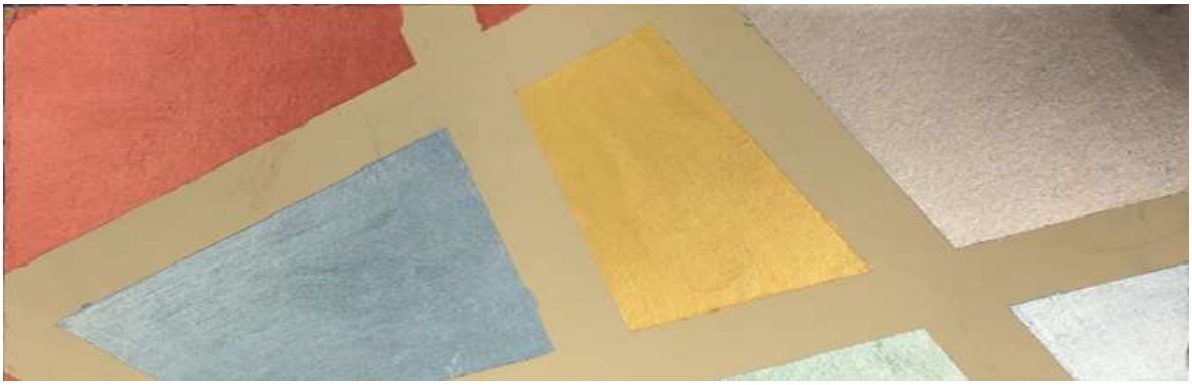
MENTAL CAPACITY REPORT:
HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

September 2020 | Issue 107



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

(1) In the Health, Welfare and Deprivation of Liberty Report: updated MCA/DoLS guidance, the anorexia Catch-22, and two important cases on deprivation of liberty;

(2) In the Property and Affairs Report: remote witnessing of wills, professional deputy remuneration and the OPG annual report;

(3) In the Practice and Procedure Report: CoP statistics, short notes on relevant procedural points and the UN principles on access to justice for persons with disabilities;

(4) In the Wider Context Report: the NICE quality standard on decision-making and capacity, litigation friends in different contexts, and a guest piece giving a perspective on living with a tracheostomy and a ventilator;

(5) In the Scotland Report: the human rights blind spot in thinking about discharge from hospital in the context of COVID-19.

You can find our past issues, our case summaries, and more on our dedicated sub-site here, where you can also find updated versions of both our capacity and best interests guides. We have taken a deliberate decision not to cover all the host of COVID-19 related matters that might have a tangential impact upon mental capacity in the Report, not least because the picture continues to change relatively rapidly. Chambers has created a dedicated COVID-19 page with resources, seminars, and more, here; Alex maintains a resources page for MCA and COVID-19 here and Neil has resources on his website here.

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

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

Contents

Updated DHSC MCA/DoLS Emergency Guidance

The DHSC's MCA/DoLS guidance has been updated on 7 September, in particular to make clear that remote assessment is not now expected to be the sole way of proceeding. In material part, the guidance provides that:

> *To carry out DoLS assessments and reviews, remote techniques can be considered, such as telephone or video calls where appropriate to do so, and the person's communication needs should be taken into consideration. Views should also be sought from those who are concerned for the person's welfare.*
>
> *Face-to-face visits by professionals are an important part of the DoLS legal framework.*
>
> *These visits should currently occur if needed, for example to meet the person's specific communication needs, urgency or if there are concerns about the person's human rights.*
>
> *When deciding whether or not to visit in person, DoLS best interests assessors and mental health assessors should work closely with hospitals and care homes to decide if visiting in person is appropriate, and how to do this safely. Visiting professionals should understand and respect their local visiting policies. Visitors must follow important local infection control policies in the setting that they visit, which are based on national government guidance.*
>
> *DoLS best interests assessors and mental health assessors should work collaboratively with hospital and care home staff. They should be mindful of their distinct, legal duties under DoLS.*

The additional guidance has also been updated to address the fact that in some cases testing and other necessary measures will be needed for the purposes of procedures like elective surgery.

> *For example, a person may lack the relevant mental capacity to consent to testing and self-isolation, before or after an appointment or surgery as an NHS inpatient. In this case, the decision-makers with responsibility for the person before and/or after the procedure, including family, care home staff and*

> *other professionals will need to work collaboratively with NHS professionals and consider what is in the person's best interests. They may conclude that it is in the person's best interests to follow infection control procedures mandated by the hospital, in order to ensure that the procedure goes ahead. Joint working and communication will be important in these cases, as the hospital will be dependent on these decision-makers, in care homes and other settings, to ensure that these decisions are taken and implemented at the right time.*

The additional guidance also reflects the expectation that, in line with assessors, RPRs should undertake face-to-face visits if needed, for example to meet the person's specific communication needs, urgency or if there are concerns about their human rights.

The updated guidance can be found alongside other relevant guidance on Alex's MCA/COVID-19 resources page here.

The anorexia Catch-22?

Northamptonshire Healthcare NHS Foundation Trust v AB [2020] EWCOP 40 (Roberts J)

Mental capacity – best interests – medical treatment

Summary

This case concerned a 28 year old woman, referred to as AB, who had suffered from anorexia nervosa since the age of 13. At the time of the application she was severely unwell, and her treating clinicians applied to the court for declarations that AB lacked capacity to make decisions '*about treatment relating to anorexia nervosa'* and that it was in her best interests not to receive any further active treatment, even though she was at imminent risk of death.

The only possible option for treatment was said to be forced feeding via a tube inserted into her stomach, with physical restraint and sedation required to prevent her from removing the tube. She would need to be hospitalised at least 6 months and sedated as often as twice a day. Neither AB nor her doctors thought this was in her best interests. The case therefore concerned the first question only, namely AB's capacity.

It was evident that AB understood that her life was at risk and what the risks and benefits of treatment were. She filed a written statement in which she discussed her illness and differentiated it from herself, saying that her decision to refuse treatment was '*a decision made by me as opposed to my illness'*. She said that she had suffered during previous hospital admissions and had been in a cyclical pattern of admission and discharge with no endpoint. She said she understood that she would die if she did not eat, and the physical risks of the possible treatment, but had realised that she would never defeat the illness and so had chosen her future path: *"the decision not to undergo further inpatient treatment is mine. The illness is a part of me, yes. It is a voice, yes. It is a bullying and powerful voice, yes. But the voice making this particular decision is mine. It is a voice made hoarse by screaming, and tearful by the prospect of being forcibly treated against my will – knowing all the while both that any such treatment may cause my death in any event, and that, even were it not to, the likelihood of it 'working' is minute. I do not believe that anyone would agree to undergo further inpatient treatment knowing what it entails, and if told, as I have been,*

that the chances of 'success' – whatever that actually means – are so low."

It was agreed that AB had capacity to conduct the proceedings, but not that she had capacity to decide to refuse treatment. The Trust said that AB lacked capacity on that issue because she could not '*weigh and use information in the limited sphere of decisions relating to her need to put on weight'*. Her beliefs about the need to reduce her calorific intake were '*overvalued ideas'* to which she attached such extreme levels of weight that she could not properly weigh in the balance other factors. In a previous assessment in 2019, she had said that having the eating disorder made her feel safe, numbed her emotions and gave her a sense of achievement, and that she feared she would not be able to cope with normal life. The medical view was that there was '*no prospect'* of recovery from anorexia for AB.

Having formulated the decision in question as being one concerning the need to put on weight, the court found that AB lacked capacity, as her fixed beliefs about eating and weight were more than just her subjective values, and were preventing her from carrying out an appropriate weighing or balancing exercise. Even though AB understood the options and the risks, her eating disorder *infected "to such a significant extent the very nature of her decision making processes which are engaged in relation to food, calories and weight gain that any decisions flowing from those processes cannot be considered as legally capacitous decisions*." So, even though AB did not give the wish to avoid putting on weight as a reason to refuse treatment, her capacity was still lacking. She "*may objectively appreciate that she will only avoid death in the weeks or months ahead if she finds the ability to overcome this illogical fear but she appears powerless to reach any other decision which will preserve her life. In my judgment, the fact that she does not want to die and sees many reasons to continue living are, in themselves, the clearest manifestation of the extent to which her judgment is impaired in relation to this narrow field of decision making."*

As a postscript, a possible appeal on AB's behalf against the finding that she lacked capacity did not proceed on her behalf following her death.

Comment

It was said on AB's behalf that the reasoning as to her lack of capacity meant that no-one with anorexia nervosa could ever be said to have capacity to make decisions about medical treatment for that condition or any related problem. The corruption of her view of reality caused by her eating disorder could not be disentangled from her decision-making, even by reframing the decision in question as one about whether to agree to in-patient admission or palliative care, rather than to put on weight, and so there was effectively a non-rebuttable presumption that people with severe anorexia lacked capacity to make treatment decisions. The submissions put on AB's behalf reflect the proposals set out in the article by Emma Cave and Jacinta Tan (2017). Severe and Enduring Anorexia Nervosa in the Court of Protection in England and Wales *International Journal of Mental Health and Capacity Law*, which sought to rescue some autonomy for people with anorexia nervosa. It is difficult to disagree with the authors of that article that the court's approach, repeated in a number of cases, does suggest that people with severe and enduring anorexia nervosa will not be able to demonstrate they

have capacity in relation to medical treatment or any other decision that touches on their illness.

The case is also of interest as being one of the situations Munby J (as he then was) thought vanishingly unlikely – where P has capacity to conduct proceedings but not to make the decisions in issue:

> *Whilst it is not difficult to think of situations where someone has subject-matter capacity whilst lacking litigation capacity, and such cases may not be that rare, I suspect that cases where someone has litigation capacity whilst lacking subject-matter capacity are likely to be very much more infrequent, indeed pretty rare. Indeed, I would go so far as to say that only in unusual circumstances will it be possible to conclude that someone who lacks subject-matter capacity can nonetheless have litigation capacity." (Sheffield City Council v E & Anor* [2004] EWHC 2808 (Fam)).

It is indeed difficult to see how AB could have capacity to give a solicitor instructions about a dispute about her capacity to make a specific decision, while simultaneously lacking capacity to make that decision, particularly when the basis for her incapacity was said to be an enduring and strongly held belief that infected all of her thinking.

Control, the acid test, and the policy of caution

A Local Authority v AB [2020] EWCOP 39 (Sir Mark Hedley)

Article 5 – deprivation of liberty

Summary

There have been very few cases concerning the meaning of deprivation of liberty in the context of adults since the immediate flurry of post-*Cheshire West* activity and the decision of the Court of Appeal in *Ferreira* about the position in relation to hospitals. The decision of Sir Mark Hedley in this case, handed down in late August 2020 but appearing on Bailii more recently, is therefore noteworthy. It is also noteworthy because it concerns the interaction between the two limbs of the 'acid test' set down by Lady Hale in *Cheshire West* to determine whether a person is confined.

AB was a 36 year old woman. She had been detained under the Mental Health Act 1983 and was then discharged under a Guardianship Order under s.7 MHA 1983 to a supported living placement. Her circumstances were described at paragraph 10 thus:

> *AB lives in a flat in supported accommodation where there is always support available at any time of the day and night. She is broadly at liberty to do as she pleases within her own flat. She is free to leave the accommodation but her leaving and returning will always be seen by a member of the supervisory staff simply because of the geography of the property. She is required to reside at that property and thus if she fails to return the police would ordinarily be notified. There is extensive support available to her but it is support for her to take up or not as she pleases. She has a long record of being unable to look after her own accommodation and accordingly staff will enter her flat for the purposes of inspecting, cleaning or repairing. Indeed they will often wait for her to leave in order to do that so as to cause the least possible distress to her. It follows that*

> *they have access to her property whenever they think fit.*

It was common ground (although this is not addressed in any detail in the judgment) that AB lacked capacity to consent to the arrangements in question; they were also clearly imputable to the state. The sole question referred to Sir Mark Hedley by the District Judge with conduct of the case, was therefore whether they amounted to a confinement so that all three limbs of the test for identifying a deprivation of liberty were made out. In answering that question, the issue in dispute was very narrow. It was common ground that the Guardianship Order (which included a condition of residence at the placement) meant that she was not free to leave the placement – the dispute was therefore she was also subject to continuous supervision and control so as satisfy the 'acid test,' Lady Hale having made clear that in *Cheshire West* that "[i]*t is possible to imagine certain situations in which a person is not free to leave but is not under such continuous supervision and control as to lead to the conclusion that he was deprived of his liberty."*

Sir Mark Hedley noted that he had been referred to two decisions of trial judges in the Family Division who have had to consider the question of deprivation of liberty (*Re RD (Deprivation or Restriction of Liberty)* [2018] EWFC 47 and *Re HC (a Minor Deprivation of Liberty*) [2018] EWHC 2961 (Fam)). However, whilst he considered these cases to be "helpful," he also noted at paragraph 9 that:

> *it is vital to bear in mind that they relate to young people who would in any event have been under the watchful eye and authority of concerned parents had they not been in public care. The case of an adult is very different, for part of the rights of an adult are to behave in ways which others might regard as foolish without those others having the right of interference. Thus what may only be a restriction of liberty in a young person may yet be a deprivation of liberty in an adult.*

The Official Solicitor contended that AB's circumstances amounted to continuous supervision and control; the local authority resisted that submission, arguing that "[t]*hat the voluntary nature of the support, the freedom to come and go as she pleases and her freedom of action once she has left the accommodation speak more powerfully of a lack of continuous control and supervision*" (paragraph 11).

As Sir Mark identified at paragraph 12, what made the case difficult was that both approaches were "*inherently reasonable. This is a case at the borderline and is, as the law of the European Court recognises, 'one of degree or intensity, and not one of substance or nature.' There is a judicial judgment required*."

Sir Mark was clear that the mere presence of a Guardianship Order with a condition of residence of itself would not amount to a deprivation of liberty, even if it must be recognised that it is a very significant restriction of liberty. There would have to be something more, which, after "very careful consideration" he found there to be in this case:

> *13.* […] *it seems to me that the question of supervision and control must be viewed in the context of the prescribed condition of residence. Thus whilst she may be free to leave the property as she chooses, she is always subject to state control requiring her return should she be*

otherwise unwilling to do so. The fact that she generally willingly returns does not of itself negate this point. Again whilst the supervision of her coming and going is not intrusive, it is the fact that all her movements are known and noted. Moreover, while she is free to do as she pleases in the community, there will inevitably be some obligation to restrain or control those movements should they become seriously detrimental to her welfare. That control could lawfully be implemented without recourse to the Court.

14. When considering a deprivation of liberty it is not sufficient just to see what actually happens in practice but to consider what the true powers of control actually are. Again the power to enter someone's private residence is a major intrusion on liberty however much, as it is here, it is to the benefit of the protected person for it to happen.

15. When looking at all these matters it is essential to consider them in the round and to ask whether in all the circumstances that actually prevail, or might reasonably come about, the arrangements amount to a deprivation of liberty. In my view they do here. In reaching that conclusion I have drawn upon the policy set out by Baroness Hale and that has, I should acknowledge, been a critical factor in my conclusion. However much these arrangements may be to the benefit of AB, and undoubtedly they are, one has to reflect on how they would be observed by an ordinary member of the public who, I strongly suspect, would regard them as a real deprivation of liberty. The policy that everyone should be treated the same leads me to the conclusion that I have set out.

It should perhaps also be noted that Sir Mark also made the observation (at paragraph 12) that "*supervision and control should be viewed as separate requirements in considering* [the acid] *test and the word 'continuous' applied to both*."

Comment

This decision is logically impeccable, following clearly as it does the logic of *Cheshire West* (which, itself did no more than repeat the test for confinement set out by the European Court of Human Rights in *HL v United Kingdom* at paragraph 91). It also sits clearly in the line of Strasbourg case-law such as *Ashingdane* and *Stanev*, both cases in which the ECtHR found that the person in question was deprived of their liberty even though they were subject to periods of time when they were on unescorted leave (of one form of another) from the place where they were required to reside. The case is therefore a helpful reminder that a leash can be long, but so long as it remains a leash, it should be characterised as such.

What this case does not answer – because it is not a question that has yet been tackled head-on by the courts – is whether and how it is legitimate to look to the concept of 'valid consent' to see whether it might give a different approach. Indeed, it is perhaps striking that because it was common ground that AB did not have capacity applying the MCA 2005 test to consent to the arrangements, there was no consideration all in the judgment of how AB might feel about them. Some might feel (and Alex certainly is one of those – see this paper) that we should listen more carefully to those who have determined to lack capacity, and to reach a determination of whether they are deprived of their liberty based upon whether the

circumstances amount to an overbearing of their will. We should emphasise that we have insufficient evidence in this case to be able to venture an opinion either way in AB's case, but there will definitely be other cases where we might have a clearer idea; this case also makes clear that attempts to 'rein in' *Cheshire West* in this context by arguing about the objective element are likely to face an uphill struggle.

Ducks, hats and deprivation of liberty – the Upper Tribunal grapples with conditional discharge

MC v Cygnet Behavioural Health Ltd and SSJ [2020] UKUT 191 (AAC) Upper Tribunal (AAC) (UTJ Jacobs)

Article 5 – deprivation of liberty

Summary

UTJ Jacobs has confirmed that the decision of the Supreme Court in *MM* [2018] UKSC 60 does not serve as a bar to the Mental Health Tribunal "coordinating" the discharge of a patient on conditional discharge with the provision of authority under the MCA to deprive her of her liberty. As UTJ Jacobs noted:

> *2. Every judge of the Upper Tribunal, the High Court and the Court of Appeal who has expressed a view has said this approach is permissible. The Supreme Court has declined to deal with the issue. No judge at any of those levels has said that it is not permissible. So what's the problem?*

He identified that there were three problems: (1) that not all First Tier Tribunal judges agreed; (2) whether the reasoning in *MM* undermined the reasoning in previous cases on patients who lack capacity, and in particular the reasoning of Charles J in *Secretary of State for Justice v KC and C Partnership NHS Foundation Trust* [2015] UKUT 376 (AAC), to the effect that authority to implement conditions selected by the MHA decision-maker giving rise to a deprivation of liberty could be given under the MCA; and (3) whether a patient's ECHR rights prevent the First-tier Tribunal from co-ordinating with the capacity decision-maker.

UTJ Jacobs did not have to address the first problem, as by his decision, binding on the First Tier judges, he would achieve consistency. Before turning to the second problem, he addressed the question as an issue of principle, helpfully encapsulating it in this way:

> *11.* […] *There are two regimes, governed by the 1983 Act and the 2005 Act. They deal with different things, but they are related. The mental health regime is concerned with detention on the basis of a mental disorder, a need to protect the patient or the public, and the availability of treatment in hospital. The mental capacity regime is concerned with the best interests of a person who lacks capacity to make decisions. Those are separate matters but they can interrelate. The mental health regime will involve a deprivation of liberty, and the mental capacity regime may do so.*
>
> *12. The difficulty arises at the point of transition as a patient moves from the mental health regime to the mental capacity regime. Suppose that a patient has a mental disorder that requires treatment for their benefit and the protection of others which could be given without the need to detain the patient*

> *under the mental health regime but only if the patient was not free to leave the place where they were living without being accompanied and supervised. The First-tier Tribunal has power to discharge a patient conditionally, but has no power to impose a condition that would involve a deprivation of liberty. The mental health regime requires the tribunal to take account of the possibility of treatment and protection being provided outside that regime, but how is that to be organised in a way that is compatible with the limited powers of the different decision-makers operating the two regimes? That is what underlies this case.*

UTJ Jacobs then undertook a review of the authorities, and noted that the Supreme Court in *MM* expressly did not deal with the issue of a patient who lacked capacity to consent to a deprivation of liberty; indeed, he considered that "[t]*he terms of paragraph 271 also show that it did not consider that its reasoning might have an impact on such a patient. Otherwise, paragraph 27 of its judgment would not have been worded as it was. But it left open the issue open for later cases to decide*." He therefore concluded that the Supreme Court's reasoning did not undermine Charles J's decision in KC which (UTJ Jacobs considered) was "*concerned with achieving a coherent interpretation of the 1983 and 2005 legislation in a way that was appropriate across the range of circumstances in which it might apply and did not leave gaps*" (paragraph 25). UTJ Jacobs considered Charles J's reasoning to be persuasive; he was equally persuaded by the judgment of Lieven J in *SR and JTA* [2019] EWCOP 28, which addressed the position from the perspective of the Court of Protection. He considered that it was "imperative" that the First-Tier Tribunal:

> 28. […] apply the 1983 Act in a way that allows a patient to be discharged if there are means by which the patient's case can be appropriately dealt with under other legislation. The 2005 Act is such legislation. If a patient's case is to be dealt with correctly under the 1983 Act and fairly and justly under the tribunal's rules of procedure, the tribunal is under a duty to find a way that allows both Acts to be applied in a co-ordinated manner.

He then turned to considering how the necessary "mental capacity arrangements" could be made. If authorisation had already been obtained (either by way of a DoLS authorisation where such was appropriate) or by way of an order from the Court of Protection, the tribunal could potentially proceed to a conditional discharge without further ado. Otherwise, he noted, there were two possibilities which had been canvassed – there might be other and better ones, but if there were he could not think of them, although he made

[1] *"27. Whether the Court of Protection could authorise a future deprivation, once the FtT has granted a conditional discharge, and whether the FtT could defer its decision for this purpose, are not issues which it would be appropriate for this court to decide at this stage in these proceedings. Assuming that both are possible, and therefore that there might be an incompatibility with article 14, read either with article 5 or with article 8, it would make no difference to the outcome of this case. The outcome of this case depends upon whether it is possible to read the words 'discharge … subject to conditions' in section 42(2) (dealing with the Secretary of State's powers) and 'conditional discharge' in section 73(2) (dealing with the FtT's powers) as including the power to impose conditions which amount to a deprivation of liberty within the meaning of article 5."*

clear that he did not intend to limit the Tribunal to these approaches if there was a more appropriate one.

The two approaches are:

1. "the different hats approach": i.e. the same judge sitting in the Court of Protection and in the First-tier Tribunal to ensure that all decisions could be made that would allow the patient to be conditionally discharged on appropriate conditions and with the benefit of a deprivation of liberty authorisation. This had been the suggestion of the Court of Appeal in *MM* (and also, although UTJ Jacobs did not mention this, the approach proposed by the Law Commission in its Mental Capacity and Deprivation of Liberty report, at 12.79), and UTJ Jacobs made clear that he considered that this was lawful and appropriate.

2. "the ducks in a row approach": i.e., if the "same hats" approach would not work, to adjourn, to make a provisional decision or to defer discharge in order to allow the necessary authorisation to be arranged (discussed further in *DC v Nottinghamshire Healthcare NHS Trust and the Secretary of State for Justice* [2012] UKUT 92 (AAC))

UTJ Jacobs noted that the choice between the two regimes:

> *32.* […] *may come to little more than a matter of preference for the tribunal. It may, though, depend on how sure the tribunal is that the mental capacity decision will be put in place and how confident it is of the terms of any such decision (the terms of the care package, for example).*

In terms of the third problem, the patient's ECHR rights, UTJ Jacobs had little hesitation in finding that it was, in fact, no such thing. Charles J had held that there was no breach of either Article 5 read in isolation or in combination with Article 14 by virtue of the existence of parallel proceedings (overseen by parallel courts). He accepted the argument advanced by the SSJ that the existence of s.17(3) MHA 1983 leave, which meant that capacitous patients could be transferred from hospital to another placement, meant that, in fact, there was no discrimination in favour of those lacking capacity. UTJ Jacobs could see "*no violation of the patient's rights in providing a procedural route that works within the limited mental health jurisdiction of the First-tier Tribunal and is in the patient's best interests. Quite the reverse*" (paragraph 34).

Comment

This judgment is helpfully clear as to the position and as to the potential options open in these parallel cases. Some, though, may want to read it in light of the observations of Charles J, now Sir William Charles, as to the impact of the decision in *MM*. In a speech given to the Judicial College (now to be found in the June 2019 Report), Sir William expressed deep concern at the use of the use of a back door route to bring about the imposition of what are, in effect, conditions dictated by the mental health decision maker in circumstances which he saw as contrary to the approach of the Supreme Court in *MM*. Given the reliance placed by UTJ Jacobs upon Charles J's decision in *KC*, it would have been of interest to see what UTJ Jacobs made of the fact that Charles J himself now considered – albeit extra-judicially – that the reasoning in that case had been

undermined by the Supreme Court's decision in *MM*.

The reality, of course, and as highlighted in the Report of the Independent Review of the MHA 1983 (at page 202) is that it is fundamentally problematic that it is necessary to have two parallel regimes. Parliament needs to be asked to consider whether it actually wants the MHA 1983 to be able to be used to authorise deprivation of liberty in the community (outside the scope of s.17(3) MHA 1983). If it does, then it should provide a regime which enables express consideration of this, and express recourse to one judge, sitting with one hat in one court. Until then, and whilst the approach of UTJ Jacobs in this case is undoubtedly helpful in terms of ensuring that – on the ground – individual patients are not stuck, the overriding impression remains that the ducks are wearing hats that do not fit.

Short note: what role clinical ethics committees?[2]

In *Great Ormond Street Hospital for Children NHS Foundation Trust v MX & Ors* [2020] EWHC 1958 (Fam), a medical treatment case concerning a 9 year old child, Roberts J had some important observations to make about clinical ethics committees. The case concerned treatment escalation in relation to a 9 year old child, who was at that point on the Paediatric Intensive Care Unit at Great Ormond Street Hospital. The observations – which are of wider relevance – are contained in two helpfully self-contained paragraphs:

21. Referral to Ethics Committee. During her latest admission to PICU X's case was referred to and discussed by the Applicant Trust Ethics Committee on 15th May 2020, where the consensus reached was that further invasive treatments, including renal replacement therapy, were not in X's best interests and that the focus should be on palliative care to maximise her comfort and quality of life prior to death. Although no external second opinions were sought this process, regrettably it did not involve the 1st and 2nd Respondents. I was told that there is no protocol or definitive guidance for the constitution and conduct of Ethics Committees, particularly as to the involvement of patients or their families in the meetings and decisions. Counsel for the child (through her guardian) drew my attention to the UK Clinical Ethics Network which on its website notes that "Current practice of most UK CECs does not usually involve patients or their families and carers in the committee's discussion but some committees have considered cases at the request of a patient's family or carer."[1] In addition I was referred to an article, Newson, Ainsley J. "The role of patients in clinical ethics support: a snapshot of practices and attitudes in the United Kingdom." Clinical Ethics 4.3 (2009): 139-145, which I have read.

22. I consider that a lack of involvement by patients and/or their families is itself an issue of medical ethics and I am most surprised that there is not guidance in place to ensure their involvement and/or participation. While it is a matter of common sense and good practice for medical professionals and members of a

[2] Note, Tor has not contributed to this, having been involved in the case.

> *multidisciplinary treating team to have discussions sans the patient or their relatives to enable an uninhibited and frank exchange of professional views and information without the need for the empathic, sensitive and supportive language used when speaking to patients and/or their families, the absence of any prior consultation or participation, cannot be good practice and should generally be unacceptable. Even at hastily assembled meetings there should be notice taken of the views of the patient and/or close relatives which could take the form of some written notes or letter submitted on their behalf. There should be guidance on patient/family participation and a clear protocol of how and when they are informed as to the arrangements being put in place for an Ethics Committee to meet along with being informed as to the outcome.*

These comments have provoked different reactions amongst ethicists: for contrasting views, see the blog posts by Daniel Sokol and Dominic Wilkinson/Michael Dunn. At a minimum, though, the observations by Roberts J are important in focusing attention on the question of what, precisely, the role of clinical ethics committees (or, as many are known, Clinical Ethics Advisory Groups) is in the type of complex decision-making that is ever-prevalent in the clinical setting in relation both to children and adults with impaired decision-making capacity.

DoLs in Wales

A joint report between the Care Inspectorate Wales and Healthcare Inspectorate Wales – delayed by COVID-19 – has now been published, looking at the position in 2018-19.

The key findings are:

- The total volume of applications received by local authorities increased by 6% in 2018-19. However, for health boards, the number of applications has remained relatively stable for the last two years.
- Roughly three quarters of applications sent to health boards are for urgent authorisations. Similarly, three quarters of applications sent to health boards are approved.
- The majority of DoLS applications are for individuals who are aged 65 or older.
- The vast majority of the applications that were refused were on the grounds of mental capacity. The authoriser required further evidence that the person lacked the mental capacity to make the decision in question before the DoLS application was accepted.
- Most Standard applications were not completed in 28 days. Supervisory bodies are unable to assure themselves that people's human rights are not being breached by being deprived of their liberty unlawfully.
- Very few people were referred to Independent Mental Capacity Advocates (IMCAs) or referred to the Court of Protection.

Amplifying this last point, a total of 64 referrals to the Court of Protection were made in 2018-19 from Wales. This is a fall of 18%, from 72 applications in 2017-18 to 59 in 2018-19. This means less than 2% of all DoLS in Wales were referred to the Court of Protection.

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Conferences

Members of the Court of Protection team are regularly presenting at webinars arranged both by Chambers and by others.

Alex is also doing a regular series of 'shedinars,' including capacity fundamentals and 'in conversation with' those who can bring light to bear upon capacity in practice. They can be found on his website.

Advertising conferences and training events

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

Our next edition will be out in October. 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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