



Welcome to the April 2019 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: an update on the Mental Capacity (Amendment) Bill; the DoLS backlog and the obligations on local authorities; capacity and social media (again); best interests and the 'institutional echo;' and judicial endorsement of the BMA/RCP guidance on CANH.

(2) In the Property and Affairs Report: a major new report on supported will-making;

(3) In the Practice and Procedure Report: a pilot designed to get the Accredited Legal Representatives scheme further off the starting block; the need for the early involvement of the court in medical treatment cases; transparency and committal; and DNA testing and the courts;

(4) In the Wider Context Report: oral care and learning disability; important consultations on criminal procedure/sentencing and those with mental disorders; the dangers of assessing in a vacuum; and a round-up of recent useful research articles.

(5) In the Scotland Report: major developments regarding the Mental Health (Care and Treatment) Scotland Act, the Adults with Incapacity Act and the Adult Support and Protection Act and a Scottish perspective on the English MHA review and compliance with the CRPD;

You can find all our past issues, our case summaries, and more on our dedicated sub-site [here](#). With thanks to all of those who have been in touch with useful observations about (and enthusiasm for the update of our [capacity assessment guide](#)), and as promised, an updated version of our [best interests guide](#) is now out.

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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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Capacity, residence, sex and social media – on the way to the Court of Appeal

With thanks to David Lock QC, we understand that North Yorkshire County Council have been given permission to appeal against the Court of Protection decision of Cobb J in *B (Capacity: Social Media: Care and Contact)* [2019] EWCOP 3 on the test for capacity to decide upon residence. The Official Solicitor has also obtained permission to appeal on the Judge's findings on her capacity in relation to sex and access to social media. The hearing has been expedited and will be on 14/15 May 2019.

LPS update

The very slow-motion game of Parliamentary ping-pong in the final stages of the Mental Capacity (Amendment) Bill continues, with the Bill returning to the Lords on 24 April. At that point, the Lords will have to consider whether to accept the Government's [proposals](#) (accepted by the Commons):

1. Not to have a statutory definition of deprivation of liberty (other than the reference to Article 5 ECHR), and to have guidance in the LPS Code, to be reviewed regularly;
- (1) In relation to the provision of information upon authorisation.

For more on the LPS and its implications, see Alex's briefing paper [here](#).

Capacity, best interests and the institutional echo

LB of Hackney v SJF [2019] EWCOP 8 (SJ Hilder)

Best interests – mental capacity – residence – contact

Summary

This case concerned the care and residence of a 56 year old woman with significant physical health problems as well as schizophrenia and a learning disability. She had lived for many years

in a first floor flat, shared with her son JJF who is described in the judgment as having his own difficulties, having attended a special needs school, and having been in prison including for assaulting his mother. Health professionals had been unwilling to enter the flat due to hostility and threats of violence from SJF's son and she had ultimately been moved to a care home on an urgent basis. Notwithstanding these problems, SJF wanted to return to her flat to live with her son.

There were practical difficulties in providing care for SF in her flat - she needed 3 insulin injections a day, kidney dialysis 3 times a week, and by the end of the proceedings, her mobility had deteriorated to such an extent that she could only manage a few steps.

Nevertheless, the court was presented with a range of options for SF's care and residence which included a return to her flat, a supported living placement, a care home, and a new ground floor flat. The proceedings had been going on for some two years by the time of the final hearing. SJF contended that she had capacity to make the relevant decisions. and professionals including her IMCA and two psychiatrists involved in DOLS assessments had agreed with her. The Official Solicitor as her litigation friend disagreed, relying on the evidence of the joint expert instructed for the proceedings, and supported declarations being made that SF lacked capacity to decide where to live, what care to receive and whether to have contact with her son, by reason of her mild learning disability. The central issue was whether SF was unable to understand or weigh information about the risk to her health of living with her son, with the negative impact that was likely to have on the

ability of health professionals to attend the property to provide care. Was SF unable to understand those risks, or was she simply affording them less weight than the professionals because of her devotion to her son and her concerns as his mother about what would happen to him if he did not live with her? The court accepted the expert's view that

she believes as a mum that her son's behaviour is going to improve. That's not necessarily because of her learning disability – many people in difficult relationships have a positive outlook of their relative's behaviour. But she does not understand the impact of him not being able to provide good enough care...[or] the impact it has on her access to professionals and support mechanisms.

.... SJF's learning disability has "several different effects – it prevents her from understanding the consequences of living with JJF, [it means] she is not able to appreciate the risks of not having appropriate care, [and] it prevents her from generating other possibilities for her son, other than living with her." When questioned by Ms. Hearnden, Dr Rippon said "[SJF] is in a difficult position. I've reflected a lot about whether her wish to return [to her flat] is a lack of capacity or the concerns of a mum. On the balance of probabilities, I believe that learning disability impacts on her decision-making.... I don't believe that she understands the impact in the care she'll receive if she lives with her son – and that's secondary to the learning disability... I don't think she adequately understands the impact on her physical health.

Senior Judge Hilder found it was in SJF's best interests, on discharge from hospital, not to return to her flat, despite her strongly held wish to do so:

The magnetic factor in this matter is SJF's need for healthcare by professionals. She is once again taking Novorapid injections, administered twice a day by care home staff; and Lantos injections, administered each morning by district nurses. Additionally her ulcers require frequent dressing and she attend dialysis three times a week. There is no realistic prospect that these healthcare needs could be met adequately or at all if she lives in first floor accommodation or with her son. The effect of failure to meet these needs will clearly be, at best, further and rapid deterioration in her health, and increased hospitalisation.

Comment

This case illustrates the difficulty in making decisions about capacity and best interests where certain familiar factors are present:

- a mild learning disability
- complex physical health needs which fluctuate and change
- a breakdown in relationships which becomes infected by what the judge called 'institutional echo', closing minds to alternative solutions to problems

Though the decision ultimately reached was perhaps inevitable given SJF's deterioration in her physical condition, one cannot help wondering whether a trial period of care at home might have been possible at an earlier date, and whether imposing stricter timetables on COP

proceedings might encourage increased use of trial periods even in apparently risky scenarios.

ADRTs, medical obligations and decision-making in relation to CANH

NHS Cumbria CCG v Rushton [2018] EWCOP 41 (Hayden J)

Best interests – medical treatment – advance decisions

Summary

Hayden J has both given clear endorsement to the BMA/RCP [guidance](#) on decisions about clinically assisted nutrition and hydration ('CANH') and reiterated the obligations imposed on medical practitioners in relation to advance decisions to refuse treatment ('ADRTs'). The judgment was delivered in December 2018, but delayed until a month after the individual in question had died.

The application before Hayden J was for the proposed withdrawal of CANH from an 85 year old former nurse, Jillian Rushton. She had sustained a traumatic head injury in December 2015, and then was in a prolonged period of disorder of consciousness, lasting 3 years by the time that the case came to be determined. A year before she sustained the head injury, she had created an ADRT that provided that "on collapse, I do not wish to be resuscitated by any means," that "I am refusing all treatment. Even if my life is at risk as a result," and that "in all circumstances of collapse that put my life at risk, this direction is to be applied." Although the judgment does not record this, given the way in which Hayden J then approached it, it appears clear that the ADRT must have been witnessed (as is required in respect of one concerning life-

sustaining treatment). Mrs Rushton also sent the ADRT to her GP.

On the 21 December 2015, Mrs Rushton fell and suffered a major trauma to her head. It was so significant that she was not expected to survive and she was placed on a palliative care plan. On admission, a naso-gastric tube was inserted to feed her. Hayden J considered that this was *"was done instinctively by conscientious medical staff, whose every instinct would have been to promote her welfare."* When, contrary to how the position appeared upon admission, her condition improved, the NG tube was replaced by a percutaneous endoscopic gastrostomy (PEG) which was inserted at the end of January 2016, in part in order to facilitate her care back at home with her son.

Hayden J considered that it was clear that the insertion of the PEG *"in the circumstances of this case, was an essentially life-sustaining treatment in circumstances where there was little, if any, prospect of meaningful recovery."* He therefore held that *"the initial insertion of the naso-gastric tube was arguably incompatible with Mrs Rushton's wishes. There can be little doubt, to my mind, that the insertion of the PEG was contrary to Mrs Rushton's written decision."*

Hayden J was taken to the clinical notes that provided the background to the decision-making. The ADRT was not available at the hospital, and *"there [was] no reason why it should have been."*

"However, the existence of the document and the identity of the GP came to light. A telephone call was made to the GP at 10.25am of the morning of 26th Jan 2016. In response to a message, the GP contacted the ward. He told them he had

checked the systems and that he knew Mrs Rushton and her family. The record of the call reads, "the only ADR (Advance Directive) in place is in regards to do not resuscitate." The GP is reported as having said that he had no knowledge of any other document. There was only one document in existence and, I must infer, that at some point in relaying its contents, it has been incorrectly interpreted. [...] Having heard from Mrs Rushton's family I have not the slightest doubt that she intended that her directive would have applied to the insertion of the PEG.

Largely, it appears, because of the way in which Mrs Rushton's family wished to approach matters, Hayden J did not then go on to examine responsibility for the incorrect interpretation of the ADRT, but noted that her circumstances:

25. [...] provide an opportunity for this Court to emphasise the importance of compliance both with the statutory provisions and the Codes of Practice, when preparing an Advance Decision. Manifestly, these are documents of the utmost importance; the statute and the codes provide essential safeguards. They are intending to strike a balance between giving proper respect and recognition to the autonomy of a competent adult and identifying the risk that a person might find himself locked into an advance refusal which he or she might wish to resile from but can no longer do so. The balance is pivoted on the emphasis, in the case of life-sustaining treatment, given to compliance with the form specified by statute and codes. The Court has highlighted the profound consequences of non-compliance with the requirements: W v M and S and A NHS

Primary Care Trust [2012] COPLR 222; Re D [2012] COPLR 493.

26. It perhaps requires to be said, though in my view it should be regarded as axiomatic, that the medical profession must give these advanced decisions the utmost care, attention and scrutiny. I am confident the profession does but I regret to say that I do not think sufficient care and scrutiny took place here. The lesson is an obvious one and needs no amplification. Where advanced decisions have been drawn up and placed with GP records there is an onerous burden on the GP to ensure, wherever possible, that they are made available to clinicians in hospital. By this I mean a copy of the decision should be made available and placed within the hospital records with the objective that the document should follow the patient. It need hardly be said that it will rarely, if ever, be sufficient to summarise an advance decision in a telephone conversation.

Hayden J then turned to the question of whether the continuation of CANH was in Mrs Rushton's best interests in circumstances where it appears that the son who had been providing her almost exclusively with care was opposed to its withdrawal, in particular because he considered her to be responsive.

Professor Wade, an expert in neurorehabilitation, was instructed, and gave evidence to the court. He indicated that he was resistant to identifying Mrs Rushton's condition as "a persistent vegetative state" because "he concluded that what was truly required was a holistic evaluation of her best interests, in the context of her wishes and feelings, in which her level of consciousness played a part." Hayden J observed that:

29 [...] That approach, very much chimes with the guidance issued [...] by the Royal College of Physicians and the BMA: "Clinically-assisted nutrition and hydration (CANH) and adults who lack the capacity to consent". At section 5 of that guidance, consideration is given to decisions concerning CANH in previously healthy patients now in a vegetative state or a minimally conscious state, following a sudden onset of brain injury. I am conscious that the phrase "vegetative state" is distressing to family members, but while it remains a medical term I am constrained to use it. The Guidance is, in my view, an extremely helpful piece of work which reflects the breadth of experience, both in the core group of representatives of the British Medical Association, Royal College of Physicians and General Medical Council as well as the multi-disciplinary advice that was drawn upon. I take the opportunity in this judgment to highlight the following:

5.1 Clinical assessments

Where patients are in Prolonged Disorder of Consciousness, PDOC, (i.e. for longer than four weeks) following a sudden-onset brain injury, providing accurate prognostic information is a very important part of the decision-making process. Assessing levels of awareness – and in particular the prospect of it increasing – however, is not a simple task and there is no single clinical sign or laboratory test of awareness. Its presence must be deduced from a range of behaviours which indicate that an individual can perceive self and surroundings, frame

intentions and interact with others. These observations need to be repeated over a period of time, with specialist analysis of the results. It is essential, therefore, that these patients have a thorough, expert assessment according to the RCP guidelines to provide a detailed evaluation of their level of awareness of themselves or their environment and to record any trajectory towards future recovery or deterioration.

There may be some cases in which there is clear evidence that the findings of detailed assessments will not affect the outcome of the best interests decision because, for example, even the most optimistic prediction of recovery would not constitute a quality of life they would find acceptable. Where this is the case, a decision can be made before these assessments have been completed.

In most cases, while these investigations are being made, careful consideration should be given to reducing or stopping sedating drugs, to ascertain the extent to which they are reducing responsiveness (if at all). This may involve risks, for example of pain or seizures, which can be distressing for those close to the patient. It is crucial that doctors clearly explain the steps they are taking, why they are taking them and what to expect during that time. If withdrawal or

reduction of medication is likely to have significant consequences for the patient, the doctor will need to weigh up the balance of benefits and harms between optimal assessment conditions and adequate symptom-control. This will include an assessment of how important a clear diagnosis of permanent VS versus MCS would be for the patient in terms of the best interests assessment.

Diagnosis and prognosis

The perceived importance of obtaining a precise and definitive diagnosis has reduced over time, as it is increasingly recognised, by clinicians and the courts, that drawing a firm distinction between VS and MCS is often artificial and unnecessary. In practice, when assessing best interests, information about the patient's current condition and prognosis for functional recovery and the level of certainty with which these can be assessed is often more important than achieving a precise diagnosis.

Hayden J continued:

30. These paragraphs are apposite. The perceived importance of a definitive diagnosis has reduced over time. As is increasingly recognised by clinicians and the Courts, drawing a firm distinction between vegetative state or a minimally conscious state is often artificial and

unnecessary. In practice, when assessing 'best interests' and analysing the information relating to the patient's current condition and prognosis for cognitive recovery, the level of certainty to which these can be assessed is often more important than an actual diagnosis. Many patients would want CANH continued until there is a clear sense of the level of recovery that can be achieved. In these patients the prognosis is important as it allows those concerned to make best interest decisions. For example, they may have refused treatment if the Prolonged Disorder of Consciousness (PDOC) assessment showed that they were likely to be left permanently unconscious, but not if they were likely to regain consciousness.

On the facts of the case before him, Hayden J was clear that Mrs Rushton "would have hoped that her wishes in her advance decision would have applied to her present situation. I cannot easily contemplate circumstances in which the views of an adult with this degree of disorder of consciousness could be communicated more volubly or unambiguously."

Hayden J then, finally, had to consider the care plan in circumstances where one of her sons had cared for her almost exclusively, with no intention to shut out family or medical professionals, but where it appeared that he was scared of losing his mother and so "battened down the hatches as best as he could to try and prevent it." The consequence was that:

36. There is a rigid, inflexible regime of care at the moment. It must be said, that is obvious that Mrs Rushton has been very well cared for. Ms Paterson, on behalf of the OS, submits that the present circumstances do not promote or

sufficiently protect either Mrs Rushton's autonomy or her dignity. Dignity at the end of life is elusive both conceptually and practically. For Mrs Rushton's life to conclude with dignity, she needs what all of us would need in that situation, peace, care, proper medical attention and the presence around her of those she has loved. I have concluded that though she would have wished to die at home, true respect of her dignity can only be achieved in a hospice and under a regime which, as her son Hugh says, "allows her some space and privacy". Tellingly, in my judgment, insightfully, Mr Hugh Rushton went on to say that his mother needed to be in a place where she was no longer "prodded and poked" by those undoubtedly well intentioned to care for her, but rather she needed a place "to rest". I entirely agree and consider that the care plan contemplates precisely this. Accordingly, I endorse it.

Comment

ADRTs

At the level of principle, the judgment is an important reminder of the intended power of ADRTs. Their utility in practice is all too often diminished by the fact that there is no central repository akin to the register of LPAs, but in this case the problem was compounded by the fact that (for whatever reason) the effect of the document was simply misunderstood in the unfortunate Chinese Whispers approach that was taken. That would have negated even the workaround that can be taken to the absence of a registry by carrying a card to indicate that a person has an ADRT has it and where it is to be found (see, for a way in which to do this, and for

a (free) process to create an ADRT, the excellent website of [Compassion in Dying](#)).

On the face of the judgment, it is a little odd that, having identified that, in fact, the insertion of the PEG was contrary to the ADRT that Mrs Rushton had made, Hayden J did not then go to hold that this gave the answer to the question of whether CANH should be continued. An ADRT does not just apply to the question of whether treatment should be carried out in the first place, but also *"at the time when the question arises whether the treatment should be [...] continued"* (see s.26(1) MCA 2005). The relief that a court can grant in relation to an ADRT is not provided for under ss.15/16 MCA but rather under s.26(4), i.e. declaring whether the ADRT exists, and/or is applicable to the treatment. It is only if the court finds that there is no valid and applicable ADRT in place that it can then go on to exercise its normal welfare jurisdiction under s.16 to determine what decision to make on the person's behalf and in their best interests. In other words, one might ask whether there was even a best interests decision for Hayden J to make. If there was not, then regardless of the family's (laudable) desire not to dig into what had happened in 2015 in terms of why CANH had been started in the first place, Hayden J had no power to undertake the best interests decision-making process he did to determine whether it should continue.

As is so often the case in Court of Protection cases, one suspects that more may have been going on than is expressly recorded on the face of the judgment. One explanation (although this is speculation) might be that Mrs Rushton's ADRT was interpreted as applying solely to the initial administration of any form of medical

treatment (perhaps because of her use of the term "upon collapse"). If this was the case, it might therefore then be said that Mrs Rushton had not expressly catered for the position where life-sustaining treatment had, in fact, been started, such that the ADRT did not strictly govern the situation. Nonetheless, as Hayden J observed, it was difficult to imagine a situation *"in which the views of an adult with this degree of disorder of consciousness could be communicated more volubly or unambiguously."*

Whatever the unanswered questions as to the precise way in which Hayden J approached his own task as Court of Protection judge on the facts of this case, however, the wider point as to the obligations upon doctors arising from ADRTs are clear and unambiguous.

The approach to decision-making in PDOC

At a purely selfish level, the endorsement by Hayden J of the BMA guidance is welcome to Alex as one of the two legal advisers to the working group. More broadly, and importantly, it is an important judicial confirmation of the message of that guidance that the approach adopted in the earlier cases of a close focus on the diagnosis and prognosis as important in and of themselves is simply incorrect; the focus should be on the extent to which the diagnosis and prognosis (and the level of certainty as to both) would have been of importance to the patient themselves.

It is important to note, however, that on the facts of the case as presented in the judgment, it is not obvious that Mrs Rushton fell within the category of circumstances covered by the paragraphs of the guidance identified by the judge. These paragraphs address decisions

about CANH in previously healthy patients in vegetative state or minimally conscious state following a sudden-onset brain injury. On the facts of the case, Mrs Rushton would appear much more likely, in fact, to have fallen into the sections of the guidance relating to patients with a sudden-onset or rapidly progressing brain injury where they have multiple comorbidities or frailty (either pre-existing or as a result of the incident that led to the brain injury) which is also likely to shorten life expectancy. The case was issued prior to the publication of the guidance, and it is not clear whether the judge was addressed on the precise application of the guidance to the facts of Mrs Rushton's case. Within the framework of the (useful) judicial endorsement of the guidance as a whole, clinicians will need to consider how the facts of any patient's case before them best fit the terms of the guidance.

The extremity of care

Hounslow CCG v RW [2019] EWCOP 12 (Hayden J)

Best interests – medical treatment

Summary¹

In the sequel to the case of *Re RW* Hayden J had to consider what arrangements should be made for RW, a 78 year old with vascular dementia, many months after the Court of Appeal had upheld the conclusion that it was not in his best interests to continue to receive Clinically Assisted Nutrition and Hydration (CANH), via a naso-gastric tube (NG tube). Parker J concluded that it was not in his best interest and made a

declaration to that effect. RW had continued to live in his home, cared for by his youngest son, PT, almost single-handedly. As Hayden J observed, “[e]very act of care has been an act of love and requires to be identified as such.” PT “strenuously objected to a regime that he regarded as slowly starving his father to death. This he sees to be the reality of the earlier court orders. For PT the preservation of his father's life is a moral obligation. It matters not, to him, that his father's condition is futile nor that the preservation of it may merely serve to continue pain. Since RW returned home to his son's care without any means of artificial nutrition or hydration PT has provided these by any means he could. He prepares small syringes of water, moist trifles, soft custard tarts which he considers his father enjoys. His objective is to keep his father alive.”

The number of professionals admitted to RW's home began to fall away in May 2018 in circumstances where PW's conduct became increasingly intimidating out of his “stress, anxiety and [...] fear for his father's survival.” The CCG became increasingly concerned about the management of RW's condition at home, and in January concluded that it would seek legal advice with a view to bringing the matter before the court, although

17. *There then followed a period of significant and wholly unacceptable delay. Delay in bringing proceedings is far too common. It is entirely unacceptable and it is not to be tolerated. Delay is itself entirely inconsistent with the obligation on the CCG to protect RW's welfare interests. Urgent decisions need to be made today because RW's*

¹ Katie Scott having been involved in the case, she has not contributed to this report.

circumstances are so profoundly grave. I do not have the time to investigate the reasons for the delay in bringing this matter to court but I can say that there can be no justifiable reason for it.

An application came before the court in March, at which point the judge was primarily concerned about necrosis of RW's leg. "To her direct question (as I understand it) PT responded that about 10 days ago 'the leg detached completely' when he was turning his father. This was, to say the least, disturbing and shocking evidence. I have never heard of a situation like this and I sensed the doctors were equally alarmed. When I asked PT about it today, I was concerned that nobody had been able to identify where the leg is. PT told me he had wrapped it in cling film and put it in the freezer." When Gwynneth Knowles J heard this, it was not surprising that she decided that RW should be removed to hospital immediately. He was admitted to hospital, where the doctors commented upon how well kept he was, and how well looked after; all were clear, however, that he had reached the very end of his life.

Against that backdrop, Hayden J had to determine what was in RW's best interests in endorsing a palliative care plan for him. Hayden:

27. [...] would very much have liked to have been able to endorse a plan which permitted RW to return home. There is no doubt at all, as the history of this case shows, that RW would want to die at home. I do not know whether he would survive the transition but I should have been prepared to take that risk. However, PT would, in my judgement, continue to try to give his father food and water. As I speak these words he indicates to me

that this is precisely what he would do. I have been told by Ms I that, at this stage, if PT were to attempt to feed his father there is a real risk that he would asphyxiate on any food given. I cannot permit RW to be exposed to the risk of ending his life in this way and, if I may say so, I would not be prepared to take that risk for PT either, especially having regard to all the loving care he has provided for his father.

28. I endorse the applicant's plan. I indicate that it is in RW's best interest to have his sons with him as much as possible. I am not prepared to be prescriptive of the times and the circumstances in which the sons may visit. In this I reject the applicant's proposals in this respect.

Comment

Even in the summary form set out above, the facts of this case are stark, and (in a different fashion to the *Rushton* case also covered in this Report) show the emotional and physical consequences of familial care at the end of life. At least some may be left with asking whether situations such as this are really best addressed in the courtroom, or whether the court is being left to pick up the pieces of jigsaw that were broken a very long time ago.

However, as with the *PW* case also covered in this Report, this case emphasises that where recourse to the court is required in the interests of the person, it is vital that it is not delayed.

Short note: covert medication, surgery and deprivation of liberty

Kings College London NHS Trust v FG [2019] EWCOP 7 concerned FG, a 37 year old man with

schizophrenia, who was being cared for at SLAM, apparently detained under the MHA 1983. He sustained a fracture and dislocation to his shoulder, which required treatment under general anaesthetic, but he refused to consent to the operation. His reasons included that he was worried about the effect of the general anaesthetic on his heart, its potential interplay with the medication clozapine which he was taking, and that the surgery had been ordered by M15. The court found no difficulty in concluding that he lacked capacity to make a decision about the operation given the influence of his paranoid and persecutory beliefs.

It was similarly clear that treatment was in his best interests, notwithstanding his expressed wishes - he was in pain, and without treatment would be unable to participate in activities he enjoyed in the future such as fishing and wood chopping. Francis J approved the care plan, including the administration of sedating medication covertly, saying in respect of that issue:

I accept that there can be exceptional circumstances in which the administration of covert medication is better than forced chemical injection under restraint. There would be very few circumstances in which it will be appropriate to administer covert medication in this kind of way and each case will have to be decided on its own facts. I do not imagine there are any rules or specific guidance that one could set out. A judge would have to decide it on a case by case basis. But having regard to the mental health and physical health matters to which I have just referred, I am

satisfied that if the surgery is to take place there should be permission to the treating team to administer covert medication in this way to sedate him.

In a further reminder that deprivation of liberty has not been entirely removed from the hospital setting by *Ferreira*, Francis J accepted – as it was by the Official Solicitor – that “*the proposed procedure will amount to a deprivation of his liberty and I authorise that deprivation of his liberty to the extent that is necessary and on the basis that any measure used to facilitate or provide the arrangements shall be the minimum necessary and that all reasonable and proportionate steps are taken to minimise distress to FG and to maintain his dignity.*”

Short note: balancing privacy and the press

In *Southern Health NHS Foundation Trust v AB & Ors* [2019] EWCOP 11, Lieven J on an ex parte application granted an application to prevent publication of a video of a patient, AB, in her treating hospital, and publication of any story which identifies her in that hospital. AB was detained under s.3 MHA 1983, suffering from a conversion disorder with comorbid acquired brain injury. Her AB's presentation and indeed capacity varies. As Lieven J recorded, “[a]t times she is catatonic and lies in a foetal position on the floor. She has a history during these periods of self-harm, and for that reason she wears protective headgear at all times. In the light of AB's condition and the difficulties in accommodating her appropriately, the Trust has had to adapt the room in which she has been living urgently, and it is true to say that the condition of the room therefore looks somewhat poor.”

AB's son took a video recording of his mother, from which she was plainly identifiable. It having been briefly on YouTube, it appeared that it was then going to be given to the Mail Online with a view to them publishing it with her face pixelated out, AB's son "*hoping [...] that this will draw attention to his mother's condition and to the problems with the mental health provision generally in the NHS or in this hospital in particular.*"

Lieven J granted the application on the basis that AB could be identified, that it was very unlikely that she had regained the capacity to give consent to her son to publish it, and that it would be an interference with her privacy and her private life – "*they are potentially degrading for AB, and clearly have the potential to cause her distress in the future.*" In holding that it was not in AB's best interests to publish at that time, Lieven J also gave permission to her son to apply at a full hearing if he wished to do so to seek to lift the injunction; she also noted that AB might well regain capacity relatively shortly, and that, if she did, publication would be a matter for her. Lieven J was also clearly struck by the fact that there was no immediate urgency in favour of publication.

DoLS, the backlog and the consequences – the LGO reports

The Local Government & Social Care Ombudsman has published a [report](#) into Staffordshire County Council's triaging of DoLS applications, where, since May 2016, the authority had not been carrying out assessment of low and medium priority applications, and had significantly delayed in the carrying out assessments in high priority cases. Whilst recognising the extent to which this situation was not necessarily of Staffordshire's own

making, the LGO found that the approach constituted fault causing injustice.

The report makes important reading at a number of levels, including as a snapshot of the pressures that local authorities are under and the decisions that they are having to take in consequence – as well as the real-life implications for the individuals concerned.

Whilst investigating another complaint, it came to the LGO's attention that Staffordshire:

- decided in May 2016 not to carry out assessments for most of the DoLS requests it receives;
- was aware this did not comply with relevant legislation and statutory guidance;
- made the decision during an informal cabinet meeting, because of lack of financial resources; and
- had a backlog of 2,927 unassessed DoLS requests at the end of March 2018 (rising to 3,033 in June 2018, with the oldest assessed request dated 11 August 2014).

The LGO decided, of its own motion, that this may have caused an injustice to members of the public and therefore decided to investigate. Staffordshire noted that no one had complained about the policy, that its triage system ensured no harm to individuals was likely because it assessed those cases where there was a real possibility that a person may be deprived of their liberty inappropriately, and that in the unlikely event a person was deprived of their liberty inappropriately, they would have a court remedy and would probably be entitled to compensation. Importantly, the LGO decided to investigate

individual complaints being brought “because the people who are likely to be affected are vulnerable, may not be aware of their rights to complain or go to court, and may not be able to complain either in their own right or through representatives.”

The LGO’s investigation found that Staffordshire was using a version of the ADASS [screening tool](#) to triage requests, but modified so that, in practice, fewer requests were categorised as high priority. The report outlines how Staffordshire were operating their triage policy, and noted that:

The Council says the priority tool “is not designed to exclude individuals but prioritise the order in which assessments are completed”. However, by deciding not to assess anything but high priority requests, excluding individuals is precisely what the Council is doing.

Staffordshire told the LGO that it would cost about £3.5 million to clear the backlog and deal with all of its incoming DoLS requests within statutory timescales, money which could only be found by reducing spending on other essential services.

Importantly, the LGO examined a sample of the 57 requests that Staffordshire had received in one week. Of these, 16 had been closed because the person had moved or died; 18 were in the unassessed backlog because they were of low or medium priority, 21 had been granted, and 2 were not granted (after 7 weeks and about 12 weeks) because the individuals concerned had

regained capacity. In one case, the LGO had “significant concerns” about how the person was being deprived of their liberty and whether it was having a potentially detrimental effect on them. However, as their circumstances were now before the Court of Protection, the LGO could not investigate further. In percentage terms, this means that almost a third of the sample applications had not been considered beyond prioritising based on “the limited information provided by the managing authorities making the request.”

The LGO concluded that Staffordshire were at fault not complying with the legislation and guidance currently in place, causing a potential injustice to about 3,000 people who have had no or delayed access to the proper legal process designed to check that any decision to deprive a person of their liberty is: properly made, lawful; and implemented for only as long as necessary.

The LGO noted that

44. Applying the process properly would not change the outcome for most of the people affected, other than confirming that it is in their best interests to be deprived of liberty. However, it is possible that some of the people stuck in the backlog for years should never have been deprived of their liberty.

The LGO acknowledged the wider context, including the potential for the law to be changed by way of the Mental Capacity (Amendment) Bill,² but noted that:

² Although in this appears to have understood that most of the responsibility would automatically be going to

care homes, when this is not the case unless the local authorities/CCGs in question decide this is appropriate.

46. [...] the current legislation is still in force. At the time of writing, it is the main legal protection available to vulnerable people deprived of their liberty in care home settings. Resource constraints are not a legitimate reason for failing to carry out assessments required by law or statutory guidance. It is only legitimate for public bodies to deviate from relevant guidance where they have cogent reasons for doing so; a lack of money is not such a reason.

47. We do not criticise the approach of prioritising applications as suggested by ADASS and endorsed by the Government. We also recognise the effort the Council is making to tackle the incoming high priority applications. But it is not acceptable that the only way low and medium priority applications are resolved is because the people involved move away or die.

The LGO set out a series of recommendations, including an action plan to be produced within 3 months of the LPS scheme being finalised by Parliament, including "a mechanism for addressing those cases where the request is eventually not approved, and an unlawful deprivation of liberty has had a potentially harmful impact on that person."

Its decision was therefore that:

The Council has acted with fault in deciding not to assess low and medium priority Deprivation of Liberty Safeguards applications. The Council is also taking too long to deal with urgent applications. This is causing a potential injustice to the thousands of people in its area who are being deprived of their liberty without the

proper checks that the restrictions they are subject to are in their best interests.

It is important to note that not all local authorities do have a backlog, but it is difficult to escape the impression that many other local authorities will be reading this decision with the twin emotions of (1) simple frustration at the position; (2) relief that they were not the ones singled out in this report which could, with variations, have been written about many others in England & Wales.

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Conferences

Conferences at which editors/contributors are speaking

Essex Autonomy Project summer school

Alex will be a speaker at the annual EAP Summer School on 11-13 July, this year's theme being: "All Change Please: New Developments, New Directions, New Standards in Human Rights and the Vocation of Care: Historical, legal, clinical perspectives." For more details, and to book, see [here](#).

Local Authorities & Mediation: Two Reports on Mediation in SEND and Court of Protection

Katie Scott is speaking about the soon to be launched Court of Protection mediation scheme at the launch event of 'Local Authorities & Mediation - Mediation in SEND and Court of Protection Reports' on 4 June 2018 at Garden Court Chambers, in central London, on Tuesday, 4 June 2019, from 2.30pm to 5pm, followed by a drinks reception. For more information and to book, see [here](#).

Advertising conferences and training events

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

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

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