



Welcome to the June 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) Act; the Court of Appeal on sex and social media; life-sustaining treatment in a 'pro-life' care home; an important Strasbourg case on deprivation of liberty; and the former Vice-President of the Court of Protection on the MHA 1983/MCA 2005 interface in the community; .

(2) In the Practice and Procedure Report: a richly deserved award for District Judge Eldergill; and civil restraint orders in the presence of impaired litigation capacity;

(3) In the Wider Context Report: a summary of the recent developments relating to learning disability, seclusion and restraint; inquests, DoLS and Article 2 ECHR; and international developments including a ground-breaking report on the right to independent living;

(4) In the Scotland Report: the Chair of the newly established review of the Mental Health (Care and Treatment) Act 2003 provides his initial thoughts; and the Stage 1 report of the Independent review of learning disability and autism in the Mental Health Act.

For lack of sufficient relevant material, we have no Property and Affairs Report this month.

You can find all our past issues, our case summaries, and more on our dedicated sub-site [here](#).

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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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Medical treatment seminar

We are holding a half-day seminar in Chambers on medical treatment on 26 June, covering such topics as fluctuating capacity, diabetes and amputation, when applications have to be made, and urgent applications. For more details, and to book, see [here](#).

LPS update

The Government has confirmed its intention is that the Liberty Protection Safeguards system will to come into force on 1 October 2020, subject to ongoing implementation planning with delivery partners and the Welsh Government and progress of the work on developing the Code of Practice and regulations for this reform.

The DHSC update circulated on 12 June 2020 continues

The Government is currently working closely with stakeholders across the

sector in England and Wales on developing draft chapters for the Code of Practice. The Code of Practice will be a vital document for practitioners, the people who rely on these protections and their families. The Government’s priority is to ensure the Code of Practice delivers on providing detailed and easy to understand guidance which will ensure the successful implementation of the new system. The focus must be on getting this right.

Good progress is being made and initial outputs from the working groups contributing to this work can be expected by summer 2019. The Government plans to do further work with expert groups and those with lived experience over the coming months and following this there will be a full public consultation. The final draft of the Code is expected to be laid before Parliament in spring 2020. The Department of Health and Social Care is working closely with the Ministry of Justice to align this work with the review

of the Mental Capacity Act Code of Practice.

The Government is also in the process of drafting the regulations brought forward by the Act. These will set out important detail regarding the reform. There will be engagement with the sector on the development of the regulations and we expect that these will also be laid before Parliament in spring 2020.

Alongside the work on the Code of Practice and the regulations, the Government is taking forward a range of activity to prepare for implementation of the Liberty Protection Safeguards, working closely with key delivery partners and stakeholders. Some initial materials will be published shortly which will be publicly available and they can be used by the sector as a starting point in the preparations for the new system. The Government is also in the process of developing training both to support staff in the sector with the change to the new system, and to approve people to become Approved Mental Capacity Professionals.

For more details of the LPS scheme, see Alex's website [here](#).

Sex, social media and 'silos'

B v A Local Authority [2019] EWCA Civ 913 (Court of Appeal (Sir Terence Etherton MR, King and Leggatt LJJ))

Mental capacity – assessing capacity – residence – sexual relations – social media

Summary

The Court of Appeal has made both general and specific observations about the assessment of

mental capacity in determining the appeal/cross-appeal against the decision of Cobb J in *Re B (Capacity: Social Media: Care and Contact)* [2019] EWCOP 3. As it noted at the outset of its judgment:

5. The important questions on these appeals are as to the factors relevant to making the determinations of capacity which are under challenge and as to the approach to assessment of capacity when the absence of capacity to make a particular decision would conflict with a conclusion that there is capacity to make some other decision.

In *Re B*, handed down at the same time as *Re A* [2019] EWCOP 2, Cobb J took the test that he had drawn up in *Re A* for capacity to decide to use social media for purpose of developing or maintaining connections with others, and applied them to a 31 year old woman, B, to make an interim declaration that she lacked that capacity. He also made interim declarations about B's capacity to decide as to residence, care, contact and sexual relations.

The Official Solicitor, as B's litigation friend, appealed against those parts of Cobb J's order relating to social media and sexual relations. The local authority cross-appealed against Cobb J's determination that B had capacity to decide upon residence.

By way of general observation, the Court of Appeal noted that:

35. Cases, like the present, which concern whether or not a person has the mental capacity to make the decision which the person would like to make involve two broad principles of social policy which, depending on the facts, may not always

be easy to reconcile. On the one hand, there is a recognition of the right of every individual to dignity and self-determination and, on the other hand, there is a need to protect individuals and safeguard their interests where their individual qualities or situation place them in a particularly vulnerable situation: comp. A.M.V v Finland (23.3.2017) ECtHR Application No.53251/13.

[...]

36. As has frequently been said, in applying those provisions the court must always be careful not to discriminate against persons suffering from a mental disability by imposing too high a test of capacity: see, for example, PH v A Local Authority [2011] EWHC 1704 (Fam) at [16xi].

Social media

The Court of Appeal had little hesitation in dismissing the Official Solicitor's appeal, because the Official Solicitor did not challenge the finding in the order that B lacked capacity in this domain, but rather the reasoning that underpinned that finding. However, "[i]t is a basic principle [...] that an appeal is against an order and not merely the reasoning of the judge in support of his or her order to which no objection is made."

The Court of Appeal limited itself to observing that there was no particular advantage to the alternative formulation that the Official Solicitor advanced for the formulation of the relevant information, and that:

44. [...] Whether the list or guideline of relevant information is shorter or longer, it is to be treated and applied as no more

than guidance to be adapted to the facts of the particular case.

Sexual relations

The Official Solicitor objected to the following aspects of Cobb J's formulation of the relevant information:

*(iii) the opportunity to say no; i.e. to choose whether or not to engage in it and the capacity to decide whether to give or withhold consent to sexual intercourse.
(iv) that there are health risks involved, particularly the acquisition of sexually transmitted and transmissible infections;
(v) that the risks of sexually transmitted infection can be reduced by the taking of precautions such as the use of a condom.*

In dismissing the Official Solicitor's appeal, the Court of Appeal confirmed (paragraph 51) that the awareness of the ability to consent or refuse sexual relations is more than just an item of relevant information (but is one), but is fundamental to having capacity. It then went on to confirm that:

57. In accordance with the MCA s.3(1)-(4), the ability to understand and retain [the risk of catching a sexually transmitted infection through unprotected sexual intercourse, and the protection against infection provided by the use of a condom, satisfy that requirement] at least for a period of time and to use or weigh them as part of the decision whether to engage in sexual intercourse are essential to capacity to make a decision whether to have sexual intercourse. What is critical is not that a person, whose capacity is being assessed, is permanently aware of how sexually transmitted infections may be

caught and that protection may be provided by a condom. The assessment is not a general knowledge test. Rather it is an assessment of whether the person being assessed has the ability to understand those matters when explained to him or her and to retain the information for a period of time and to use or weigh it in deciding whether or not to consent to sexual relations.

58. We are not bound by any of the authorities cited to us to reach a different conclusion. None of them state expressly that capacity is sufficiently demonstrated by a mere awareness that some kind of ill health may result from sexual relations even if that awareness is no more than a wholly misguided notion of how or why the ill health is caused and has nothing to do with what are in fact sexually transmitted infections or how they may be caused. We respectfully disagree with Parker J in *London Borough of Southwark v KA* at [72] that it is not necessary to understand condom use. The only practical purpose of understanding that sexually transmitted infections can be caused through sexual intercourse is to know how to reduce the risk of infection since the purpose cannot be to encourage abstinence from intercourse completely.

As the Court of Appeal noted:

59. There are those who would object that many capacitous persons have unprotected sexual intercourse. Indeed, the MCA s.1(4) provides that a person is not to be treated as unable to make a decision merely because he makes an unwise decision. As Peter Jackson J said in *Heart of England NHS Foundation Trust v JB* [2014] EWHC 342 (COP) at [7], the temptation to base a judgement of a

person's capacity upon whether they seem to have made a good or bad decision, and in particular upon whether they have accepted or rejected medical advice, is absolutely to be avoided "as it would allow the tail of welfare to wag the dog of capacity". It is important always to bear in mind, however, as stated in paragraph 4.40 of Chapter 4 of the Code of Practice, that there is a fundamental and principled distinction between an unwise decision, which a person has the right to make, and decisions based on a lack of ability to understand and weigh up information relevant to a decision, including the foreseeable consequences of a decision. As the Code of Practice says, information about decisions the person has made based on a lack of understanding of risks or inability to weigh up the information can form part of a capacity assessment, particularly if someone repeatedly makes decisions that put themselves at risk or result in harm to them.

The Court of Appeal, by way of "brief postscript," noted that B had been previously assessed on a number of occasions as having capacity to consent to sexual relations:

61. [...] the MCA s.1(3) provides that a person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success. In her oral evidence Dr Rippon accepted that she had not asked B about condoms. At one point in his oral submissions Mr Lock appeared to admit that there had been a breach of the MCA s.1(3) because Dr Rippon had not reminded B how sexually transmitted infections were passed and the role of condoms in reducing the risk of infection. We make no observations

and no findings in relation to that aspect because it does not form a ground of appeal and only arose in the course of exchanges between Mr Lock and ourselves in the course of the hearing. Further work on whether B has sufficient understanding of sexually transmitted infections and how to reduce the risk of them will no doubt form part of the continuing engagement with B prior to a final decision on capacity to consent to sexual relations under the MCA s.15.

Residence

The local authority cross-appealed Cobb J's decision that B had capacity to decide on residence, criticising his use of the list of relevant information set out in the decision of Theis J in Re LBX. The Court of Appeal observed that:

62. So far as concerns the appropriateness of the list, as in the case of the list specified by Cobb J in relation to a decision to use social media, we see no principled problem with the list provided that it is treated and applied as no more than guidance to be expanded or contracted or otherwise adapted to the facts of the particular case.

At the heart of the local authority's appeal was the argument that Cobb J's conclusion on B's capacity to make decisions on residence, in particular whether to move to Mr C's property or to remain at her parents' home or to move into residential care, was fundamentally flawed in:

(1) failing to take into account relevant information relating to the consequences of each of those decisions, and (2) producing a situation in which there was an irreconcilable conflict with his conclusion on B's incapacity to make

other decisions, and so (3) making the Local Authority's care for and treatment of B practically impossible. Mr Lock submitted that the Judge's flawed conclusion followed from his approach in analysing B's capacity in respect of different decisions as self-contained "silos" without regard to the overlap between them.

The Court of Appeal agreed.

Comment

This appeal/cross-appeal, which was both heard and determined at commendable speed, is of importance both for the Court of Appeal's specific observations about capacity to consent to sexual relations – in particular in endorsing the fundamental nature of the need to understand that it is a consensual act – and also for its general observations about how to determine relevant information. It is helpful for confirming – in principle – the use of lists of/guidelines as to information drawn up by courts in different cases (and set out in our Guide to the assessment of capacity), whilst calibrating this with the obvious point that they are guidance to be applied to the facts of any given case. It is also helpful for confirming, in essence, the need to ensure that being too narrowly focused decision-specificity (which, in fairness Cobb J observed did pose its own problems) did not lead to conclusions that are mutually incompatible.

Finally, it will be extremely interesting to see whether Hayden J follows the rather broad hint given by the Court of Appeal that a flexible approach would be acceptable to enable him to resolve the conundrum in the case before him

concerning capacity to consent to sexual relations in the context of marriage:

49. [...] *it is not in dispute on this appeal that the test for capacity to consent to sexual relationships is general and issue specific, rather than person or event specific. The application of that test in other cases is, however, a live matter as it is currently under consideration by Hayden J in London Borough of Tower Hamlets v NB [2019] EWCOP 17. In that case the judge observed in his interim judgment (at [12]) that there was only one individual with whom it was really contemplated that NB was likely to have a sexual relationship, her husband of 27 years; and it therefore seemed to the judge entirely artificial to be assessing her capacity in general terms when the reality was entirely specific. He added (at [13]) that it might be that NB's lack of understanding of sexually transmitted disease and pregnancy might not serve to vitiate her consent to have sex with her husband. There was no reason to suggest that her husband had had sexual relations outside the marriage and there was no history of sexually transmitted disease. Hayden J has reserved his judgment on the issue. Another example would be a post-menopausal woman, for whom the risk of pregnancy is irrelevant. In IM (at [[75]-[79]) the Court of Appeal held that, by contrast with the criminal law where the focus, in the context of sexual offences, will always be upon a particular specific past event, in the context of mental capacity to enter into sexual relations the test is general and issue specific. The argument before Hayden J in London Borough of Tower Hamlets v NB was presumably that the conclusion in IM does not preclude the tailoring of relevant information to accommodate*

the individual characteristics of the person being assessed. We heard no argument on these points and do not need to decide them on the present appeals since it was not contended by the OS that anything in Cobb J's guideline was inapplicable because of B's personal characteristics.

Life-sustaining treatment – what would P have done? And does it make a difference that she is in a ‘pro-life’ nursing home?

A Clinical Commissioning Group v P (Withdrawal of CANH) [2019] EWCOP 18 (MacDonald J)

Best interests – medical treatment

Summary

In this case MacDonald J gave a detailed judgment to explain why he endorsed an agreed position that he would not consent on behalf of a woman to the continuation of Clinically Assisted Nutrition and Hydration (‘CANH’). It is of some importance as the paradigm example of a case that still has to come to court following *An NHS Trust v Y* [2018] UKSC 46, in which the Supreme Court had made clear that where there is a disagreement as to a proposed course of action, or where the approach is finely balanced, “an application to the court can and should be made.”

Given the intense focus on P's wishes and feelings in medical treatment cases, the judgment contains a considerable amount of very personal information about the person at the centre of this case, a woman who took an overdose of heroin, went into cardiorespiratory arrest, and suffered a severe hypoxic brain injury. For present purposes, one feature is key, namely

that she had had a relationship with a man who had suffered a traumatic brain injury that required him to be placed on life support. P was involved in the decision to terminate his life support. She told her mother that she would not want to be left in such condition if anything happened to her.

After P had suffered the hypoxic brain injury in April 2014 after a heroin overdose, best interests meetings were held. At what appears to have been the first formal one, in June 2014, P's mother had made clear that she did not consider P would wish to live in the circumstances she found herself in.

Following initial treatment in hospital, P was discharged to a nursing home in August 2014. As MacDonald J noted, the nursing home (the Unit):

is committed to rehabilitation work with those who suffer from neurological impairment. The home endeavours to improve the quality of life for all its residents, each of whom have very severe neurological disabilities. It is clear from the evidence before this court that the ethos of the Unit is about making the most of the lives of each individual labouring under neurological disability and endeavouring to maximise their potential. Within this context, a number of the staff at the Unit have made clear within the context of these proceedings that they have a strong 'pro-life' (their term) ethos.

P's diagnosis was the subject of some variation; she was initially considered to be in a vegetative state, and then, some months later, to be in a minimally conscious state. Importantly, there was a difference of opinion between the views of

the Unit caring for her and of her family as to her level of awareness, those caring for her at the Unit taking a much more optimistic view than that of the family.

The consultant in neurological rehabilitation medicine, Dr H, and Dr N, P's GP, declined to act as decision-makers in relation to withdrawal of CANH. Dr N did not explain why this was; Dr H explained that he was one of two Consultants in Neurological Rehabilitation in the area assessing patients at different stages of recovery from brain injury. He therefore "*adopted a blanket policy of maintaining a neutral position and not expressing a view as to best interests, in order not to be categorised as someone who was either pushing for withdrawal or not.*"

The Unit was opposed to any discontinuation of CANH for two linked reasons:

First, because the staff at the Unit considered that P felt pain, laughed, grimaced, and reacted, despite her all-encompassing dependence. Second, staff felt that any decision to discontinue CANH in relation to P could apply equally to all patients at the Unit. More generally, Ms PL (Clinical Lead at the Unit) told Dr Pinder [the independent expert] that in stating that both she and her staff would not want CANH withdrawn, she stated that this was not particularly because they felt it was against the best interests, but because "... they are all 'pro-life' in general and do not agree with actively doing anything that is likely to shorten someone's life." Amongst the staff more widely, opposition to any withdrawal of CANH from P tended to involve general objections in principle to withdrawing CANH from a patient like P, a desire to continue caring for her and reluctance to

be involved personally in the withdrawal, but also included opposition on the basis of the quality of P's life.

Ultimately and given the "consistent and firmly expressed opinion of P's eldest daughter, TD, half-sister, LD, and former partner, NG in favour of the withdrawal of CANH," the CCG funding her care agreed to take the lead in considering invoking the legal process to obtain a decision on whether it was in P's best interests for CANH to be withdrawn. As part of doing so, and prior to bringing proceedings, they instructed an independent expert, before convening a further best interests meeting in January 2019, at which the Unit maintained its expressed reservations with respect to the removal of CANH, and P's family maintained their position that P would not have wanted to live as she was. The CCG then made the application to the Court of Protection.

Although there was no formal dispute before the court (the CCG being neutral, and the Official Solicitor on P's behalf agreeing with P's family that it was not in her best interests for CANH to be continued), MacDonald J gave a detailed judgment. He agreed that with the Official Solicitor that (following *Briggs*) "P's past wishes and feelings on such an intensely personal issue as whether her CANH should be withdrawn can be ascertained with sufficient certainty and, on the particular facts of this application, should prevail over the very strong presumption in favour of preserving her life where those wishes were clearly against being kept alive in her current situation."

MacDonald J gave:

Careful consideration to the views of the staff of the home in which P is cared for. They have the advantage of regular contact with P and are in a position to

develop a detailed picture of her current presentation. Against this, they have not had the benefit that the family have had of knowing P when she was capacitous and of seeing and experiencing all of the many varied facets of her character, what she thought, what was dear to her, what she wished for the future and, importantly, what she believed about the situation in which she now finds herself. Whilst the 'pro-life' approach (as they themselves describe it) taken by a number of the members of staff in the current situation is a valid point of view, in the circumstances of this case I am satisfied that it is contrary to the clearly expressed view of P before she lost capacity.

However, having conducted a detailed analysis of relevant parts of P's life, including, in particular, what had happened around the time of the death of her former partner, MacDonald J expressed himself:

sufficiently certain that P would not in her current situation have consented to ongoing life sustaining treatment, a position that is consistent with all that the court understands about her beliefs, her outlook and her personality, and with the clearly and consistently expressed views of her loving family, borne of their direct experience of her views and wishes and of who she was. In all the circumstances, I am satisfied that the sanctity of P's life should now give way to what I am satisfied was her settled view on the decision before the court prior to the fateful day of her overdose in April 2014.

Comment

The CCG in this case undoubtedly did the right thing in terms of bringing the case to court; the fact that it had also 'front-loaded' the application by obtaining independent expert evidence in advance also meant that it was possible for the proceedings to be resolved much more quickly than would otherwise have been the case.

However, it is very problematic that it took over four years to address the fact that there was a clear disagreement as to whether continuing CANH was in P's best interests. It is sincerely to be hoped that with the publication of the [BMA/RCP Guidance](#) on CANH, which featured briefly in the decision (see paragraph 25), the nettle will be grasped very much earlier in other cases. In this context, it is perhaps to be regretted that MacDonald J did not highlight the discussion in the Guidance about conscientious objection, including that:

Provider organisations, including care homes, that carry religious or other convictions that would prevent them from making and implementing particular decisions about CANH should be open about that fact when a best interests decision is needed. All such organisations have a duty, however, to comply with the law, including ensuring that best interests assessments are carried out on a regular basis. These assessments should specifically consider the question of whether CANH continues to be in the patient's best interests as part of the care plan review. Where necessary, organisations should make arrangements for these

assessments to be carried out in, or by staff from, another establishment.

In relation to the BMA/RCP Guidance, we also note that training materials and case studies to accompany the Guidance have now been published and can be found [here](#).

In terms of the substance of the decision, it is the model of a post-*Aintree* approach to best interests, with a clear eye to the gravity of the decision and of the principles in play. In its intense focus on seeking to reconstruct what P would have done, we would suggest that it also represents the implementation of the 'best interpretation of the will and preferences' of the person that the Committee on the Rights of Persons with Disabilities have to date held must govern steps being taken to secure the exercise of legal capacity where the person concerned is unable to express any views. In the case of Vincent Lambert (see the May Mental Capacity [Report](#)¹), the Committee are being invited to adopt, in effect, a blanket position that life-sustaining treatment can never be withdrawn from a person in a prolonged disorder of consciousness. It will be of huge importance to see whether the Committee maintains its previous position in the face of this invitation.

Finally, and rather bathetically, a very small point in relation to the title of the judgment. Whilst the anonymisation by way of initials means that it will be difficult easily to refer to it in future, it is very helpful to give (as MacDonald J has done in other [cases](#)) a 'sub-heading' to flag what the case is about.

¹ Since that Report was published, the French courts have ordered that life-sustaining treatment be

continued pending the outcome of the Committee's deliberations.

Testing the faith

Manchester University NHS Foundation Trust v DE
[2019] EWCOP 19 (Lieven J)

Best interests – medical treatment

Summary

This was an urgent out of hours telephone application made by the applicant Trust for an order enabling it to provide a blood transfusion to DE in the event that it should become clinically necessary.

DE was a 49 year old woman who suffers from autism and mild learning difficulties. She and her mother were Jehovah's Witnesses. On 11 April 2019 DE suffered a serious break to her left femur and tibia. She required surgical fixation of the femur and possibly the tibia. There was said to be a risk that during the operation DE would require a blood transfusion or blood products.

The Trust had assessed DE as lacking capacity to make decisions about whether to accept a blood transfusion or blood products.

The court heard oral evidence and submissions over the telephone, but adjourned the application overnight so as to allow the Official Solicitor lawyer to visit DE and seek her views.

The Official Solicitor lawyer's attendance note of that visit recorded that he had visited DE and met her with her mother and brother. DE said that she was a Jehovah's Witness but made it very clear that she wanted the operation to happen as soon as possible. She could not explain why blood transfusions were prohibited under the religion. She did not appear too concerned about having a transfusion.

Having met with DE, Official Solicitor agreed that the order should be made.

The Court accepted the evidence that DE lacked the capacity to make the decision as to whether to accept blood transfusion if clinically necessary. The Court also held that clinically it would be in DE's best interests to have a blood transfusions in the event that it becomes clinically necessary. The Court articulated the central issue as *"the degree to which DE's wishes and feelings would be overborne by a decision to allow a blood transfusion, in the light of her being a Jehovah's Witness; and therefore whether there was a disproportionate interference in DE's article 8 rights."*

The Court found that *"although DE described herself as a Jehovah's Witness she was not someone for whom those beliefs were central to her personality or sense of identity."* The Court's view gained at the oral hearing was reinforced by the information from the Official Solicitor, namely that DE was not strongly identifying herself with the beliefs of Jehovah's Witnesses, and indeed her mother supported the operation going ahead. Unsurprisingly therefore the Court granted the Trust's application.

Comment

This case is interesting in the finding that, while DE identified as a Jehovah's Witness, this was not central to her sense of self. It is not entirely clear from the evidence whether DE had been baptised as a Jehovah's Witness and had actively chosen to live as one, or whether she was regarded as one because she had been brought up in a Witness household and had not made a deliberate choice to embrace the faith and live as one. Ordering transfusion in respect

of the former is clearly more serious than the latter. We should further emphasise that this case was very fact specific, and should, in particular, not be taken as licence to override refusals by Jehovah's Witnesses by clinicians – this was undoubtedly a case requiring consideration by the Court of Protection. For guidance more generally in relation to medical decision-making involving Jehovah's Witnesses, we recommend the Association of Anaesthetists' *Anaesthesia and peri-operative care for Jehovah's Witnesses and patients who refuse blood* (July 2018).

Deprivation of liberty – appropriate places and appropriate treatment

Rooman v Belgium [2019] ECHR 19 (European Court of Human Rights (Grand Chamber))

Article 5 ECHR – deprivation of liberty

Summary

In an important case determined at the start of 2019, the Grand Chamber of the European Court of Human Rights undertook a review and clarification of its approach to Article 3 and Article 5 ECHR in the context of deprivation of liberty on the basis of 'unsoundness of mind.'

The case was brought by a Belgian prisoner detained in a "social-protection facility," who contended that, that as a result of the failure to provide psychiatric and psychological treatment in the facility in which he was detained, his compulsory confinement entailed a violation of Articles 3 and 5(1) ECHR.

Article 3

The Grand Chamber took the opportunity to 'recapitulate' its principles in relation to Article 3

ECHR. Most of these were relevant to the position of prisoners, but in a statement that perhaps reveals that Strasbourg has a different idea about deprivation of liberty to the Supreme Court in *Cheshire West*, the Grand Chamber observed (at paragraph 142) that "[m]easures depriving persons of their liberty inevitably involve an element of suffering and humiliation." It noted that "the detention of a person who is ill in inappropriate physical and medical conditions may in principle amount to treatment contrary to Article 3" (paragraph 144), highlighting the particular vulnerability of detainees with mental disorders. It further noted that it takes account of the adequacy of the medical assistance and care provided in detention, and that "[a] lack of appropriate medical care for persons in custody is therefore capable of engaging a State's responsibility under Article 3 [...] In addition, it is not enough for such detainees to be examined and a diagnosis made; instead, it is essential that proper treatment for the problem diagnosed should also be provided [...], by qualified staff [...]" (paragraph 146). Logically, therefore "[w]here the treatment cannot be provided in the place of detention, it must be possible to transfer the detainee to hospital or to a specialised unit" (paragraph 148).

Article 5

Turning to Article 5 ECHR, the Grand Chamber considered that "in the light of the developments in its case-law and the current international standards [including the CRPD] which attach significant weight to the need to provide treatment for the mental health of persons in compulsory confinement, it is necessary to acknowledge expressly, in addition to the function of social protection, the therapeutic aspect of the aim referred to in Article 5 § 1 (e), and thus to recognise

explicitly that there exists an obligation on the authorities to ensure appropriate and individualised therapy, based on the specific features of the compulsory confinement, such as the conditions of the detention regime, the treatment proposed or the duration of the detention" (paragraph 205).

Conversely, and in the most explicit terms used to date, the Grand Chamber made clear that "Article 5, as currently interpreted, does not contain a prohibition on detention on the basis of impairment, in contrast to what is proposed by the UN Committee on the Rights of Persons with Disabilities in points 6-9 of its 2015 Guidelines concerning Article 14 of the CRPD."

The Grand Chamber undertook a detailed examination and review of its own case-law to highlight that:

208. [...] the current case-law clearly indicates that the administration of suitable therapy has become a requirement in the context of the wider concept of the "lawfulness" of the deprivation of liberty. Any detention of mentally ill persons must have a therapeutic purpose, aimed specifically, and in so far as possible, at curing or alleviating their mental-health condition, including, where appropriate, bringing about a reduction in or control over their dangerousness. The Court has stressed that, irrespective of the facility in which those persons are placed, they are entitled to be provided with a suitable medical environment accompanied by real therapeutic measures, with a view to preparing them for their eventual release.

The Grand Chamber further emphasised at paragraph 209 that the level of care required must go beyond basic care: "[m]ere access to

health professionals, consultations and the provision of medication cannot suffice for a treatment to be considered appropriate and thus satisfactory under Article 5." It then highlighted the fact that deprivation of liberty had to take place in an appropriate institution, and such that a "specialised psychiatric institution which, by definition, ought to be appropriate may prove incapable of providing the necessary treatment" (paragraph 210). It had, earlier, noted (paragraph 203) that "although the persistent attitude of a person deprived of his or her liberty may contribute to preventing a change in their detention regime, this does not dispense the authorities from taking the appropriate initiatives with a view to providing this person with treatment that is suitable for his or her condition and that would help him or her to regain liberty"

The interaction between Articles 3 and 5

The court noted that the

question of a continued link between the purpose of detention and the conditions in which it is carried out, and the question of whether those conditions attain a particular threshold of gravity, are of differing intensity. This implies that there may be situations in which a care path may correspond to the requirements of Article 3 but be insufficient with regard to the need to maintain the purpose of the compulsory confinement, and thus lead to a finding that there has been a violation of Article 5 § 1. In consequence, a finding that there has been no violation of Article 3 does not automatically lead to a finding that there has been no violation of Article 5 § 1, although a finding of a violation of Article 3 on account of a lack of appropriate treatment may also result in

a finding that there has been a violation of Article 5 § 1 on the same grounds.

214 . This interaction in the assessment of complaints which are similar but are examined under one or other provision arises naturally from the very essence of the protected rights. The assessment of a threshold for Article 3, guaranteeing an absolute right, to come into play is relative, and depends on all the circumstances of the case, such as the duration of the treatment, its physical and mental effects and, in some cases, the sex, age and state of health of the victim. With regard to Article 5 § 1 (e), the deprivation of liberty is ordered, inter alia, on account of the existence of a mental disorder. In order to ensure that the link between this deprivation of liberty and the conditions of execution of this measure is preserved, the Court assesses the appropriateness of the institution, including its capacity to provide the patient with the treatment that he or she requires.

On the facts of the case, the court found that there had been breaches of both articles for a period from 2004 to August 2017, but that, following changes in the regime for the complainant, there was no breach for the subsequent period. Partially dissenting judgments from six of the judges made it clear that they would have found that the breaches continued, in essence on the basis that the changes were inadequate.

Comment

It is also clear now beyond shadow of doubt that the clash between Strasbourg and Geneva regarding deprivation of liberty in the context of disability is not going to be resolved any time

soon, but this comment will not dwell on this because the stalemate is, frankly, not very productive, and diverts attention from all the steps that can be taken to ensure that the only decision to take is whether to detain or not.

This decision is both extremely useful, as a summary and clarification of what is now an extensive body of case-law, and challenging for 'how things are done' in the mental health context, in particular. An immediate observation is that it is remarkably difficult in face of this decision to see the basis upon which the majority of those with learning disability/autism can sensibly be said to lawfully to be deprived of their liberty in ATUs or psychiatric hospitals (whether this is under the framework of the MHA or DOLS), as it would appear difficult to see the basis upon which such institutions can be said to be appropriate. The case may also suggest that we need to revisit in the DoLS / LPS context the previous reluctance of the courts to investigate the appropriateness of particular facilities once a broad 'umbrella' justification for deprivation of liberty on the basis of unsoundness of mind has been established: see, for instance, *North Yorkshire CC v MAG* [2016] EWCOP 6.

It also interesting to note the observation by the Grand Chamber that, almost axiomatically, deprivation of liberty involves an element of suffering and humiliation. This presumably applies to MIG and MEG in the Supreme Court before *Cheshire West*, or Steven Neary if he is to be found to be deprived of his liberty on the *Re X* application currently before the Court of Protection. Is that quite right? Or does it suggest that we have developed a domestic concept of deprivation of liberty going beyond the

overbearing of the will suggested by this decision – in a situation where, over 5 years on from *Cheshire West*, the Strasbourg court has yet to declare any situation resembling that of MIG or MEG to be a deprivation of liberty.

Does the Court of Protection have a role in respect of conditionally discharged restricted or detained patients whose living arrangements amount to a deprivation of liberty?

[Editorial note: we are delighted to be able to reproduce here the text of a talk delivered by the former Vice-President of the Court of Protection, Sir William Charles, to the Judicial College, on recent decisions concerning Mental Health Act and Mental Capacity Act powers in relation to living arrangements which amount to deprivation of liberty.]

Introduction

This talk engages some detailed and complex points that I am going to have to take at a gallop

At this stage of the day it may well be difficult to take them on board. But the good news is that my message is that all you need take away is that if you get a case in which the Court of Protection is being invited to address deprivation of liberty issues relating to the regime of care of a conditionally discharged restricted or detained patient send it to a Tier 3 Judge.

This because in my view it is far from clear that the approach set out in guidance issued by HM Prison & Probation Service- Mental Health Casework Section in January 2019 entitled: "Guidance: Discharge Conditions that amount to deprivation of liberty" and which is advanced by

others provides a lawful solution to the problems created by the acceptance by the Supreme Court of the SofS's argument that a deprivation of liberty outside hospital cannot be lawfully created in exercise of MHA powers even though the patient consents to it.

Further introduction

As a law student I thought that an attractive aspect of the study of law as an academic subject was that the House of Lords now the Supreme Court (as the voice of infallibility – even if only by a narrow majority) provided the right answer.

Experience has shown me that it only provides a binding answer. The relevant answers for present purposes are those provided by: (1) *Cheshire West* [2014] UKSC 19; (2) *SoS for Justice v MM* [2018] UKSC 60; and (3) *Welsh Ministers v PJ* [2018] UKSC 66

As many of you will know I was the High Court judge in *MM* and *PJ* and so at risk of being accused of having sour grapes.

MM addressed the issue relating to a patient with capacity identified in *SoS for Justice v KC* [2015] UKUT0376 (AAC) in which I had decided that the argument of the SofS, based on existing Court of Appeal authority, that the discharge of a restricted patient could not create a deprivation of liberty was wrong and that it could do so if that deprivation of liberty was rendered lawful under the MCA or obiter by the consent of the patient. *KC* was not appealed and was I believe applied to patients who lacked relevant capacity.

KC also showed that there was an overlap between the deprivation of liberty issues in cases relating to restricted patients and those

relating to detained patients and those subject to guardianship *PJ* was the vehicle for addressing some of those issues in the higher courts although the arguments in the tribunal were more focused and the appellant refused to take part in them.

These cases give rise to the question: *Whether the Court of Protection has a role if the regime of care, support and supervision of a conditionally discharged restricted or detained patient creates a deprivation of liberty.*

This is the question I shall address. And so, I am not addressing residence in a care home to which the DOLS could apply.

As is apparent from *KC* I am sympathetic to the view that the COP should have a role to render lawful a situation that fulfils the purpose of the MHA to return a patient to the community when their mental disorder no longer requires their detention in a hospital for treatment, but a power of recall is necessary.

My approach to achieving this is destroyed by the decisions of the Supreme Court in *MM* and *PJ*.

But, the parts of *KC* founded on the hypothesis that the SofS's jurisdictional argument was right remain relevant and merit consideration.

Some background points

- (1) *Cheshire West* confirms and decides that a deprivation of liberty has objective and subjective elements and thus that if a valid consent is given to the objective element there is no breach of Article 5.
- (2) *PJ* confirms that when issues relating to deprivation of liberty are concerned the

Convention must be practical and effective and so the courts and other decision makers must look at the concrete situation of the person concerned, otherwise all kinds of unlawful detention might go unremedied and this is the antithesis of what protection of personal liberty by the ancient writ of habeus corpus, and now by Article 5 of the Convention is about (see paragraph 18).

- (3) So artificial or back door routes to rendering a deprivation of liberty lawful are unlikely to work.
- (4) DOLS (and LPS) work by the giving of an authorisation.
- (5) Although the result is effectively the same, and s. 16A refers to including provision in a welfare order that authorises a person to be deprived of his liberty, sections 4A (3) and (4) provide that *D may deprive P of his liberty if, by doing so, D is giving effect to an order under s. 16(2)(a) in relation to a matter concerning P's personal welfare.* And s.16(2)(a) provides that the court *may by making an order make the decision or decisions on P's behalf in relation to the matter or matters in question.*
- (6) Accordingly, the underlying approach of s. 16 is, as it states, that by making the order the Court of Protection is making the relevant decision which P lacks the capacity to make on behalf of P and it is the welfare order that renders the deprivation of liberty lawful. So, references to authorisation by the court are founded on the court deciding on P's behalf to accept or consent to a living regime that creates a deprivation of liberty and in doing this the court would have to consider that consequence of the living

regime and so whether it was the least restrictive option.

(7) The approach under s. 16 founds or is reflected in:

- a. paragraph 18 of the judgment of Lady Hale in *Aintree University Hospitals NHS Trust v James* [2013] UKSC 67, [2014] AC 591 where she says that the MCA:

is concerned with doing for the patient what he could do for himself if of full capacity, but it goes no further,

and the points that

- b. the Court of Protection can only choose between available options

and so that:

- c. when, for example, the decision on where a person should live is vested in a guardian appointed under the MHA the Court of Protection cannot in that person's best interests make an order that he is to live somewhere else (see *C v Blackburn and Darwen Borough Council* [2011] EWHC 3321 (COP) and to similar effect *Re T (A child: murdered parent)* [2011] EWHC B4 (Fam), [2011] MHLR 133), and
- d. a local authority or health authority can seek to rule out an option by not offering it and assert (correctly) that its decision can only be challenged on administrative law grounds and the Court of Protection cannot deal with a challenge on those grounds (see *KD v A Borough Council, the Department of*

Health and Others [2015] UTUK 0251 (AAC) in particular at paragraphs 44 to 54).

(8) In short,

- a. the MCA does not put a person who lacks relevant capacity in a better position than a person who has capacity in respect of the choices of regimes of care, support and supervision made available to them by public authorities in exercise of their statutory duties and powers,
- b. in general, the court can only obtain and do for P what he could have got and done for himself if he had the relevant capacity, and
- c. whether or not a care plan involves a deprivation of liberty, the approach of the Court of Protection is to consent to a regime and its effects selected and implemented by others on behalf of P, and the same applies, for example, in respect of medical treatment that the Court of Protection concludes is in P's best interests.

All of that leads to;

The point that the COP does not set up the relevant living arrangements but gives consent on behalf of P to an available alternative regime that is decided on and provided by others in their exercise of their duties and powers and so in the case of conditionally discharged detained and restricted patients MHA decision makers and providers of accommodation, support and supervision out of hospital.

The question whether the court can give an effective consent to and so authorise a regime which is founded on an unlawful exercise of a statutory power and/or if P could not do have done so himself if he had the capacity to do so.

The binding decisions in MM and PJ

This is not the time or place to address the reasoning in these cases in detail. However, I should record that I do not agree with the 39 Essex Street Report that the majority conclusion in *MM* is based on iron logic.

Having got that off my chest, I naturally accept that all COP judges are bound by the ratio of the conclusions in *MM* and *PJ*.

As already indicated, I think that this is that as a matter of statutory construction the MHA does not empower the MHA decision maker to “impose” (their language), or to specify (the language of s. 17) conditions amounting to a *Cheshire West* deprivation of liberty upon a conditionally discharged restricted or detained patient.

Also, the two cases provide confirmation, should it be needed, that the relevant MHA decision maker is in complete control of the exercise of the power of recall and the conditions of a conditional discharge.

So, the reasons for the conditions and the need for a power of recall are matters that the MHA decision maker must take into account. My references to MHA reasons cover both.

So, the starting point is that the agreement of a capacitous conditionally discharged restricted or detained patient to a deprivation of liberty that is imposed or specified for MHA reasons does not

render the deprivation of liberty lawful because it is outside the ambit of the relevant MHA statutory power.

Article 5(1) reflects the common law principle (see paragraph 18 of *PJ*) and so it seems to me that inherent in the ratio of these cases are the points that the consent of a capacitous patient to such a deprivation of liberty does not satisfy the subjective element of Article 5 or mean that the patient is free to leave.

The references to the Court of Protection by the Supreme Court and the Court of Appeal – and so by inference to the possibility that the engagement of Article 5(1)(e) and the jurisdiction of the MCA enables the lawful deprivation of liberty of a restricted or detained patient who lacks the capacity to consent to the terms and effect of his living arrangements outside hospital.

Lady Hale refers to the reference to the Court of Protection by the Court of Appeal in paragraph 25 of *MM* and wrongly says that the discrimination argument was a new one prompted by that reference. I say wrongly because it was a live argument in *KC* (see paragraphs 116 to 123).

Then, on an assumption that the Court of Protection could “authorise” a deprivation of liberty of a conditionally discharged patient who is not “ineligible” and so there might be an incompatibility within Article 14 between patients who have and do not have capacity, she says this incompatibility did not matter because it would not affect whether it was possible to read the relevant sections as including a power to “impose” conditions that create an Article 5 deprivation of liberty.

It seems to me that this conclusion ignores:

- the subjective element of an Article 5 deprivation of liberty, and
- the possibility of a construction of the MHA being incompatible with Convention rights.

The assertion by the Court of Appeal in paragraph 35 that *the power of deferment to permit arrangements to be made for discharge could be used in an appropriate case to invoke the jurisdiction of the Court of Protection to authorise a deprivation of liberty if the patient is incapacitated is:*

- dicta,
- unexplained and
- does not appear to be founded on argument – but may go back to my decision in *KC* which is founded on a different interpretation of *RB* that cannot stand considering paragraphs 17,18 and 21 of the judgment of the Court of Appeal and now because of the decisions of the Supreme Court.

Accordingly, it does not found a solid foundation for the existence of an exercisable jurisdiction of the Court of Protection.

So, if and to the extent that, the guidance issued by HM Prison & Probation Service- Mental Health Casework Section in January 2019 is founded on either:

- the references to the jurisdiction of the Court of Protection by the Supreme Court and the Court of Appeal, or
- my decision in *KC*

it is built on sand.

Does the Court of Protection have an exercisable jurisdiction?

The Guidance I have referred to envisages a role for and so an exercisable jurisdiction of the Court of Protection, but it does not explain why the court has that jurisdiction.

Also, the approach taken in the guidance chimes with the jurisdictional solution using the MCA taken by the SoS in *KC* which was founded on his position on the construction of the MHA that has been found to be correct by the Supreme Court.

I was of the view that this jurisdictional solution involved:

- MHA decision makers wrongly trying to pass decisions to the MCA decision make, and
- an artificial distinction between the conditions created by the care plan and the conditions of the discharge.

At paragraphs 69 to 73 I said:

69. The jurisdictional solution suggested by the Secretary of State recognises the difficulties placed in the way of achieving the underlying purpose of s. 73 MHA by his submission on the ratio of the RB case. But his correct acceptance that the MHA decision maker has to consider what protective conditions are needed and be satisfied that they will be in place on a conditional discharge mean that his jurisdictional solution for a restricted patient who lacks capacity to consent to protective conditions seeks to achieve a result which, on his submission, cannot be achieved under the MHA “through the front door”.

70. Accordingly, this jurisdictional suggestion seeks to utilise a "back door".

71. In my view, if the Secretary of State is right about the ratio of the RB case his "back door" jurisdictional suggestion is not a permissible solution because:

- a. the MHA decision maker has to consider what the protective conditions should be,
- b. if the MHA decision maker concludes that they are required to protect the public or the patient (or for any other reason applying the MHA tests) he cannot direct or support a conditional discharge of the restricted patient without them being in place,
- c. the suggestion that the MHA decision maker can effectively require the imposition of the protective conditions but leave them out of the conditions he imposes and so the s. 73(4) statutory duty on the basis that they are or are to be included in a care plan approved by the Court of Protection (or authorised under the DOLS provided by the MCA) does not reflect the reality of the position,
- d. that reality is that the MHA decision maker is making the choice on what the protective conditions are to be and is thereby limiting the choices open to the Court of Protection (or under the DOLS) and so imposing those protective conditions of the conditional discharge, and
- e. the MCA does not fill the jurisdictional gap by providing an alternative regime that serves the same purpose as the MHA or creates the s. 73(4) statutory duty

72. *If I am right, the jurisdictional solution suggested by the Secretary of State to achieve the result that he, the FTT and KC supported has to be founded on a conclusion that the ratio of the RB case is not that suggested by Secretary of State but is that the MHA decision maker cannot choose and impose conditions that when they are implemented would be in breach of Article 5 and so unlawful.*

73. *If that conclusion on the ratio of the RB case is correct it "opens the door" to any deprivation of liberty resulting from the protective conditions being authorised by the Court of Protection or under the DOLS and so rendered lawful (and not a deprivation of liberty under Article 5) (This door is now shut)*

I remind you:

- of the confirmation in *PJ* that an artificial approach and so one that does not reflect the concrete position on the ground is inappropriate, and
- that MHA reasons include the reason for the need for the power to recall.

In *KC* the artificiality or back door nature of this jurisdictional route to protective conditions was demonstrated by the stance taken by the SoS that the care plan approved by the court had to include notification provisions to the SofS so that he could consider a recall if *KC* acted in breach of the terms of the care plan or it broke down for any reason.

This need clearly linked the deprivation of liberty created by the care plan to MHA reasons and purposes.

Also test it this way: Would the conditional discharge of MM have been lawful if the deprivation of liberty was not founded on a condition of the discharge? I suggest that the answer is "No" because the need for it was founded on MHA reasons.

This answer is reflected in paragraph 3 of the guidance by the conclusion that when the responsible clinician considers that a capacitous patient no longer requires treatment in hospital but is not yet suitable for discharge without constant supervision, that patient cannot consent to the deprivation of liberty that supervision would create but the SoS can consider escorted leave of absence under s.17(3) MHA.

The artificiality or back door nature of the different approach suggested in the guidance depending on whether the patient has or does not have relevant capacity is that:

- if a patient for MHA reasons (the only ones the SoS and FTT can apply) a patient needs a care plan that provides constant supervision it is a necessary element of the conditional discharge which should not be granted / imposed absent that regime being in place, and
- this applies whether or not the patient has the capacity to consent to a care plan that deprives them of their liberty

Whether it applies to a patient who has or does not have relevant capacity such a care plan does not have some free-standing or pre-existing or separate existence created by a provider separately from the discharge. Rather, it is created and agreed with a provider as part of the discharge and is an integral part of it.

Also, in the case of a patient within the jurisdiction of the MCA, the care plan is not created by the Court of Protection. Rather, in such a case the court is being asked to conclude that it is in P's best interests to enable a conditional discharge for MHA reasons that cannot lawfully be put in place under the MHA.

And, an MCA decision maker cannot make an unlawful exercise of an MHA power and its unlawful effects lawful.

Pausing there, it seems to me that *if the reality is that the care plan is or is in part founded on MHA reasons* the MCA does not provide an exercisable jurisdictional route that renders a deprivation of liberty of a conditionally discharged restricted or detained patient who lacks capacity lawful on the basis that all or parts of it are in the best interests of that patient.

The guidance does not address this reality issue.

The guidance takes an approach based on an identification of the reasons why the relevant conditions create a deprivation of liberty are needed.

The first is when the need for a regime of residence and supervision that creates an objective deprivation of liberty is the inability of the patient to perform activities of daily living or self-care. I shall return to this.

The second is to prevent re-offending and the trauma and risk from others to the patient this would involve. It is clearly so categorised because of case law that supports the view that this can be in P's best interests.

But, as seems to be recognised in paragraph 4.2 of the guidance, this second cause will also

engage risk to the public (victims of the re-offending). Also, I find it hard to envisage cases where the benefits of avoiding harm to the patient caused by re-offending are not inextricably linked to the reasons for the need to be able to recall the patient to hospital if he re-offends.

A distinction between a condition and so a statutory duty not to re-offend and the need for living arrangements that create a deprivation of liberty to avert that risk and /or are one of the reasons for a power of recall is artificial.

So, it seems to me that the isolation of the second cause identified in the guidance to provide a best interests decision under the MCA is artificial. This is because in reality the deprivation of liberty is, in the words of the Supreme Court being imposed by the MHA decision maker for MHA reasons and so per the Supreme Court is an unlawful exercise of power by the MHA decision maker.

The point that it can also be said to be in the patient's best interests does not alter that conclusion.

In my view, after *MM* and *PJ* if the real or concrete situation on the ground is that for an MHA reason the conditional discharge would not be made unless a regime is in place that creates a deprivation of liberty:

- under the guidance the Court of Protection is being invited to consent on P's behalf to, and so authorise, an unlawful exercise of an MHA power – and I do accept that it can do that, and in any event

- the Court of Protection cannot cure the unlawfulness of such an exercise of an MHA power and its result.

I return to the first reason identified in the guidance - namely an inability to perform activities of daily living and not the discharge from hospital or the need for a power of recall.

I am sympathetic to a view that if the patient had been in hospital for physical reasons and could not be discharged until a placement that objectively created a deprivation of liberty was found then that deprivation of liberty has nothing to do with the discharge or the need for a power of recall so:

- it can be authorised under the DOLS (if at a care home) or be the subject of a welfare order, and
- the need for delay to get the authorisation is simply to render the placement involving a deprivation of liberty lawful.

However, the line between on the one hand the MHA reason "*necessary for the health and safety of the patient*" and the reasons for the power of recall and on the other an inability to perform activities of daily living or self-care is a fine one and it seems to me that the Court of Protection needs to have this possibility fully argued before it adopts it.

If it is to work, it seems clear to me that the patient can have no MHA duty to comply with conditions that create the deprivation of liberty (e.g. to live at a particular place under a particular care plan).

Assuming that is the case, it still seems to me that problems arise if for MHA reasons the

existence of such a deprivation of liberty (and so placement) is relevant to and so a reason for the grant of the conditional discharge and/or the existence or exercise of the power of recall. Such a situation would be an indication that without it, for MHA reasons, the conditional discharge would not have been granted if the patient was not being deprived of his liberty outside hospital. Going back to *PJ's* graphic description it is an indication that unless he continues to be deprived of his liberty outside hospital he is fucked – and so in reality the deprivation of liberty is being imposed unlawfully by the MHA decision maker for MHA reasons.

There is a second and parallel issue that needs careful consideration, namely whether as suggested in the guidance the Court of Protection, in exercise its power under s. 16 MCA to make a decision on behalf of P, can bring about a result that P could not have achieved by making his own decision.

On the face of it this is a surprising result if, as is often said, the MCA only enables a patient to do what he could have done himself with capacity and so removes discrimination between those who have and those who do not have the relevant capacity.

The Supreme Court has decided that the decision of *MM* and *PJ* (if he had capacity) to consent to further their best interests could not render an exercise of the relevant MHA power in a way that deprived them of their liberty lawful.

It follows that the court has to ask and answer whether it can do so on their behalf.

This not pedantic, and I do not dispute that the effect of the welfare order can be described as an authorisation.

But as the process to that authorisation is one in which the court makes the decision to consent to the care plan and its effect on behalf of P. If Ps cannot do that themselves it is not clear to me how the Court of Protection can do it for them applying s. 16 and/or the approach described by Lady Hale that the MCA is concerned with doing for the patient what he could do for himself if of full capacity, but it goes no further.

Also, I repeat that it seems to me that nothing done under the MCA would render an unlawful exercise of an MHA power, and so an unlawful situation on the ground created by it, lawful.

A way of testing this in a particular case might be to consider whether, applying *MM* and *PJ*, the patient could by a capacitous consent create a lawful result. There is some unreality in this because it is likely that these reasons for a deprivation of liberty are less likely to apply to capacitous patients. But this approach may show that there is clear blue water between the living arrangements and the MHA reasons because they would not apply to a capacitous patient.

I have toyed with the idea that a way round this might be to adopt the doctrine of “double effect” as in *CANH* cases. This excludes the purpose of causing death and allows it to be knowingly caused as a side-effect and so draws a distinction between the intention underlying an action of the one hand and the consequences that are foreseen but not intended on the other (see *Briggs* at para (18)).

But I do not think this works because what the court is being asked to do:

- decide to accept on P's behalf the effect of the relevant provisions of the care plan, and
- an unlawful exercise of an MHA power and P could not do this himself.

So, as I said at the start, if you get a case in which you are asked to address the deprivation of liberty of a conditionally discharged restricted or detained patient send it to a Tier 3 judge.

Postscript

I pose two hypothetical questions.

Does the analysis and conclusion in *MM* and *PJ*:

1. Have an impact on the informal admission of patients? This is based on their consent which on one view cannot be said to be freely given and creates a situation in which they are free to leave – because if they tried to they would be sectioned. Why is that different to *PJ*'s graphic description of what would happen if he broke the conditions of his conditional discharge.
2. Have an impact on the terms of care plans based on statutory powers? The approach in those two cases is that a statutory power for MHA purposes cannot be exercised to impose or create a deprivation of liberty unless that is expressly provided for. And this may give rise to the question how can this be lawfully done under powers that are directed to providing other care, supervision, treatment or support?

Sir William Charles

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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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Conferences

Conferences at which editors/contributors are speaking

Medical decision-making and the law

Tor is giving a speech at Green Templeton College in Oxford on 20 June on medical decision-making and the law. For more details, and to book (tickets are free but limited), see [here](#).

Human Rights in End of Life

Tor is speaking at a free conference hosted by Sue Ryder on 27 June in London on applying a human rights approach to end of life care practice. For more details, and to book, see [here](#).

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](#).

Liberty Protection Safeguards: Implementation of the Mental Capacity (Amendment) Act 2019

Alex is chairing and speaking at a conference about the LPS on Monday 23 September in London, alongside speakers including Tim Spencer-Lane. 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 July. 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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[For all our mental capacity resources, click here](#)