in law in failing to leave neglect to the jury.

The Divisional Court held that this was not a case in which there had been an assumption of responsibility on the part of the State; and the chain of events that led up to Ms Maguire's death was not capable of demonstrating systemic failure or dysfunction. The Divisional Court found that such failings as there may have been were attributable to individual actions and so did not require the state to be called to account. The Divisional Court also found, on the facts, that Coroner had been entitled to find there was no individual failing on the part of those involved which could safely be said to be gross, so as to require him to leave a finding to the neglect.

The application for judicial review was therefore refused.

#### *The appeal*

Her mother appealed to the Court of Appeal in relation to the Coroner's approach to Article 2 ECHR.

The core of the appeal concerned the question of whether the case was a 'medical' case, or whether it was a case where the State had assumed responsibility for Ms Maguire. If it was a 'medical' case, then, following the Grand Chamber's decision in *Lopes de Sousa Fernandez v Portugal* (2018) 66 EHRR 28, it would only be in "very exceptional" circumstances that the State's substantive responsibility under Article 2

ECHR would be engaged. Absent those circumstances, there is no 'parasitic' obligation upon the State to ensure the discharge of the heightened procedural obligations that arise from a death for which the State is responsible.

Determining the appeal required the Court of Appeal to undertake a detailed analysis of the complex Strasbourg case-law. It also then had to grapple with how those mapped onto the DoLS regime, and at paragraphs 52 onwards, gave a potted history of that regime, which in material part reads as follows:

*52. Jackie was placed by Blackpool Council in the small private residential home run by United Response in 1993. In doing so they were discharging their statutory functions of support for an adult with Jackie's combination of difficulties. She had lived at home between 1982 and 1991 but then exhibited bouts of extreme behaviour, diagnosed as a cyclothymic personality disorder. She first moved to an assessment centre before going to the United Response home. She could communicate – indeed her mother described her as a chatterbox. In recent years spinal problems had restricted her mobility to the extent she used a wheelchair for trips outside the home.*

*53. Jackie was unable to care for herself and her circumstances made it unrealistic to suppose that she could continue to live with her family. The home provided a safe and caring environment in which Jackie could live. She was neither physically capable nor sufficiently aware to be able to leave the home on her own. It would have been dangerous for her to do so. As is universally the case in such homes, and in residential and*

*nursing homes looking after the elderly who might harm themselves if they leave unsupervised, entrance and exit was strictly controlled. That ensured that residents could not leave unnoticed and thereby expose themselves (and others) to danger.*

*54. That state of affairs had been the reality on the ground for many decades. Nonetheless, the question whether such individuals were deprived of their liberty for the purposes of article 5 ECHR arose for consideration only relatively recently. The significance of the question, for the purposes of article 5 ECHR, was that deprivation of liberty is permitted in limited circumstances and then only supported by clear legal mechanisms.*

*55. In HL v. United Kingdom (2004) 40 EHRR 761 the Strasbourg Court was concerned with the question whether a mentally disabled and autistic man informally admitted to hospital for a protracted period, where he was sedated, kept under close supervision and would have been physically prevented from leaving had he tried to do so, was detained for the purposes of article 5. He was later detained under the Mental Health Act 1983. The court concluded that the care professionals exercised complete control over him and he was not free to leave. He was therefore deprived of his liberty. As Lady Hale later put it in P v. Cheshire West and Chester Council [2014] 1AC 896, at para. 8:*

*"It therefore became necessary for this country to introduce some ... machinery for the many thousands of mentally incapacitated people who are regularly deprived of their liberty in hospitals, care homes and elsewhere."*

56. The legislative solution was to amend the Mental Capacity Act 2005 by the Mental Health Act 2007. Deprivation of liberty was permitted: (a) if authorised by the Court of Protection; (b) if authorised under the procedures provided for in Schedule A1 which deals with hospitals and care homes within the meaning of the Care Standards Act 2000; and (c) in order to give life sustaining treatment or to prevent a serious deterioration in a person's condition whilst court proceedings are pending. The safeguards in the second category were designed to secure a professional assessment independent of the hospital or care home in which the person concerned was resident, directed at two questions. First whether the person lacks capacity to make the decision whether to be in the hospital or care home for care or treatment. Secondly, whether it is in his or her best interests to be detained. If the answer to both questions is yes, then a standard authorisation may be granted administratively, subject to challenge in the Court of Protection.

57. The degree to which an individual's living circumstances could be construed as constituting a deprivation of liberty within the meaning of Article 5 ECHR so as to require authorisation of the Court or some other form of administrative authorisation was considered in *Cheshire West*. Two of the appellants before the Supreme Court were young adults. One lived in foster care, the other in an NHS facility. Both had complex needs including learning disabilities. The third was a man in his 30s with Down's Syndrome and cerebral palsy who had lived with his mother until her health deteriorated. The local authority obtained orders from the Court of Protection that it

was in his best interests to live in accommodation arranged by them. There was no dispute that all the placements were suitable for all three with "positive features". Nonetheless, the question was whether they were deprived of their liberty. The Court of Appeal had concluded that they were not, but the Supreme Court, by a majority of four to three, came to the opposite conclusion.

58. The result was that across the country steps were taken in a substantial number of instances to seek authority to deprive people of their liberty in circumstances which had been thought unnecessary until then. Nothing changed in the practical arrangements in place for many in hospitals and care homes, but the appropriate authority was sought.

Mapping the Strasbourg obligations onto the facts of Ms Maguire's case, the Court of Appeal noted that:

68. Jackie was a vulnerable adult who was unable to care for herself. She had learning disabilities which affected her ability to make choices for herself. She lacked capacity to make decisions affecting her living arrangements, healthcare and welfare. She shared those characteristics with a large number of young adults who, for a wide variety of reasons, are in a similar position. An increasing number of elderly adults are in a parallel situation as a result of the infirmities of old age, especially diminished mental faculties or dementia. Individuals who share these characteristics may be accommodated in a range of different circumstances. Many live at home cared for by family members. Large numbers live in care or nursing homes, some paying for the care



*themselves, others with public funding. Others are under the more direct care of a local authority or the NHS. Since the amendment to the Mental Capacity Act 2005 made in 2007, and more particularly since the decision of the Supreme Court in Cheshire West, a substantial number of them will be subject to DoLS with the consequence that were they to seek to leave the home or hospital in which they reside their carers would have lawful authority to stop them.*

The underlying argument made by the Appellant was that “*the undeniable vulnerability of an individual in Jackie's position, coupled with the fact of a DoLS authorisation dictates that she was owed the operational duty under of article 2 ECHR with the result that the procedural obligation explained in Middleton applied and the jury should have been able to comment on the quality of medical care provided to Jackie and the absence of any plan for emergency admission*” (paragraph 70).

However, the Court of Appeal observed, it was important to focus on the scope of the operational duty and why it might be owed. Its analysis of the Strasbourg case-law led it to conclude (at paragraphs 72-3) that:

1. The Divisional Court was right to identify the unifying feature of the application of the operational obligation or duty to protect life as one of state responsibility, and arising in circumstances where the State owes a substantive to the people concerned to protect them from a type of harm entirely within the control of those who cared for them. Examples of this situation included those considered in the case of (1) *Nencheva v. Bulgaria* (App. No 48606/06), where the Bulgarian state was in breach of its positive

obligation for failing to take prompt action to protect the lives of young people in a residential care home where 15 disabled children died, in circumstances where the authorities were aware of the appalling conditions in the care home and of an increased mortality; and (2) *Câmpeanu v. Romania* [GC] (App. No. 47848/08), where the Romanian authorities knew that the facility in which the deceased was kept lacked proper heating and food, had a shortage of medical staff and resources and inadequate supplies of medication, such that placing the individual in question in the institution unreasonably put his life in danger, a danger compounded by their continuing failure to provide him with medical care. The Court of Appeal therefore concluded that this meant that the Article 2 substantive obligation is tailored to harms from which the authorities have a responsibility to protect those under its care (paragraph 73);

2. The fact that an operational duty to protect life exists does not lead to the conclusion that for all purposes the death of a person owed that duty is to be judged by Article 2 standards. Relying heavily on the case of *Dumpe v Latvia*, in which on (the Court of Appeal considered) similar facts, the ECtHR had considered that the operational duty did not apply to the provision of medical treatment of someone in a care home, the Court of Appeal concluded that the procedural obligation is not the same where the death has not resulted from neglect or abuse for which the State could or should be held liable. Rather, the procedural obligation is to set up an effective judicial system to determine liability – which could include the

civil courts, as well as the operation of an inquest.

Rejecting the central grounds of appeal, the Court of Appeal held that:

*96. The question whether an operational duty under article 2 was owed to Jackie is not an abstract one which delivers a "yes" or "no" answer in all circumstances. She was a vulnerable adult incapable of looking after herself and lacking capacity to make decisions about her care. As the decisions of the Strasbourg Court in Nencheva and Câmpeanu show, the article 2 operational duty is owed to vulnerable people under the care of the state for some purposes. If a death in this jurisdiction in a hospital or care home for which the state was responsible resulted from conditions described in either of those cases, the substantive or operational duty under article 2 ECHR would be engaged. So too if the state was aware of the shortcomings, through regulatory inspections, and did not act on them. There would be a direct analogy in the latter situation with the failure of social services to protect children over a prolonged period when they knew of serious abuse (Z v. United Kingdom discussed in para. 46 above). The potential application of the operational duty discussed in Watts v. United Kingdom (see para. 45 above) when moving vulnerable elderly people from one home to another on account of the exceptional risk involved is another example of the operational duty arising within a defined area of activity.*

*97. The approach illuminated by those cases (and the prison cases) does not support a conclusion that for all purposes an operational duty is owed to those in a*

*vulnerable position in care homes, which then spawns the distinct procedural obligation (with all its components) in the event of a death which follows either alleged failures or inadequate interventions by medical professionals. On the contrary, as Dumpe most clearly demonstrates, it is necessary to consider the scope of any operational duty. Had Mr Dumpe's death followed ill-treatment or neglect of the sort considered by the Strasbourg Court in Nencheva and Câmpeanu the position would have been different. The circumstances of the death would be judged by reference to the operational duty.*

*98. In our view, there is a close analogy between the circumstances of Jackie's death and that of Mr Dumpe. The criticisms of medical care in Dumpe were in fact more wide-ranging. Dumpe was a decision of a Chamber of the Strasbourg Court and so lacks the authority of a Grand Chamber judgment.*

[...]

*99. The decision in Dumpe may not represent "clear and constant jurisprudence of the Strasbourg Court" but there is no decision of that court to which our attention has been drawn which suggests that the operational duty is owed to those in an analogous position to Jackie in connection with seeking ordinary medical treatment. To hold that the operational duty was engaged in this case would certainly be to move beyond any jurisprudence of the Strasbourg Court. The conclusion would not flow naturally from existing Strasbourg jurisprudence, as the conclusion in Rabone did in respect of involuntary psychiatric patients at risk of suicide (see Lord Brown's observation quoted in para.*

43 above). In any event, we respectfully agree with the reasoning in *Dumpe* which in our view flows from the decisions to which the court referred, is consistent with the approach to deaths from natural causes of prisoners, and applied the decision of the Grand Chamber in *Lopes de Sousa*. The caveat in para. 163 of *Lopes de Sousa*<sup>9</sup> does not affect the outcome in a case of this sort.

[...]

100. In our judgment, the coroner was right to conclude that, on the evidence adduced at the inquest, there was no basis for believing that Jackie's death was the result of a breach of the operational duty of the state to protect life. It followed that the procedural obligations on the state identified in *Jordan* did not arise. For the purposes of the inquest the conclusions were governed by section 5(1) of the 2013 Act and in particular "how Jackie came by her death" rather than "how and in what circumstances".

101. Jackie's circumstances were not analogous with a psychiatric patient who is in hospital to guard against the risk of suicide. She was accommodated by United Response to provide a home in which she could be looked after by carers, because she was unable to look after herself and it was not possible for her to live with her family. She was not there for medical treatment. If she needed medical treatment it was sought, in the usual way, from the NHS. Her position would not have been different had she been able to

continue to live with her family with social services input and been subject to an authorisation from the Court of Protection in respect of her deprivation of liberty whilst in their care.

The Court of Appeal then rejected the alternative submission that, even if this was a "medical case", it fell into the category of "very exceptional circumstances" which can give rise to a breach of the operational duty under Article 2. It noted that:

106. There is nothing in the materials before us which suggests that there is a widespread difficulty in taking individuals with learning disabilities (or elderly dementia patients) to hospital when it is in their interests to do so. The criticism of the care home, the paramedics and the out of hours GP is that between them they failed to get Jackie to hospital on the evening of 21 February; and that a plan, protocol or guidance should have been in place that would have achieved that end. That is remote from the sort of systemic regulatory failing which the Strasbourg Court has in mind as underpinning the very exceptional circumstances in which a breach of the operational duty to protect life might be found in a medical case. The making of plans in individual cases and the detail of guidance given to paramedics is far removed from what the court describes in the passage we have set out.

### Comment

It is, one might think, a strange asymmetry in the

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<sup>9</sup> "The Court would emphasise at the outset that different considerations arise in certain other contexts, in particular with regard to medical treatment of persons deprived of their liberty or of particularly vulnerable persons under the

care of the state, where the state has direct responsibility for the welfare of these individuals. Such circumstances are not in issue in the present case."

law that the State may have authorised a deprivation of liberty of a person, in a State-regulated facility, but not at the same time be considered to be under an operational duty to secure the right to life of that person such as to give rise to the full-fledged duty to investigate and account for the circumstances of their death.<sup>10</sup>

It is, with respect, perhaps a little challenging that the Court of Appeal had to find the answer to that question in the decision in the case of *Dumpe* – an admissibility decision in which the Strasbourg court had not had to grapple with the full thorniness of the different levels of Article 2 obligation because it could find that the applicant had not exhausted their domestic remedies. As the Court of Appeal noted, the Strasbourg court had also not – in that case – grappled with the question of the relevance of State involvement in authorising deprivation of liberty, as Article 5 had not formed part of its consideration.

With respect, therefore, *Dumpe* does not provide the soundest of foundations upon which to establish the distinction that the Court of Appeal found itself constrained to identify.

The real answer may lie in the fact that the concept of deprivation of liberty as developed in England and Wales has escaped very significantly beyond the bounds of that identified by Strasbourg. The potted history of the DoLS regime given by the Court of Appeal gives a hint of this, emphasising the universality (and, the tenor suggests, the unexceptionable nature) of the arrangements made for those in the position

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<sup>10</sup> At least in circumstances where there could be any suggestion that the State's failings may have brought about or hastened the person's death, as opposed to

of Ms Maguire.

If the concept had retained the link to the exercise of coercion that was so central to the underlying Strasbourg case-law, then there would be no need to engage in the challenging intellectual exercise of explaining why not all deprivations of liberty are equal when it comes to engaging the obligations of the State under Article 2 ECHR. Put another way, if every deprivation of liberty always and everywhere involved the exercise of power (either directly by, or sanctioned by the State) to bring about a state of affairs contrary to the will of the person, then it would be very difficult to see why that should not carry with it the corollary that an obligation would arise to secure the right to life of that person. Conversely if – as is now the case in England & Wales – a deprivation of liberty can arise in circumstances where there is no indication that the person was unhappy with the situation, but they lacked the capacity to consent to the arrangements for them, then it is not so obvious why the operation of reactive mechanisms to ensure a check on those arrangements should automatically give rise to such an obligation.

Entirely coincidentally, just before this judgment was handed down, Alex recorded a conversation with Dr Lucy Series discussing her work on the evolution of the concept of confinement for purposes of care, their conversation being available [here](#).

As a final note, it may have been the case that there was nothing on the materials before the Court of Appeal to suggest that – at the time it

the position where there could be no suggestion but that the death was as a result of natural causes with no suggestion of any failure on the part of the State.

considered the matter in February 2020 – there was a “widespread difficulty in taking individuals with learning disabilities (or elderly dementia patients) to hospital when it is in their interests to do so.” However, many might consider that the issue over the past few months of the COVID-19 is not so clear-cut.

### The Ombudsman’s office bares its teeth

The Local Government and Social Care Ombudsman has **published** an important report into its investigation into the complaint against City of Bradford Metropolitan District Council.

The complainant was a woman, ‘Ms G’ described as having Autism Spectrum Disorder, severe anxiety disorder, depressive disorder and physical impairments including hypertension and severe chronic pain. The council carried out a social care assessment in June 2014 via the Ms G’s psychiatrist, with who she had a good relationship, which found that she had eligible needs. The council eventually agreed to make direct payments available so that she could fund a support worker. In fact, no support was provided, and the Ombudsman’s decision sets out the various meetings, complaints, and correspondence that took place as Ms G tried to access the support to which she was entitled. Her difficulties in communicating arising from her autism were not understood by the Council, which failed to accommodate them or to consider appointing an advocate for her. The Ombudsman found multiple failings in addition to the failure to provide support, including failing to respond to Ms G’s request for a payment that she could use to help someone to complete the necessary financial assessment, failing to make reasonable adjustments as required by the Equality Act, and causing distress to Ms G by

describing her as difficult and uncooperative. In addition to an apology, the Ombudsman recommended that the Council:

*pays Ms G £60,000 to acknowledge the substantial adverse impact on her wellbeing caused by the failure to provide her with the support the Council assessed she needed and the associated distress and severe anxiety she experienced. The impact includes (but is not limited to) the adverse and severe impact on her ability to get the support she needed with daily living skills such as meal preparation and planning, dealing with day to day matters with other organisations, accessing health services with suitable support, avoiding social isolation and travelling safely to and from her home. This is likely to have exacerbated her severe anxiety and depressive disorders. The remedy is calculated based on the substantial difficulty Ms G has had since being assessed and left without formal support for over five years. This equates to £1,000 monthly x 60 months; and*

*discusses with Ms G and her representative whether the payment will impact on her entitlement to benefits/finances and if necessary, pay an independent professional person to provide her with financial advice.*

The Ombudsman also made wider recommendations that the Council:

*reviews the findings of this investigation and consider whether training is needed for officers responsible for care and support planning around autism and the duty to make reasonable adjustments; and*

*consider whether its policies and procedures relating to people who use services who are autistic and have associated mental health disorders is in line with best practice.*

It is very unusual for the Ombudsman to recommend payment of such a substantial sum, but it undoubtedly reflects the dire straits in which Ms G was left for over 5 years.

### Parole Board hearings, participation and impaired decision-making capacity

*R (EG) v Parole Board & Ors* [2020] EWHC 1457 (Admin) (Administrative Court (May J))

*Other proceedings – judicial review*

#### Summary<sup>11</sup>

A prisoner, EG, had learning difficulties which prevented him from instructing a (legal) representative to act for him in the review the Parole Board was conducting of the necessity of his continued detention. He challenged the failure of the Parole Board and the Secretary of State for Justice to secure his effective participation in his parole process so as to ensure a timely review of his continued detention as required by Article 5 of the European Convention on Human Rights.

It was not in dispute that an oral hearing was necessary in EG's case; nor was it contested that if the Parole Board Rules did not provide a proper mechanism to enable EG, as a person lacking capacity, to participate in his hearing then he would have been prevented from having a fair hearing and would have been entitled to succeed

in his claim.

The claim had a long and complex history, not least because of the publication (part-way through) of a new set of Parole Board Rules in 2019, which provided (at Rule 10(6)(b)) for the appointment of "a representative (solicitor or barrister or other representative) [...] where the prisoner lacks the capacity to appoint a representative and the panel chair or duty member believes that it is in the prisoner's best interests for the prisoner to be represented."

The claim was very widely framed, including by reference to the Equality Act 2010 and the Public Sector Equality Duty, but, not least because of the way in which the wider aspects had been pleaded and developed, May J confined herself to specific consideration of EG's position, in particular the need for a litigation friend (or other mechanism) to enable his effective participation in his parole process.

The key issues May J had to decide were therefore: (1) whether a solicitor can act in a dual capacity in parole reviews, as they do in the Mental Health Tribunals; (2) whether the 2019 Rules, properly construed, permit the appointment of a litigation friend; and (3) the role of the Official Solicitor as litigation friend of "last resort" for prisoners in their parole review. Before deciding these, however, she made some observations about the dispute between the parties (including the intervener Equality and Human Rights Commission) as to the precise number of prisoners who might require steps to be taken to secure their participation. She declined to resolve the dispute, however, noting

<sup>11</sup> Note, as Alex was involved in this case, and whilst he drafted the summary, he did not draft the comment.

that it was something of a red herring as “[t]he case of EG shows that the issue of prisoners lacking capacity to participate in their parole review is not theoretical and that there is a need to be addressed” (paragraph 74).

#### *Solicitors acting in a dual capacity*

After a careful review of the evidence, including that adduced by the Law Society as intervener, May J concluded that “the safeguards in terms of training and accreditation, taken together with specific legal aid funding arrangements create, in my view, a very particular mechanism for the representation by solicitors acting in the best interests of patients lacking capacity to participate effectively at a hearing before the MHT. There is currently no similar accreditation scheme, and different arrangements for public funding, in respect of a parole review for a prisoner who lacks capacity” (paragraph 85). She continued

*87. [...] For a prisoner who lacks capacity, the risk assessment process that is fundamental to a parole review considering release from prison engages a consideration of many similar matters to those arising at a MHT where the tribunal is considering release from hospital, such as: mental capacity and human rights, housing, risk to others and a suitable care package. In the MHT the effective participation in his or her hearing by a patient lacking capacity is in my view able to be secured because they are represented by someone who has had to demonstrate extensive experience, who has attended at a special training course and who has been screened and interviewed. I do not see how effective participation in their parole review for a prisoner who lacks capacity*

*could be ensured if they were to be represented by a “best interests” solicitor without similar safeguards. That some prisoners lacking capacity may in the past have been represented by a solicitor acting in their best interests without challenge is not, in my view, an answer to the issue which has now been raised.*

*88. Accordingly I agree with submissions made by the other parties that, in the absence of an analogous system of accreditation to that operating in the MHT, EG needs a litigation friend to act in his best interests, amongst other things to give instructions to his solicitors. That raises the question of whether the 2019 Rules enable the Board to make such an appointment.*

#### *The 2019 Rules*

May J concluded that: “*whilst considerably wanting in clarity, the Rules must and do permit the Board to appoint a litigation friend where one is needed to facilitate access of a non-capacitous prisoner to his or her parole review*” (paragraph 93). She considered that the plain wording of Rule 10(6) in its reference to “*other representative*” to encompass the potential for a litigation friend, but that, bearing in mind the obligations under s.3(1) HRA 1998 to construe legislation compatibly with the ECHR:

*99 [...] even if I am wrong to do so, it would in my view require much clearer wording for me to conclude that the 2019 Rules prevented the Board from being able to appoint a litigation friend where it was necessary to ensure a fair hearing. The disadvantage to which a prisoner lacking capacity risks being subject, without a person to act in his best interests upon the available material and to instruct a*

*solicitor or other legal representative to act in his parole review, would be so extreme that an explicit exclusion would be required before a court could conclude that this was what Parliament had intended. I think Mr Auburn is right to say that having a litigation friend is so fundamental to ensuring a fair hearing for a person who lacks mental capacity that it would require words which clearly exclude such an appointment before a court could find that it was not provided for.*

In this, May J also held that, even if Rule 10(6) did not assist, it would be possible to construe the wider case management power in Rule 6 so as to enable the appointment of a litigation friend.

#### *The role of the Official Solicitor*

By the time the matter came before May J, the Official Solicitor had agreed to act for EG in the parole process subject to certain conditions. However, going forward, complex arguments were advanced by the Official Solicitor (in her own right) as to her powers to act before the Parole Board. May J did not express a final conclusion on the construction of the relevant provisions (s.90(3A) Senior Courts Act 1981), but provisionally preferred the wider construction advanced by the Parole Board to the effect that the Official Solicitor **did** have such power, but she *“could not be expected reasonably to exercise that power in circumstances where her department was untrained or otherwise ill-equipped to do so”* (paragraph 116). She made no finding as to whether that was the case there, but noted that *“one of the purposes of consulting affected parties, like the OS, when introducing rule changes must be to identify and address such*

*issues,”* the OS not having been consulted.

#### *Discrimination*

Declining to consider in detail the wide-ranging claims formulated in this regard, May J’s conclusion was:

*131. [...] confined to the existence of a mechanism for affording EG full and proper representation in preparation for, and at, his oral hearing. In his case no other difficulty has been identified: his lack of capacity was picked up at an early stage and his solicitors have got legal aid to represent him in his parole process; what is wanting is a litigation friend to represent his best interests in giving his solicitors instructions, alternatively an accreditation system (or similar) to permit his solicitors properly and ethically to act in a dual capacity, as solicitors are able to do in the MHT.*

#### *Delay*

On the facts, May J found that *“[e]ven for a prisoner with his complex needs, a delay of over two and a half years appears to me to involve a breach of [his Article 5(4) rights].* She identified a number of relevant considerations going to the further consideration of the consequences of this delay, but did not resolve them in the judgment.

#### **Comment**

The case is a clear example of the importance of the HRA 1988 in safeguarding the rights of vulnerable people. While May J concluded that the references to “other representative” in the Parole Board Rules 2019 permitted the appointment of a litigation friend, importantly she relied heavily on the interpretative duty in



s.3(1) HRA 1988 to bolster this conclusion. Indeed, as set out above, May J explained that given the fundamental nature of rights involved, it would only be possible to draw the contrary conclusion in the event of an “explicit exclusion”. As such, this case is not only significant for mental capacity and prison law practitioners, but it also adds to the jurisprudence on the approach to s.3 HRA 1988, indicating that that court should be slow to reach the conclusion that no human rights compatible interpretation is possible.

### Inclusive justice: a system designed for all

The Equality and Human Rights Commission has [published](#) an important report looking both at how the criminal justice system currently fails to respond the needs of those with disabilities or with mental health conditions, and what steps would be required to bring about an inclusive system.

## THE WIDER WORLD

### ECtHR’s guide on Article 5 ECHR

The Court has updated (on 30 April 2020) its guide on the right to liberty and security which provides a useful, concise summary of its jurisprudence. Relevant to the pandemic, it stresses that the context of measures is important when determining whether liberty is restricted or deprived, “*since situations commonly occur in modern society where the public may be called on to endure restrictions on freedom of movement or liberty in the interests of the common good*” (para 6).

As to the objective element, firstly, the relevant factors include “*the possibility to leave the*

*restricted area, the degree of supervision and control over the person’s movements, the extent of isolation and the availability of social contacts*” (para 11). Secondly, as to the subjective element, “[t]he fact that a person lacks legal capacity does not necessarily mean that he is unable to understand the consent to [the] situation” (para 16). And for a fuller discussion of “legal” and “mental” capacity in the context of consent to deprivation of liberty, see Alex’s [paper](#). Thirdly, State responsibility “*is engaged if it acquiesces in a person’s loss of liberty by private individuals or fails to put an end to the situation*” (para 22).

What might in due course be of relevance when LPS comes into force (see paras 21-22 of Neil’s [blog](#)), factors relevant to the “quality of law” which safeguards against arbitrariness “*include the existence of clear legal provisions ... for setting time-limits for detention*” (para 34). Given the absence of urgent time-limits prior to an LPS authorisation, this could prove significant.

The guide also incorporates the significant [Rooman](#) decision which is worth setting out in full as to when deprivation of liberty is justified for purposes of Article 5(1)(e) (the relevant limb for purposes of both DoLS and the MHA 1983):

*121. The administration of suitable therapy has become a requirement of the wider concept of the “lawfulness” of the deprivation of liberty. Any detention of mentally ill persons must have a therapeutic purpose, aimed at curing or alleviating their mental-health condition, including, where appropriate, bringing about a reduction in or control over their dangerousness (Rooman v. Belgium [GC], § 208).*

*122. The deprivation of liberty under*

*Article 5 § 1(e) thus has a dual function: on the one hand, the social function of protection, and on the other a therapeutic function that is related to the individual interest of the person of unsound mind in receiving an appropriate and individualised form of therapy or course of treatment. Appropriate and individualised treatment is an essential part of the notion of "appropriate institution" (Rooman v. Belgium [GC], § 210).*

Finally, rather than looking at the right to compensation in Article 5(5) through the lens of a procedural versus substantive violation, the guide reminds up that the court focuses more on the seriousness of the violation:

*295. [C]ompensation which is negligible or wholly disproportionate to the seriousness of the violation would not comply with the requirements of Article 5 § 5 as this would render the right guaranteed by that provision theoretical and illusory (Vasilevskiy and Bogdanov v. Russia, § 22 and 26; Cumber v. the United Kingdom, Commission decision; Attard v. Malta (dec.)).*

It might be argued that this approach would be subtly different if one could logically have a serious violation which would have ultimately made no difference to the outcome. In other words, should we be focusing on the seriousness of the violator's conduct and lack of legal compliance ('procedural justice'), rather than concentrating on whether the outcome would have been any different ('substantive justice')? From the ruminations of Neil, a frustrated human rights lawyer...

## When should a relationship not attract the protection of Article 8 ECHR?

*Evers v Germany* [2020] ECHR 356 (European Court of Human Rights, Fifth Section)

### *Article 8 ECHR – right to family life*

This case concerned the application of Articles 8 and 6 in the context of a private (sexual) relationship between a man (the applicant) and the adult daughter of his partner. The background facts are of great importance.

The daughter, referred to as V, had a moderate learning disability: *"She was highly restricted in her ability to comprehend, concentrate and memorise things, as well as in her sense of orientation. Her ability to communicate was limited to word fragments, which rendered impossible any meaningful communication. She had no ability to make judgments, as her intellectual development corresponded to that of a four-year-old child."*

V's mother, the man's partner, had been appointed V's guardian. Criminal proceedings were instigated against the applicant in 2009, when he was around 70 years old and V was 22 years old. His partner had reported sexual contact between them and that the applicant had admitted the same and *"attributed the incident to the fact that [his partner] had refused the applicant sexual intercourse in the past."* V became pregnant by the applicant. His partner subsequently withdrew the allegations, and said she consented to the planned marriage of her partner and her daughter.

The criminal proceedings were discontinued on the basis that V's GP said she was *'perfectly capable of physical resistance'* if she had not consented to sexual relations with the applicant.

V was later placed in a residential home for people with disabilities, and a professional guardian appointed in place of her mother, on the basis that her mother had failed to prevent her from suffering sexual abuse by the applicant. These decisions were made by a district civil court which obtained expert evidence as to V's mental functioning and found that she had no comprehension of sex, marriage or pregnancy, and was susceptible to "every seemingly friendly suggestion." In light of their decisions, criminal proceedings were re-instigated against the applicant. By this time, V had given birth to a son who had been placed with a foster family. The applicant and V had separate contact with the son every 4-6 weeks. The criminal proceedings were eventually discontinued on the basis that the applicant and V's mother both paid fines to non-profit organisations.

Subsequently, the applicant and his partner visited V at the care home, and V became so distressed she required medication. The guardian decided to prohibit contact between V and the applicant, who had continued to say that he wanted to pursue an intimate relationship with V, and between V and her mother. The applicant said that the reason for V's distress was that she wanted to come him and live with them, and he objected to her having been fitted with a contraceptive coil. He and his partner set up a website about their fight for a common family life. The district court was asked to determine whether the contact ban should remain. V had a guardian ad litem appointed and the judge met V with her guardian and guardian ad litem at the care home. The contact ban was upheld. The European Court summarised the court's reasons as follows: "[t]he applicant's and V's child was the result of a severe, massive and

*illegal violation of V.'s personality rights - not to say the criminal sexual abuse of a person incapable of resistance. V. had been fully incapable of forming the will to resist seemingly friendly suggestions. Her mental disorder had precluded the ability even to grasp the substance, consequences and risks of sexual acts and pregnancy; her blindly confident and obedient personality had meant that convincing her to engage in sexual relations had not required significant effort."* The Court also noted that V had never asked after the applicant or given any indication she wanted to see him, or that she had any grasp of who he was other than a friend of her mother's.

The applicant alleged that his rights under Article 8 and Article 6 had been breached. The ECtHR found that his Article 8 rights were not even engaged, but that there had been an Article 6 breach. Interesting dissenting opinions found instead that Article 8 was engaged but not breached, and that Article 6 was not breached either.

The majority held that:

1. there was no issue of the applicant having a family life under Article 8. "*The mere fact that the applicant had been living in a common household with [his partner] and V and that he is the biological father of V's child does not, in the circumstances of the present case, constitute a family link which would fall under the protection of Article 8 of the Convention under its 'family life' head;*
2. nor could the applicant rely on a right to private life under Article 8. It did not guarantee a right to establish a relationship with a *particular person, and in any event 'private life does not as a rule come into play in*

*situations where a complainant does not enjoy "family life" within the meaning of Article 8 in relation to that person and where the latter does not share the wish for contact. This is all the more so if the person with whom it is wished to maintain contact has been the victim of behaviour which has been deemed detrimental by the domestic courts."*

3. However, the District Court's decision to uphold the contact ban breached Article 6 because even though they had sufficient evidence for their conclusion, and had been justified in disclosing only parts of the guardianship case file to the applicant, there should have been an oral hearing at which the applicant was heard, not only V. This was because of the far-reaching nature of the contact ban and the need for the court to *"form their own impression of the applicant and [V] to explain his personal situation."*

No damages were awarded.

The dissenting judgments took a completely different approach, finding that Article 8 was engaged, though it had not been breached, and pointing out the inconsistency between finding that there was a relevant civil right for Article 6 purposes, but no engagement of Article 8. The question that should have been asked was *'whether the ban affected an aspect of the applicant's own social identity with the result that his right to a private life under Article 8 of the Convention could have been said to be engaged to this limited extent'*. This would, in the view of the minority, have ensured that the court considered both aspects of the applicant's case from the right perspective:

*In short, viewing the decision-making*

*process through the lens of Article 8 of the Convention would have ensured that the rights of the absent "party" - V. - remained centre stage. Shifting the focus to Article 6 of the Convention meant, in contrast, that the applicant risked becoming the central if not sole focus of the Court's assessment. In addition, when assessing the balance struck by the national courts via Article 8 of the Convention, the Court could have emphasised the very limited nature of the private life interest on which he could rely thereunder - namely his own social identity - and the fact that he had no unilateral right to insist on contact with a person like V. The State's positive duty to protect V. as a vulnerable person from acts of abuse would also have come fully into play."*

On Article 6, the dissenting judges considered that there was no underlying civil right for the applicant to have contact with V. There was no such right in statutory law as V was not a child. The minority considered that there was no material difference between not having a civil right to contact and the existence of an order prohibiting contact. One judge, who found that that neither A6 nor A8 was engaged, quoted Milan Kundera:

*...the more the fight for human rights gains in popularity, the more it loses any concrete content, becoming a kind of universal stance of everyone toward everything, the world has become man's rights and everything in it has become a right: the desire for love the right to love, the desire for rest the right to rest, the desire for friendship the right to friendship, the desire to exceed the speed limit the right to exceed the speed limit, the desire for happiness the right to*

*happiness, the desire to publish a book the right to publish a book, the desire to shout in the street in the middle of the night the right to shout in the street.*

Another concluded, more prosaically, that “[i]t is difficult not to avoid the impression in the circumstances of the present case that the wrong conclusion has been reached in the wrong case involving the wrong applicant.”

### Comment

This decision of ECtHR is of considerable interest. The pragmatic reasons for the majority's refusal to say that Article 8 was engaged are clear, even if the legal basis is less obvious. They are careful to tie their reasoning to the particular circumstances of the case - obviously horrified by the relationship between the applicant and his partner's daughter. It may be that the case can therefore be distinguished when looking at other private and family relationships concerning a person with a mental disability, or family law cases where the parent of a child has been accused or convicted of assault against that person. The case is, at the very least, a reminder that it should not be automatically assumed that Article 8 protects every relationship, and that in particular it does not generate a right to have contact with a specific person. The minority's reasoning, however, is perhaps more convincing.

### Escalation and Articles 2 and 5 ECHR

*Aftanache v Romania* [2020] ECHR 339 (European Court of Human Rights, Fourth Section)

*Article 2 ECHR – duty to protect life – Article 5 ECHR – deprivation of liberty*

### Summary

In *Aftanache v Romania*, the applicant contended that his life was put at risk by medical personnel from the ambulance service and hospitals, who refused to administer his insulin treatment despite his precarious condition. He also argued that he had been unlawfully deprived of his liberty when he was taken against his will to hospital for testing, in disregard of his actual medical condition.

The facts of the case are on their face sufficiently unlikely that they do not afford of an easy summary. The story started when Mr Aftanache went to a pharmacy to get some medicine, having been feeling ill for around 10 days and taking cold medication. On arrival, he had to sit down as he was feeling weak. He explained his situation to the pharmacist and she called an ambulance to help him. When the ambulance arrived, one of the nurses suspected had taken drugs and confronted him. He denied having taken drugs and informed the paramedics about his medical condition. A blood test performed in the ambulance confirmed an imbalance in his glucose level. As there was no insulin available in the ambulance, the applicant asked the paramedics to help him walk home to take his treatment. They refused and allegedly told him that they would first take him to hospital to check what prohibited drugs he had taken, and only after that would he receive insulin. He refused to be taken to the hospital; according to him, the paramedics then closed the ambulance door and restrained him on a stretcher. One of the paramedics called the police for help. In the commotion, Mr Aftanache managed to alert his wife.

When the police arrived, he told them he needed to take his insulin from his home and reiterated

that he was not under the influence of drugs. He asked the police officers to accompany him to his home. They refused, but assured him that he would get his insulin at the hospital. They accompanied the ambulance to hospital; when he arrived he told the doctor on duty that he had diabetes and needed to take his insulin. The ambulance paramedics told the doctor that Mr Aftanache was on drugs. The doctor refused to administer the insulin, asking him to take a blood test for prohibited drugs first. He refused to take the test. The doctor then decided that his state did not qualify for emergency treatment and sent him to the local psychiatric hospital. He was taken there by the same ambulance under the same police escort. There, he was again restrained on a stretcher and the medical personnel tried to inject him with medication to calm him down. He refused the medication and eventually managed to untie himself, and called his diabetologist. When he told her about his situation, she tried to talk to the medical personnel, but they refused to take the call. His diabetologist phoned a nurse whom she knew was working in the same medical facility and asked her to explain the applicant's situation to the medical team attending him. Meanwhile, wife arrived at the hospital. She was informed that the applicant would be transferred to another psychiatric hospital outside town, where he would receive appropriate treatment for his drug addiction. Together with the nurse sent by the applicant's diabetologist, she insisted that the applicant's situation had been caused by his chronic disease and that he was not a drug addict. Eventually, the applicant relented and accepted to be tested for drugs. To that end, he was taken back to the originally hospital by the same ambulance and police escort. The doctor tested his blood and confirmed that he had not

taken any prohibited drugs. The applicant then received insulin, but in a dose that was different from his prescribed treatment. The blood test also revealed that the applicant was severely anaemic. Because of that, and since the applicant still had a fever, he was advised to go to a different hospital, where he ultimately went (with his wife, rather than by ambulance, and via his home to get his insulin), and received adequate treatment.

Mr Aftanache having failed to get any satisfaction from the domestic authorities, who conducted a distinctly half-hearted criminal investigation, he took his case to Strasbourg.

#### *Article 2*

The ECtHR helpfully recalled that Article 2 can be in play even if the person whose right to life was allegedly breached did not die, referring back to the Grand Chamber decision in *Nicolae Virgiliu Tănase v. Romania* [2019] ECHR 491. Where the complaint is made by a person with a serious illness, and where the person is not killed but survived, and where they do not allege any intent to kill, the criteria for a complaint to be examined are:

*49. [...] firstly, whether the person was the victim of an activity, whether public or private, which by its very nature put his or her life at real and imminent risk and, secondly, whether he or she has suffered injuries that appear life-threatening as they occur. Other factors, such as whether escaping death was purely fortuitous, may also come into play. The Court's assessment depends on the circumstances. While there is no general rule, it appears that if the activity involved by its very nature is dangerous and puts a person's life at real and imminent risk,*

*the level of injuries sustained may not be decisive and, in the absence of injuries, a complaint in such cases may still fall to be examined under Article 2 (see Nicolae Virgiliu Tănase, cited above, § 140, with further references).*

*50. The Court has further held that an issue may arise under Article 2 where it is shown that the authorities of a Contracting State have put an individual's life at risk through the denial of the health care which they have undertaken to make available to the population generally (see Lopes de Sousa Fernandes v. Portugal [GC], no. 56080/13, § 173, 19 December 2017).*

On the facts of the case as presented by the applicant, to which the Government of Romania had not presented “any sustainable alternative version,” it was clear that he and his wife had informed all those involved of his condition and his urgent need for medication; his diabetologist had also tried to speak with the hospital doctors, but her intervention had been ignored; and the denial of treatment caused a threat to his life serious enough to engage the State's responsibility under Article 2 ECHR to carry out a proper procedural investigation. The ECtHR had little hesitation in finding that the Romanian authorities had not discharged their duty to do so, such that the duty was breached. Interestingly, the court considered that “the gross deficiencies identified in the domestic investigation make it impossible to assess whether the State complied with its positive obligation to protect the applicant's life. For that reason, the Court will not make a separate assessment of the admissibility and merits of this part of the complaint” (paragraph 73).

#### Article 5

The court reiterated that Article 5(1) can apply to deprivations of liberty of a very short length. It continued:

*81. The Court has already established in its case-law that the taking of a person by the police to a psychiatric hospital against his or her will amounts to “deprivation of liberty” (see Ulisei Grosu v. Romania, no. 60113/12, §§ 27-32, 22 March 2016). In the present case, there is nothing to suggest that, as a matter of fact, the applicant could have freely decided not to accompany the paramedics and police officers to the hospitals or that, once there, he could have left at any time without incurring adverse consequences (ibid., § 28).*

*82. The Court considers that throughout the events there was an element of coercion which, notwithstanding the relatively short duration of the events, that is about six hours (see paragraph 19 above), was indicative of a deprivation of liberty within the meaning of Article 5 § 1.*

No legal basis was offered by the authorities for the applicant's deprivation of liberty, but the court of its own motion identified possible reasons, dismissing each in turn. Of particular note is the court's observation that:

*99. The Court accepts that the applicant, faced with a denial of treatment that he considered vital for him, could have been uncooperative. However, it cannot but note that not only was he denied treatment, but he was also falsely accused of drug use and threatened with psychiatric confinement. Throughout that time, he was suffering from an imbalance in his blood sugar level. A*

*certain state of discomfort and agitation is thus understandable in those circumstances. However, there is no evidence that the medical professionals had considered his personal circumstances and the possible explanations for his behaviour before recommending admission to the psychiatric hospital. Consequently, the Court considers that the applicant's alleged agitation was not sufficient to render the measure of confinement necessary.*

The court therefore had little hesitation in finding that there was a breach of Article 5(1) as well.

### Comment

Whilst the facts of the case appear on their face almost unbelievable, many will be able to recall situations of escalation in other situations leading – sometimes – to fatal outcomes (another, domestic, example, in the MCA context, is the case of ZH, although in that case, fortunately, the individual did not die, even if they suffered serious psychiatric injury in consequence). The case is of wider interest, perhaps, for three key points:

- (1) The important reminder of the scope of Article 2 even where the individual in question does not die, but the relevant failures of the state put their life at sufficient risk;
- (2) The reminder that deprivation of liberty can arise in a short period of time – in this case, around 6 hours;
- (3) The reiteration of the importance of the presence of coercion when identifying if a situation gives rise to a deprivation of

liberty. This is a routine mantra in the Strasbourg case-law, which sits at an interesting tangent to the way in which the case-law has developed in England and Wales in which deprivation of liberty can arise in a situation such as MIG's where it is difficult to identify any element of coercion (for more on this, see Alex's [discussion paper](#)).

### Supported decision-making report

The European Network of National Human Rights Institutions and Mental Health Europe have published a new report on supported decision-making for people with disabilities. It highlights what supported decision-making entails in theory and in practice, as well as outlining developments in Europe and the role of National Human Rights Institutions in ensuring compliance with international standards. The report contains a useful review of the position in many European states, although, oddly, only singles out (within the UK) the amendment in Scotland to the Mental Health (Care and Treatment) Act 2003 in 2015 which enabled the making of advance statements in the psychiatric context. On the face of it, the Mental Capacity Act (Northern Ireland) 2016, which allows for advance decisions to refuse all forms of treatment – whether for mental disorder or physical disorder – looks much more radical.

It would also – perhaps – have been useful if the authors of the report not blinkered themselves by seeing legislation using the term 'best interests' as leading to the same end point of automatic overriding of the person's will in favour of the judgment of professionals. They could, for instance, have considered the raft of cases before the Court of Protection (including



some considered in this month's report) in which it can be said with a straight face that the decision made properly respected the individual's rights, will and preferences – and, importantly, **responded** to situations where the individual in question could not on any view be said to be in a position to make the decision themselves: the case of MSP, for instance. The case-law of the Court of Protection also contains decisions that address the quintessentially hard cases that the Committee on the Rights of Persons with Disabilities has historically found so hard to address.

The MCA is undoubtedly not perfect, or perfectly applied, but it is capable of being applied in a way that does not meet the caricature of the type of legislation against which the Committee has – rightly – set its face.<sup>12</sup>

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<sup>12</sup> Although, as Alex has noted, it may be that, when it has put before it draft legislative frameworks which actually does address those cases, the new constitution of the Committee is willing to take a much more constructive approach.

<sup>13</sup> Although not referred to in the handbook, a rather easier read for those who want to navigate their way through the provisions of the MHA is the opening part of

### Book review

The Approved Mental Health Professional Practice Handbook (Kevin Stone, Sarah Vicary, Tim Spencer-Lane, 2020, Policy Press, c.£20.00)

This book fulfils a very important role for those who are training to become Approved Mental Health Professionals, those acting as AMHPs, and - I suggest - those working alongside AMHPs. It does not seek to be a one-stop shop for the legal provisions that are so central to the discharge by AMHPs of their role (nor to replace the acknowledged Bible of the law in this area, Richard Jones' Mental Health Act Manual<sup>13</sup>). Nor does it seek to direct AMHPs in the way that the Codes(s) of Practice to the Mental Health Act.<sup>14</sup> Rather, it seeks to put the role of the AMHP into its wider context, and to enable putative and practising AMHPs to reflect upon their complex – and crucial – role. It does so in clear, accessible text, divided into three parts: (1) the AMHP in context; (2) the AMHP in practice; and (3) the AMHP in theory.

A key message of the book is the evolution both of mental health (and connected) legislation and its application in practice – and the authors even manage to address the (so far unimplemented amendments to the MHA 1983 contained in the Coronavirus Act 2020, as well as flagging areas where further change

the Mental Health Tribunal Handbook (LAG 2015), which contains an excellent and accessible outline of the Act.

<sup>14</sup> One of the book's strengths is the way that it addresses the numerous differences between the way that the MHA is implemented in practice in England and Wales, not least through the operation of separate statutory Codes for both.

is likely, to be addressed in [online resources](#) (the page at present awaiting updates).

The authors are to be congratulated on a work which contains a huge amount within a (relatively) short compass, and will be sure rapidly and rightly to be bought and thumbed extensively by those working in this complex but vital role.

[Full disclosure: Alex was sent a review copy by the authors. He is always happy to review works in or related to the field of mental capacity, health and mental law (broadly defined)]

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## SCOTLAND

### Scott Review – Interim Report

An Interim Report from John Scott QC, Chair of the Scottish Mental Health Law Review, was promised for the end of May 2020 and duly issued, despite delays caused by current circumstances. It is available [here](#). It was followed on 12<sup>th</sup> June by the June issue of the Scottish Mental Health Law Review Newsletter, available [here](#).

The Interim Report is necessarily more interim than originally intended. The deadline for contributions to the online consultation seeking views and experiences of mental health law in Scotland was extended by a month to 29<sup>th</sup> May 2020, so that all of the responses – particularly those submitted closer to the deadline – had not yet been considered and analysed by the time that the Interim Report was issued. It is commendable that the Interim Report was nevertheless issued on time. It is a valuable and interesting document, containing much to commend, though both leaving and creating uncertainties that are potential causes for concern. However, it is understood that the Review Team is pressing forward with consideration of all responses received to the consultation, and it is possible that a further document will be issued by the Review in time for us to cover it in the July Report. It is understood that the intention is that the Interim Report already issued, together with that further document, will form “partner pieces”, to be read together. Accordingly, while the commendations in this Report are unqualified, the concerns must be read as provisional, subject to re-consideration when the full picture

of the Review’s intentions at this point in time and going forward is clarified.

The Interim Report commences with a statement of the very reasons why we welcomed John Scott’s appointment to lead the Review, when first announced. He has an impressive background in human rights, and of discharging similar remits in other spheres. He has always been clear that he has no significant experience as a practitioner in the area to be addressed by the Review. Thus, as he now writes, he “set out to inform myself with as much information, evidence and views as possible”. For the broad purposes of the Review, that is far better than the potentially more limited area of vision of anyone already immersed in parts of the subject. The subject overall is too wide, with too many sources of potentially valuable information, and developing too rapidly, for an adequate picture to be gained other than by the commendable methodology adopted by the Review.

The Call for Views and Experiences of Mental Health Law in Scotland is only one part of the story. John Scott narrates how he personally has attended conferences and meetings, including meetings of a lived experience group. He has read extensively and listened to a wide variety of people – including “those with lived experience, carers, practitioners, professionals, lawyers, and members of the judiciary”. This has led him to comment, inevitably but reassuringly, that: “This began my appreciation of the wide range of sincerely-held but often very different, sometimes incompatible, views held on fundamental aspects of mental health law”. Not having done so before, he arranged to observe proceedings at the Edinburgh Guardianship Court and, with consent of all parties, to attend a

hearing of the Mental Health Tribunal for Scotland. That also is commendable, though as the arrangements were made respectively by (now retired) Sheriff Fiona Reith and Laura Dunlop QC, President of the Mental Health Tribunal, unsurprising that this was helpfully facilitated. The overall methodology of the Review to date presents as careful and inclusive. That, and the standards of openness and communication evidenced by the issue of the Interim Report at this point in time, are important features of the work of the Review which, one trusts, will be retained going forward. The Interim Report should be read by all interested in the subject: this Report does not attempt even to summarise the range of content.

The uncertainties created by the Interim Report, and not removed by the ensuring Newsletter, raise fundamental issues as to whether the Review will in fact fulfil its purpose. Put minimally, the uncertainties relate to the need better to communicate and express how the Review will fully address its purpose from now on. One already hears significant anxieties as to whether there is an apparent intent of the Review to narrow its own scope substantially. If such a narrowing were in fact to be sustained, it would greatly reduce the value of the Review's concluding output.

The Review's Terms of Reference refer to all three relevant areas of legislation, including ensuring compliance with human rights requirements, considering the need for convergence, addressing "how equal and non-discriminatory enjoyment of rights can be achieved", how decision-making autonomy can be maximised whenever interventions are considered under all three pieces of legislation

(with reference to roles under all three), and "the overlaps in legislation and practice between" all three.

The requirement in the Terms of Reference to consider previous and ongoing work commences with reference to "Scotland's Mental Health and Capacity Law: The Case for Reform" (published by the Centre for Mental Health and Capacity Law, Napier University and the Mental Welfare Commission, May 2017), which adopts a similarly holistic approach.

All of this contrasts starkly with the very limited proposed output of the Review appearing on page 36 of the Interim Report (and in slightly abbreviated form on page 10), and on the Review's website, as follows:

*"Stage 3: What we think should happen*

*"In this stage we will obtain opinions on our recommendations for change to mental health law and practice before publishing a report. It might be that further investigation and reports follow this."*

This indicates a substantial narrowing from the required scope of the Review down to mental health law (that is to say, the area of law currently covered by the 2003 Act). The broader requirements of the Terms of Reference will not be fulfilled if that occurs.

The terminology employed in the Interim Report appears to create further uncertainty, including as to whether an even further narrowing beyond the matters provided for in the 2003 Act is envisaged.

The report "Scotland's Mental Health and Capacity Law: The Case for Reform"

commences by referring to “rights based mental health and capacity law to protect the rights of people with mental illness, learning disability, dementia and associated conditions”. The Interim Report refers frequently to “mental health” and to “mental health law”. “Mental health” is the counterpart of “mental illness”, so that the references to that phrase are relevant only to people with mental illness, excluding those with “learning disability, dementia and associated conditions”. References to “mental health law” are broader, but still limited. They can cover people with “mental illness, learning disability, dementia and associated conditions” to the extent that they are currently brought within the scope of mental health law, but not all of their needs within the legal environment.

In Scotland, objections to the inappropriate medicalisation of the great range of relevant disabilities beyond the consequences of mental illness go back at least four decades.

The initial focus to date on mental health law has been entirely appropriate. This is the first significant review of experience under the 2003 Act. However, mental health law has now caught up with adult incapacity law, and is ahead of adult support and protection law, so the Review needs to proceed on all fronts from now on. The process of review of adult incapacity law is far from complete. It has already been protracted, commencing with review of deprivation of liberty issues which concluded with the Scottish Law Commission Report on Adults with Incapacity of October 2014. Following initial consultation, that process widened rapidly to identify wide-ranging needs for reform of adult incapacity law as a whole, in conjunction with the other two areas. In

welcoming the establishment of the Review, we took the position that the advantages of a comprehensive review outweighed the disadvantages of delay, and could be turned to good use by steps to improve practice within existing legislation in the meantime, including the proposed reviews of relevant Codes of Practice. Self-evidently, that does not in any way remove the need for reform and updating of legislation.

If any area of law now lags behind, it is adult support and protection law, which has still not been similarly reviewed since first enacted in 2007.

We have to look forward to early clarification and reassurance that the Review will from now on proceed to address its full remit.

I submitted a personal Critique of the Interim Report to John. He has kindly permitted me to make my Critique public. It is available [here](#).

*Adrian D Ward*

### **Scott Review – more time for submissions**

As we went to press, the Scott Review extended the time for contributions to the online consultation seeking views and experiences of mental health law in Scotland. As narrated in the preceding item, it was already extended by a month to 29<sup>th</sup> May 2020. The Secretariat to the Review recently confirmed that it would continue to accept submissions after 29<sup>th</sup> May 2020. The Secretariat advised on 16<sup>th</sup> June that responses received after close of business on 18<sup>th</sup> June 2020 would still be considered in relation to the overall objectives of the Review, but would not

be published with the responses for Phase 1 of the consultation.

*Adrian D Ward*

### MH case – leave to appeal refused

On 5<sup>th</sup> June 2020 the Supreme Court refused permission to appeal the decision of the Inner House of the Court of Session on 3<sup>rd</sup> May 2019 in the case *MH (AP) v Mental Health Tribunal for Scotland*. That decision addressed issues relating to access to justice and the actual physical presence of members of the judiciary in hearings concerning the liberty and autonomy of persons with mental disabilities. We described the decision in our [May 2019](#) issue. In two separate items, Jill commented upon the decision as to whether it was necessary for the convener of a Mental Health Tribunal hearing to be personally present at the hearing, and upon the issue of whether the patient in that case – indeed patients in proceedings before the Tribunal generally – should be entitled to anonymity. The court decided that personal presence was not essential, and that patients would require to justify being accorded anonymity in each case. The decision on the personal presence of the convener was reported at 2019 SLT 615, and that report was followed by a note advising that, following submission of a medical report, the court had decided that the appellant's name should be anonymised in those proceedings. We reported that in the [June 2019](#) Report. We undertook to report whether leave for appeals in respect of either or both decisions to the Supreme Court was sought, and if so whether granted.

Leave has been sought. It has been refused. There was widespread interest across the United Kingdom in this case, and there is now significant disappointment that the jurisdictions of the United Kingdom are not to benefit from consideration by the Supreme Court, for the first time, of how vulnerable adults with mental health issues are treated across the four jurisdictions of the United Kingdom, and the anticipation that, given the points of general principle for the use of compulsory measures of detention and treatment in relation to people suffering from mental ill-health, applications for public interest interventions were expected from NGOs and others working in this area across the United Kingdom. The Supreme Court customarily only gives the briefest of reasons for refusals of permission to appeal, or for that matter to intervene. In this case, the Supreme Court asserted only that: "... the application does not raise an arguable point of law of general public importance which ought to be considered by the Supreme Court at this time. On the facts, the Panel does not consider the complaint of unfairness to be arguable". One is left to speculate as to the basis on which the Supreme Court arrived at those conclusions, and whether the conclusions would be the same if previously untested questions had been raised on equivalent issues concerning processes affecting fundamental interference, otherwise unlawful, with the liberties and personal integrity, and rights to privacy, of persons not having mental or intellectual disabilities.

*Adrian D Ward*

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



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



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## Conferences

At present, most externally conferences are being postponed, cancelled, or moved online. 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.

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Our next edition will be out in July 2020. 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](mailto:marketing@39essex.com).

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