



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

- (1) In the Health, Welfare and Deprivation of Liberty Report: vaccination; interim authority to treat pending a final order, and a further LPS impact assessment;
- (2) In the Property and Affairs Report: guidance following ACC for professional deputies;
- (3) In the Practice and Procedure Report: a checklist for international relocation, covert treatment and the courts, and recording of court proceedings;
- (4) In the Wider Context Report: decision-making and 16/17 year olds, FAQs following the *Devon* judgment on personal assessment, spotting coercion and control and the BIHR's resources for service providers;
- (5) In the Scotland Report: further developments relating to the Scott review, including an update from the Chair, and Scottish consideration of relocation.

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

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

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Vaccination and the Court of Protection

E (Vaccine) [2021] EWCOP 7 (Hayden J)

Best interests – medical treatment

The Vice-President of the Court of Protection, Hayden J, has given the first reported judgment on capacity and best interests in relation to the COVID-19 vaccine. Whilst the judgment is fact-specific, it gives some clear and important reminders of the approach to be taken to this question (see also in this regard our [vaccination guide](#)).

The issue arose in the context of ongoing proceedings concerning the residence and care arrangements for an 80 year old woman, E. E was resident at the time in a care home in which there had been a number of cases of COVID-19. On 8 January 2021, the local authority informed her Accredited Legal Representative (i.e. the lawyer acting for her in the proceedings) that she

was to be offered the vaccination on 11 January 2021. Her son objected to this, and her representatives made an urgent application for a declaration that it would be in her best interests to receive the vaccine at the next possible date (the slot on 11 January being missed in consequence of the son’s objection).

Capacity

In relation to the question of Mrs E’s capacity, Hayden J was directed to an attendance note of a video conversation between Mrs E, her ALR and her GP. It is worth setting out the relevant paragraph (10) of the judgment in full as to what the attendance note said:

During the call, Dr Wade, who is based at the surgery where Mrs E receives medical treatment, asked Mrs E if she remembered Dr Wade explaining that there was a dangerous sickness called coronavirus. Mrs E replied that she did

not. Dr Wade then asked her whether she remembered an earlier visit made by her and her colleague, Dr F, when they came to the care home to deliver injections to protect her against the virus. Mrs E did not reply. Dr Wade asked Mrs E whether she wanted the injection, to which Mrs E replied "Whatever is best for me. What do I have to do?". She was reassured by Dr Wade that she did not have to do anything at the moment, and that Dr Wade only wanted to know what Mrs E wanted. Mrs E repeated that she wanted "whatever is best for me". The conclusion of Dr Wade (which was not, in her assessment, in any way delicately balanced) is that Mrs E does not have the capacity to determine whether she should receive the Covid-19 vaccine offered to her.

Hayden J acknowledged the informality of the assessment, but was nonetheless satisfied that it was sufficiently rigorous, concluding that she was (1) unable to understand information concerning the existence of the Covid-19 virus and the potential danger it posed to her health; (2) unable to weigh information relating to any advantages or disadvantages of receiving the vaccine; and (3) could not retain information long enough to use it to make a decision, and that this was because of her dementia.

Of wider note is Hayden J's observation at paragraph 11 that:

Evaluating capacity on this single and entirely fact specific issue is unlikely to be a complex or overly sophisticated process when undertaken, for example, by experienced GPs and with the assistance of family members or care staff who know P well.

At paragraph 12, Hayden J recognised that assessment in the context of the pandemic and in relation to those in a care home posed an "challenge of unprecedented dimensions," but took the view that Dr Wade "got the balance entirely right. Her enquiries respected Mrs E's autonomy and delicately assessed her range of understanding."

Best interests

Hayden J directed himself first by reference to s.4(6), requiring him to consider, so far as is reasonably ascertainable, her past and present wishes and feelings, the beliefs and values that would be likely to influence her decision if she had capacity, and any other factors she would be likely to take into account if she were able to do so. He noted at paragraph 13 that:

Mrs E had, prior to her diagnosis of dementia, willingly received the influenza vaccine and is also recorded as receiving a vaccination for swine flu in 2009. I consider the fact that, when she had capacity, Mrs E chose to be vaccinated in line with public health advice, to be relevant to my assessment of what she would choose in relation to receiving the Covid-19 vaccine today.

He also noted that, whilst she lacked capacity to consent to receiving it, she had "articulated a degree of trust in the views of the health professionals who care for her by saying to Dr Wade that she wanted 'whatever is best for me'". Hayden J considered that it was important to emphasise this statement "particularly as it has been repeated. This is to respect Mrs E's autonomy, which is not eclipsed by her dementia. Moreover, her straightforward and uncomplicated approach resonates with the trust that she has placed in the

medical profession in the course of her life, illustrated by her earlier reaction to vaccination."

Her son, whose views had to be considered by virtue of s.4(7), was "deeply sceptical about the efficacy of the vaccine, the speed at which it was authorised, whether it has been adequately tested on the cohort to which his mother belongs, and, importantly, whether his mother's true wishes and feelings have been canvassed. He also queries whether the tests have properly incorporated issues relating to ethnicity" (paragraph 15 – her ethnicity is not disclosed in the judgment). It is perhaps important to note that W told the court that he did not object to the vaccination in principle: he just did not consider that now was the right time for his mother to receive it.

At paragraph 15, Hayden J made clear that he respected W's right to his own views, but that:

they strike me as a facet of his own temperament and personality and not reflective of his mother's more placid and sociable character. It is Mrs E's approach to life that I am considering here and not her son's. Mrs E remains, as she must do, securely in the centre of this process.

More broadly, Hayden J recognised that:

17. [...] the world faces the challenge of an alarming and insidious virus. Nobody can possibly have missed the well-publicised and statistically established vulnerability of the elderly living in care homes. I have had many occasions to confront it, in the Court of Protection, over the course of the pandemic. For the avoidance of doubt and though no epidemiological evidence has been presented, I take judicial note of the particularly high risk of serious illness

*and death to the elderly living in care homes. In stark terms the balance Mrs E, aged 80, must confront is between a real risk to her life and the unidentified possibility of an adverse reaction to the virus. This risk matrix is not, to my mind, a delicately balanced one. It does not involve weighing a small risk against a very serious consequence. **On the contrary, there is for Mrs E and many in her circumstances a real and significant risk to her health and safety were she not to have the vaccine administered to her.*** (emphasis added)

At paragraph 18, Hayden J identified the following characteristics which compounded Mrs E's vulnerability to becoming seriously ill with, or die from, Covid-19: (1) she was in her eighties; (2) she was living in a care home; (3) the care home in which she lives had confirmed recent positive cases of Covid-19; (4) she had been diagnosed with Type II diabetes; and (5) she lacked the capacity to understand the nature or transmission of Covid-19 and was "inevitably challenged, as so many living with dementia in care homes are, by the rigours of compliance with social distancing restrictions." In the circumstances, his conclusion is perhaps not a surprise:

19 It is a fact that Mrs E lives in a country which has one of the highest death rates per capita, due to Covid-19, in the world. By virtue of her vulnerabilities, the prospects for her if she contracts the virus are not propitious; it is a risk of death, and it is required to be confronted as such. The vaccination reduces that risk dramatically and I have no hesitation in concluding that it is in her best interests to receive it. Accordingly, I make the declaration, sought by Mrs E's

representatives, pursuant to section 15 MCA 2005. I would add that, in the light of the Covid-19 outbreak at the home, I consider that Mrs E should receive the vaccine as soon as practically possible. I have delivered an ex tempore judgment on this application in order to avoid any further delay.

Comment

It is important to note that this judgment is fact-specific, although more broadly relevant are: (1) the observations about the nature of the consideration of capacity; and (2) the approach to best interests (in particular the focus on the person, rather than on the views of their family/others interested in their welfare, save insofar as those views shed light on the person's likely decision). It undoubtedly helped in this case that Hayden J had what on the face of the judgment appeared to be reliable evidence to help make clear that this was a situation in which it was likely that, had Mrs E had capacity to make the decision, she would have consented to the vaccination. To that end, the judgment reinforces the importance of ensuring – as clearly had taken place here – that the process of considering capacity and (where required) best interests takes place in advance of the proposed vaccination so that there can be as little doubt as possible as to what **on an individual basis** is the right decision to take.

Finally, it should be noted that even if W had been granted Lasting Power of Attorney by his mother to make decisions in relation to her health and welfare (which it is clear from the judgment he could not have been), what would no doubt have been his refusal on her behalf to agree to the vaccination would not necessarily have been the end of the story. If discussion with him – in

particular discussion aimed at ensuring that he understood that his role was to consider what decision she would have taken, not what decision he wanted to take – did not resolve the position, those involved would have had to consider whether to take the matter to the Court of Protection. At that point, the Court of Protection would have had to make the decision on her behalf – taking due account of W's views (and the weight to be given to the fact that she had trusted him with decision-making in relation to health and welfare), but proceeding ultimately by what was in her best interests.

Getting the stages of the capacity test in the right order (and where rights, will and preferences do not pull in the same direction)

Pennine Acute Hospitals NHS Trust v TM [2021] EW COP 8 (Hayden J)

Best interests – medical treatment

In this case, Hayden J considered an urgent application made by the Pennine Acute Hospitals NHS Trust in respect of a male patient, TM. It was not possible to be entirely accurate about TM's age, but he was thought to be 42, and was believed to come from Zimbabwe. The applicant Trust was seeking to perform a bilateral below-knee amputation upon TM, without which his treating clinicians believed he would develop sepsis and suffer life-threatening renal and cardiac failure very soon. TM strongly objects to the proposed surgery and treatment, and says he believed that his condition would improve without it.

In the course of his judgment Hayden J observed, as he has on previous occasions, that

"[o]ne of the surprising developments following the Court's move to video conferencing platforms during the pandemic is that it has become much easier for judges to visit the protected party." With the agreement of the parties, he met remotely with TM, and observed him on the ward with one of his doctors; his short meeting confirmed everything that his treating consultant understood, namely that he was not man who wished to die; rather, he was a man who had consistently maintained, and Hayden J considered genuinely to believe that he would get better without treatment. Unfortunately, however, *"that possibility is entirely irreconcilable with the medical evidence"* (paragraph 25).

In relation to TM's capacity, Hayden J emphasised that it is the ability of the person to take the decision, not the outcome of the decision which is the focus, and that *"[t]his cornerstone of the court's assessment of a person's capacity to make a decision for him or herself remains equally applicable where the outcome of the person's decision is an untimely and unpleasant death"* (paragraph 29). Somewhat tantalising, as he did not develop this line of reasoning more, Hayden J went on to say in the next paragraph *"[h]owever, it does not follow that the outcome of a decision is wholly irrelevant to the court's assessment of capacity where a person's ability to understand and weigh the consequences of a decision is in contention."*

The Official Solicitor initially agreed with the Trust that KM lacked capacity to decide upon the amputation, but then contended that the Trust had failed to adduce sufficient evidence to displace the presumption. Counsel for the Official Solicitor emphasised that:

32. [...] on each occasion that TM has

been asked about amputation and treatment, he has declined it. He has consistently refused the procedure. But what is significant to my mind is the fact that, equally consistently, he has been unable to acknowledge the consequences of refusing treatment. Indeed, it is plain to me that he does not take on board those consequences or understand them; he simply insists that, in fact, he will get better without further treatment. This puts TM in a fundamentally different position from a patient who, having understood that refusing treatment would very likely lead to their death, nevertheless considers this preferable to the consequences of receiving the treatment.

On the evidence before him Hayden J found that TM's treating consultant was correct to conclude that TM lacked the ability to understand and weigh the information necessary to consent to the amputation because he genuinely and honestly believed that he would get better without medical intervention.

Of no little interest is the fact that the Official Solicitor also submitted that TM should be found to have capacity because the Trust had not demonstrated on the balance of probabilities that TM's inability to contemplate the consequences of refusing treatment was because of an impairment or disturbance in the functioning of his mind or brain. A number of reasons had been advanced by his treating consultant, and Hayden J considered at paragraph 37 that it was

[...] clear therefore that there are a number of identified pathologies which separately or in combination are likely to explain the disturbance or functioning in

TM's mind or brain. It might well have been possible to be more precise if TM had been able to cooperate with the MRI scan. It is a misunderstanding of section 3 MCA 2005 to read it as requiring the identification of a precise causal link when there are various, entirely viable causes. Insistence on identifying the precise pathology as necessary to establish the causal link is misconceived. Such an approach strikes me as inconsistent with the philosophy of the MCA 2005. What is clear, on the evidence, is that the Trust has established an impairment of mind or brain and that has, in light of the consequences I have identified, rebutted the presumption of capacity.

As to best interests, Hayden J noted that there "would in some circumstances be force" in the Official Solicitor's submission that TM's resistance had been so consistently expressed that his wishes should be respected notwithstanding his lack of capacity, and that in WA and MSP he had taken that approach. However, Hayden J considered that in both of those cases that it was significant that in his analysis the person concerned recognised that refusal of treatment would lead to certain death. By contrast, TM did not recognise this "[a]s I have been at pains to emphasise, the life force beats very strongly within him. TM wants to live. He has an entirely misguided belief that he will recover without any treatment. The pervasiveness of this misguided belief contracts and substantially diminishes the weight that might, in other circumstances, properly be given to consistently expressed wishes" (paragraph 39). He also found that neither of the possible other arguments against treatment advanced by the Official Solicitor (a likely lack of support following the amputation given his

social isolation and the length of time TM would need to spend in hospital following the operation) carried weight. He agreed with Counsel for the Official Solicitor that "a bilateral amputation for a relatively young man of around forty-two, and who has enjoyed sports, is a profoundly traumatic prospect. I can understand that some individuals may not feel they have the fortitude to cope with such a disability and may choose not to. This would be their choice and the Court would respect it. I can find no cogent evidence that this reflects TM's thinking. For the reasons I have set out above, I do not consider it does." Although Hayden J did not, in fact, expressly reach this conclusion, it is clear that he found that the procedure would be in TM's best interests.

Comment

In relation to capacity, this is a good opportunity to remind people that the Code of Practice is wrong when it talks of a two stage test, starting with a diagnostic element. Rather, the law requires, as Hayden J followed here (and the Code of Practice should in due course reflect when it is updated), an analysis starting with the question of whether the person is able to make the decision (i.e. understand, retain, use and weigh the information relevant to the decision, and to communicate that decision). It is only if they cannot do so – having been given all practicable support – that the question arises of why they cannot do so, which then leads to the analysis of whether that inability is because of an impairment or disturbance in the functioning of the mind or brain (incapacity for purposes of the MCA 2005) or because of some other factor (potentially a situation to be considered by the

High Court under its inherent jurisdiction in relation to vulnerable adults). This decision is useful for highlighting that if there are multiple potential impairments in play, the fact that it is not possible to pinpoint exactly which one is causing the functional inability does not mean that the test for incapacity cannot be satisfied. For further guidance as to assessing and recording capacity determinations, see further our guidance note.

In relation to the decision as to TM's best interests this might, yet again, be thought to be in a situation which brings to life the realities of the duty under Article 12 UNCRPD to "respect the rights, will and preferences" of the individual in circumstances where they do not all pull in the same direction. To act upon TM's very clear preference – not to have the procedure – would have been to fail to respect both his will (to live) and his rights (including his positive right to life under Articles 2 ECHR and 10 CRPD, which would clearly have been breached had those involved simply acted upon his 'no' in the circumstances).

Deprivation of liberty, family members and what s4B does (and doesn't) say

Re AEL [2021] EWCOP 9 (SJ Hilder)

Article 5 ECHR – deprivation of liberty

In this case, SJ Hilder considered very strong objections levelled by a family member to the idea that they were depriving their adult child of their liberty. She also helpfully clarified the current (limited) scope of s.4B MCA 2005.

AEL was a 31 year old woman with diagnosis of Trisomy 4p syndrome, a rare chromosomal condition leading to a number of physical and

mental disabilities. She had severe learning disability, significant visual impairment and profound deafness. She suffered from asthma, eczema and severe allergies. She was non-verbal and could only walk short distances. She did not have a regular sleep pattern. At times, she behaved in a way which caused herself injury. From a young age AEL she had attended a specialist school, latterly living in a residential unit under the school's management. When that placement closed in July 2015, after a few months in an alternative placement, she returned to live in the family home with her parents. Since 2016 a care package had been funded by direct payments.

The local authority, LB Hillingdon, assessed AEL as needing 24-hour care and supervision, with 2:1 support for some activities in the community. In addition to her parents, two private carers were consistently involved in AEL's care for some time. She did not require sedation or restraint, and no assistive technology is used in her care arrangements. If the current level of care was not provided, the local authority considered that AEL would be a danger to herself and others because she had no concept of road safety, was unable to alert others to her needs, and was unable to manage her own nourishment or hygiene.

In light of the arrangements for AEL, to which it appeared to be clear that she could not consent, LB Hillingdon, had applied for a so-called community DoL order; at an attended hearing in 2017, the parties agreed, and the court declared that "in so far as AEL's care arrangements amounted to a deprivation of her liberty," such was authorised by the court." This was a compromise to avoid unnecessary litigation but

also ensure appropriate oversight of AEL's circumstances. Unfortunately, that compromise led to extended disagreement at each review hearing as to whether or not the arrangements did, in fact, amount to a deprivation of her liberty. SJ Hilder identified that it was "everyone's ardent wish that further such proceedings can be avoided. The purpose of this judgment is therefore to determine the issue, for as long as AEL's current care arrangements subsist" (paragraph 3).

The hearing took place in the absence of AEL's father (the court being satisfied that he had chosen not to participate), but on the basis of a very clear understanding as to his position, namely that it was "obvious to him that AEL 'is not the subject of 'continuous control'... [...], given that his approach to his daughter's care is founded on 'the principle' that 'AEL decides what she wants to do and when she wants to do it excepting if her safety could be compromised'" (paragraph 21). JSL, who represented himself, considered that the exception to giving effect to AEL's wishes if her safety could be compromised was "allowed by the Mental Capacity Act 2005 and as such not considered a deprivation of liberty," Senior Judge Hilder noting that this appeared to be based upon his understanding of s.4B MCA 2005.

Seeking to persuade SJ Hilder that his daughter's circumstances did not amount to a deprivation of liberty, JSL relied upon three cases. SJ Hilder identified that "there is limited usefulness in comparing facts of reported cases, since whether or not a deprivation of liberty exists is to be determined on the facts of each specific case and not by analogy. In any event, in my judgment, the three authorities on which JSL relies in truth do not assist him" (paragraph 42). The

three authorities were:

a. *W City Council v. L* [2015] EWCOP 20:

Mrs. L continued to live in the home where she had lived before she lost capacity. Bodey J identified (at paragraph 8) the facts relied on for considering that her care arrangements amounted to a deprivation of Mrs L's liberty as that:

(a) the garden gate is kept shut, thereby preventing or deterring her from leaving the property unless escorted;

(b) door sensors are activated at night, so that Mrs L could and would be escorted home if she left; and

(c) that there might be circumstances in an emergency, say if the sensors failed to operate at night, when the front door of the flat might have to be locked on its mortice lock, which Mrs L cannot operate (as distinct from the Yale lock, which she can). She would then be confined to her flat;

and noted (at paragraph 14) acceptance even by the applicant that there are periods of the day when Mrs L was left to her own devices. Carers' visits three times a day were described (at paragraph 26) as "the minimum necessary for her safety and wellbeing, being largely concerned to ensure that she is eating, taking liquids and coping generally in other respects." Bodey J concluded that the restrictions in place "are not continuous or complete. Mrs L has ample time to spend as she wishes."

Mrs. L's arrangements are markedly different to AEL's. There is no factual basis for contending that the same

conclusions should also be drawn in respect of AEL.

b. Bournemouth BC v PS & DS [2015] EWCOP 39:

Mostyn J identified (at paragraph 14) that the subject of the proceedings, Ben, had some privacy, including periods of free unsupervised access to all parts of the bungalow where he lived and the garden; and (at paragraph 33) that "he is free to leave. Were he to do so his carers would seek to persuade him to return but such persuasion would not cross the line into coercion."

At paragraph 16 there is reference to a social worker acknowledging that "[i]f Ben was unescorted in the community it is highly likely he would walk out into the road..." and so he is escorted and "staff would intervene should he put himself at risk of significant harm." In the following paragraph Mostyn J noted that the social worker "accepted under cross-examination that such an act of humanity could not amount to a deprivation of liberty, and I emphatically agree." It may be that JSL is particularly focussed on this vignette.

However, care arrangements must be considered as a whole package. The "act of humanity" vignette in the context of the wider arrangements for Ben is clearly different to "the principle" which JSL says underlies AEL's care. The supervision and control of the activities which AEL is permitted to choose is more generalised than a response to immediate danger, as is seen clearly in JSL's account of the difficulties which the covid pandemic have brought for AEL. Again, there is no factual basis for contending that the Bournemouth BC v PS &

DS conclusions should also be drawn in respect of AEL.

c. Rochdale MBC v. KW [2014] EWCOP 45:

The third case relied upon by JSL was a first instance decision of Mostyn J which was overturned by the Court of Appeal. The appeal was allowed by consent, with a statement of reasons attached to the approved order recording that

'The reason for inviting the Court of Appeal to allow the appeal by consent is that the learned judge erred in law in holding that there was not a deprivation of liberty. He was bound by the decision of the Supreme Court in P (by his litigation friend the Official Solicitor) v Cheshire West and Chester Council and others [2014] UKSC 19, [2014] AC 986 ('Cheshire West') to the effect that a person is deprived of their liberty in circumstances in which they are placed by the State in a limited place from which they are not free to leave. It is accepted by both parties on facts which are agreed that this was the position in the case of KW.'

In a subsequent judgment reported at [2015] EWCA Civ 1054, following Mostyn J's second consideration of the matter, the Court of Appeal confirmed (at paragraph 31) that the Supreme Court had settled the question of what amounts to deprivation of liberty and accordingly Mostyn J's analysis "was, and could be, of no legal effect. It was irrelevant."

SJ Hilder found that it was clear that:

46. The law is now settled, and the facts of AEL's care arrangements are not in

dispute. Viewed objectively, the key aspects of AEL's experience are that:

a. she requires, and is given, 24-hour care and supervision - she is never "left to her own devices" but is accompanied by carers at all times; and

b. although she is regularly given the opportunity to make choices, and carers generally strive to facilitate realisation of her choices, there is an acknowledged limit to AEL's ability to do what she wants – ultimately, all the activities she undertakes are risk assessed by AEL's parents and/or carers [...] and "the principle" of such assessment is that they may decide not to allow her to do anything which they consider could compromise her safety.

This meant, SJ Hilder, found that:

47. In my judgment, these two aspects of AEL's living arrangements clearly amount to "continuous supervision and control." Even if carers are available and willing to take AEL to McDonald's at whatever hour she wishes, she is not "free to leave" their care. The reality of her disabilities is that AEL's safety is permanently at risk unless she has support. Therefore, she has 24-hour support and she is thereby under continuous control in the sense that her freedom may be interfered with at any moment. The intention may be benevolent; the arrangements may indeed ensure that she has a much happier, healthier and longer life than she would otherwise have; but "a gilded cage is still a cage." The 'acid test' of deprivation of liberty is made out."

SJ Hilder found that JSL was wrong in his understanding of the impact of s.4B MCA 2005.

At paragraph 34, she had made clear that

It is important to understand that that sections 4A and B do not provide a general, unrestricted authority to deprive a person of their liberty if that is considered necessary to maintain their safety. The three "conditions" must be fulfilled before it applies. So, section 4A sets out the statutory basis of authorisation to deprive someone of their liberty; and section 4B permits deprivation of liberty wholly or partly consisting of limited acts for limited purposes whilst a decision is sought from the court. (emphasis in the original)

This meant, she reiterated at paragraph 48, that s.4B could not be interpreted as a stand-alone provision as "unrestricted authority to deprive a person of freedom of action whenever a third party considers her safety is at risk."

SJ Hilder looked at AEL's circumstances in the round, with regard to the "underlying principle" of *Cheshire West* - what it means to be deprived of liberty must be the same for everyone. She noted that, "[a]lthough I have not asked him, rhetorically I invite JSL to consider how he would categorise AEL's living arrangements and "the principle" if they were applied to him. I strongly suspect that he, and ordinary members of the public, would consider such arrangements to deprive them of their liberty) (paragraph 49). Finally, and as Sir Mark Hedley had done in *A Local Authority v AB*, SJ Hilder had:

50. [...] regard to the "policy" of Cheshire West. However benevolent AEL's carers, however much all relevant parties consider that the current arrangements for her care are in her best interests,

AEL's disabilities make her vulnerable. If there is any room for doubt as to whether or not AEL's living arrangements are a deprivation of her liberty (which in my judgment there is not), as Baroness Hale identified, we should err on the side of caution. AEL should have the benefit of a periodic, independent check that arrangements continue to be in her best interests. Such requirement is not to stigmatise her or her loving family, but quite the opposite – to ensure recognition of her equal dignity and status as a human being. (emphasis added)

Comment

On a procedural point, it is perhaps of some note that it is arguable that the court should not have made an order on the “in so far” basis in 2017 – the Court of Appeal in *Re KW* had had doubts about the wording in the then-template order (“to the extent that the restrictions in place pursuant to the Care Plan amount to a deprivation of [X's] liberty, such deprivation is hereby authorised”), because it left ambiguous what the court was holding. It said that it would be “*undoubtedly preferable*” to use the wording that “*P is deprived of liberty as a result of arrangements in the Care Plan and these are lawful*” (paragraph 18). It is clear, however, that the court was seeking to avoid unnecessary disagreements by the compromise wording used, even if, sadly, as so often is the case, it is clear in retrospect that grasping the nettle at the outset would have caused less pain all round.

More substantively this case, as with *AB*, is a clear indication that the courts (at least in those decisions which are reported) are loyally following the Supreme Court’s policy in *Cheshire West*. This decision is of particular interest

because SJ Hilder took on and carefully distinguished three cases sometimes relied upon to narrow the scope of that decision, and made clear that, in truth, they do not provide a sound basis to do so.

One real irony of this judgment, given the intense focus upon AEL’s circumstances, is that the approach apparently mandated by the Supreme Court means that there is no attention paid to AEL’s wishes and feelings in determining whether or not she is deprived of her liberty. Those wishes and feelings were not ignored by the court, given that there was clear agreement that the arrangements for her were in her best interests. We might wonder, though, whether recognition of AEL’s dignity and status as a human being might not lead us to allow those wishes and feelings to decide whether her will is being overborne (which is, at the end of the day, the conception of deprivation of liberty which the European Court of Human Rights appears to have).

Finally, the discussion of s.4B serves as a useful reminder of a health warning that has to be given about legislation.gov.uk. This otherwise wonderful website has the [text of the MCA 2005](#) including those amendments introduced by the Mental Capacity (Amendment) Act 2019. What is – annoyingly – unclear from the version of the MCA on the legislation.gov.uk website is that these amendments are not yet in force. When those amendments come into force in 2022, s.4B **will** provide a standalone power to deprive someone of their liberty in an emergency (to provide life-saving treatment or prevent a serious deterioration in their condition). At present, though, s.4B is only relevant (in this context) where an application has been made to

the Court of Protection.

Deprivation of liberty – paying the price

LB Haringey v Emile [2020] MHLO (CC) (County Court, HHJ Saggerson)

Summary¹

This is a rare example of a contested determination of damages for deprivation of liberty in the context of DoLS. It arose out of a claim by the local authority for unpaid care home fees in respect of Ms Emile, who was placed in a care home by it in 2008 in the context of concerns about her welfare. The local authority took no steps to authorise the deprivation of liberty at that time or at the point when her placement was made permanent in 2010. She remained there until 2016 when she was moved to a nursing home, her condition having deteriorated; a DoLS authorisation was obtained at that point. Care home fees remained outstanding between 2013 and 2017. Ms Emile counterclaimed (by her litigation friend) for wrongful detention on the basis that, as she had lacked capacity to make decisions as to her residence, and the local authority required authority to take the steps which had done; as it had not sought that authority, it had no authority to detain her. Importantly, the local authority's argument in response was that, even if she had lacked capacity and been wrongfully detained, the failure to undertake the correct processes to authorise her detention was only a technical breach of the appropriate safeguards and protocols and proper authorisation would have inevitably followed had the local authority appreciated her lack of relevant capacity in

2008. The local authority contended, therefore, that this was a case for only nominal damages.

At first instance, the District Judge held that this was not a case for nominal damages. Whilst he allowed the local authority's claim for unpaid care home fees, he awarded Ms Emile the sum of £130,000 on the counterclaim for damages for unlawful detention for the entire period claimed plus a 10% uplift based on *Simmons v Castle*, amounting to £143,000.00. The local authority appealed on the basis that (1) the District Judge was wrong to find that this was a case for nominal damages and (2) the award of damages was excessive (other grounds of appeal related to interest and costs, which are less relevant here).

On appeal HHJ Saggerson identified that it was clear that the District Judge had found that there were options short of (or other than) residential care, so the District Judge found, on the basis of the family's evidence that he accepted, that were not fully considered by the local authority. He decided that this all derived from the fact that the local authority thought that Ms Emile had capacity to make her own residential decisions rather than a conscientious consideration of less intrusive options including family options. HHJ Saggerson found that the District Judge was entitled to bear in mind that the personal reflections of Ms Emile tended to depend on who she was talking to as he was entitled to have in mind her historical preference not to be consigned to a care home.

This was the foundation of the District Judge's conclusion that this was not a case for nominal

¹ Note, this case does not appear on Bailii. It comes via the Mental Health Law Online website, and we

understand, in turn that it was provided by Leonie Hirst, Counsel for Ms Emile.

damages:

20. [...]. He was plainly satisfied on the facts that care home 9 residence was not inevitable despite the Defendant's difficult and deteriorating condition and the complications presented by a struggling husband up to 2013. He was entitled so to conclude particularly as the burden of demonstrating that care home residence was inevitable (from whatever date) was on the local authority. The reality was that the Defendant's position was not reviewed at all between 2010 and 2016. The District Judge obviously considered this to be a further significant failure on the part of the local authority. So it was.

21. The District Judge was entitled to conclude that the local authority's failure to comply with the Mental Capacity Act 2005 particularly with regard to the best interests provisions of Schedule A1 were substantial and causative of harm. He was entitled to conclude as he plainly did that the local authority had not proved that it was inevitable that the Defendant's care would have been the same had the statutory framework been properly deployed in 2008 or at any other time before August 2016 and that it was speculative to proceed on the basis of what the Court of Protection might or might not have done had a challenge been initiated. He was entitled to proceed on the basis that the local authority's failures were more than merely technical ones.

Turning to the quantum of damages, HHJ Saggerson identified that the question of whether the award "so far off the wall or was based on inappropriate considerations such as to warrant reassessment" (paragraph 23). The

Circuit Judge noted (at paragraph 24) that:

The District Judge did not apply a tariff. He did not award monthly damages and in doing so fail to taper the award. All he did was to try and maintain his bearings by a broad comparison with cases such as Neary with appropriate adjustments. He awarded a single lump sum covering a very long period of time, implicitly recognising that over such a long period of time there would be ebbs and flows with regard to the harmful impact on [Ms Emile] within that period.

HHJ Saggerson held that it was:

24 [...] impossible to criticise the District Judge for concluding that such a long period of time is likely to yield a significant sum of money in compensation once he had decided that it was not a nominal damages case. I do not consider that the "lump sum" approach is open to challenge in principle. I doubt that the District Judge considered that in adopting this approach there was any risk that others might crudely divide his total by 94 equal months in a forlorn attempt to find some sort precedent or benchmark.

In an important passage, HHJ Saggerson observed at paragraph 25:

In assessing the damages the District Judge was entitled to bear in mind that for nearly 8 years the local authority had been unwittingly officious and had overridden properly formulated considerations of the Defendant's best interests and the potential this yielded for trespassing on her freedom of movement more than was essential in the light of family or other supported residential

options that could have been considered short of consigning her to a care home. He was entitled to bear in mind that historically the Defendant had expressed a firm preference not to live in a residential home and that for 6 years the local authority had not properly reviewed the Defendant's status; neither had the position been properly reviewed after the death of her husband in 2013. Any award would also have to take into account, as did the District Judge, the fact that in her declining years the Defendant was unlawfully subject to routine direction by residential staff, had her daily life and visits subjected to a formal regime and contact with family subjected to official approval (however benign), or at least there was a greater degree of control than the family's evidence would have warranted. These are all real consequences of a confinement albeit falling short of being locked down or physically restrained.

At paragraph 28, HHJ Saggerson observed that, if “[i]f the submission was that the damages awarded were very generous; on the high side or even at the very top end of the permissible range for this sort of ‘benign’ confinement I would be inclined to agree.” But that was not the test on appeal, and the award was not so disproportionate to the harm suffered by Ms Emile. as to warrant its being set aside: “[t]he District Judge was not only entitled, but obliged, to take into account the fact that as a result of the local authority’s failures the Defendant’s freedom was unlawfully compromised for the greater part of the last decade of her life where less intrusive options of accommodation and care should have been considered. The good intentions and benign motives of the local authority are scant consolation to the person deprived of their liberty.”

HHJ Saggerson made the important observation that comparison with personal injury damages (which the local authority sought to draw to identify that the damages award had been excessive) were necessarily inexact:

30. [...] Comparisons with personal injury damages are only likely to be of some assistance in those cases where there has been short term incarceration where the shock element of the immediate loss of freedom is of particular importance and comparable to small personal injury claims for anxiety and distress. In addition the District Judge was entitled to bear in mind, as he obviously did, that limits on a citizen's freedom of movement in circumstances that are not lawful, warrant appropriately substantial damages.

At paragraph 31, addressing an argument that many local authority readers may have in their minds, HHJ Saggerson identified that:

the fact that the local authority perceives itself to be beleaguered by what it may see as the shifting sands of guidance and continuing changes in emphasis regarding their legal obligations under 13 DoLS standards with significant impact on its resources, these factors do not disclose any error of law or principle on the part of the District Judge and are not grounds for reducing any damages awarded.

Interestingly, the case was framed on the basis of unlawful detention – i.e. the common law tort. It was common ground, HHJ Saggerson identified, that “Article 5 adds nothing in relation to the quantum of damages in the event that substantial damages are awarded. The point, therefore, does not fall for consideration in the

present appeal" (paragraph 34).

Comment

This case, coincidentally, came onto our radar at the same time as the LGO's decision into complaint against Cheshire East Council ([19 010 786](#)) where the local authority supervisory body failed to provide a DoLS authorisation for the first 11 months the complainant's father was in a care home. The Ombudsman found that the Council was at fault for not processing the (timely) DoLS authorisation applied for by the care home for 11 months, but that this fault "*did not cause Mr Y injustice. During the period of delay Mr Y was cared for in an appropriate environment and several best interest decisions confirmed it was in his best interests to stay at the Care Home, despite no DoLS authorisation being in place. I do not consider the fault caused Mr Y to lose the opportunity to be cared for at home or in a different care home*" (paragraph 50). However, the Ombudsman identified that:

56. As it seemed that the DoLS application for Mr Y may have been delayed significantly, I considered this might be a wider issue and that the Council's handling of DoLS applications may have caused injustice to other members of the public. I used our powers under Section 26D of the Local Government Act 1974 to look wider than just Mr X's complaint.

Having obtained evidence from the Council about its triage policy for DoLS, the Ombudsman found that:

58. The Mental Capacity (Amendment) Act 2019 provides for the repeal of the DoLS and their replacement with a new system called the Liberty Protection

Safeguards (LPS). The Act will not be implemented fully until 2022. Meanwhile, the current DoLS are the main legal protection available to vulnerable people deprived of their liberty in care home settings.

59. Having such a backlog of DoLS applications awaiting assessment means the Council is at fault. For each case in the backlog, the Council is failing to comply with the Mental Capacity Act 2005 and DoLS Code of Practice. Without an authorisation in place, the people that are the subject of these applications are being unlawfully deprived of their liberty.

60. Applying the process properly may not have changed the outcome for many of the people affected, other than confirming that it is in their best interests to be deprived of liberty. However, it is possible some of the people stuck in the backlog should never have been deprived of their liberty or there may have been less restrictive options available to meet their needs.

The judgment in the *Emile* case is an important reminder that detention without authority carries both an emotional cost for the person and can carry a real financial cost for the body which is responsible for the arrangements. That body will not be the local authority supervisory body in a DoLS case, unless the local authority is also the body which has taken the steps in question to confine the person. Conversely, it could equally be a CCG arranging care which gives rise to a confinement of a person receiving CHC-funded care in a care or nursing home, or in their own home. In any such case, and in line with *Lumba* (in the Supreme Court) and *Bostridge* (in the Court of Appeal), and as the, the burden of proof

will not lie with the person who has been detained to show that the actions/omissions of the public authority led to loss. Rather, the burden then lies with the public authority to establish that they made no difference. Otherwise, *"the result would be to transform the tort of false imprisonment from being one actionable without proof of damage into one in which the claimant, in a large number of cases, would have to prove loss. [such an approach is] incompatible with the approach of the Supreme Court in Lumba. If the [public body] wishes to say that a claimant would have been detained anyway, [they] must establish that proposition"* *R(EO & Ors) v SSHD [2013] EWHC 1236 (Admin)* per Burnett J at paragraph 74.

It should, finally, be noted that it is not in all cases that there will be a complete identity between a wrongful detention claim and a claim for breach of Article 5 ECHR. The two concepts are not identical, and there may be situations – in particular, those where (unlike here) the person is unaware that they are confined, and do not seek to express any desire to leave – where it may not be entirely easy to establish that they are falsely imprisoned at common law, even if for purposes of Article 5 ECHR they are clearly deprived of their liberty. It is entirely possible, therefore, that a self-funder in a private care home/hospital may well have no recourse against the care home/hospital which does not seek a DOLS. If they do not meet the rather tighter test for false imprisonment, they could not bring a claim for deprivation of liberty under the HRA 1998 against the care home/private hospital. As the Law Commission identified in its Mental Capacity and Deprivation of Liberty report, it is not obvious why this gap in protection is justified – its attempts to solve the gap by

statutory means were not taken forward in the Mental Capacity (Amendment) Act 2019, so it will remain for the courts to craft a solution by (we suggest) bringing the common law concept of 'imprisonment' into alignment with the Article 5 concept of 'confinement'.

Capacity, sex and marriage

AMDC v AG and CI (No 2) [2021] EWCOP 5 (Poole J)

Mental capacity – contact – marriage – sexual relations

Summary

These proceedings involve the development of a relationship between two care home residents. In light of the interim judgment, which we covered at [2020] EWCOP 58, the matter was adjourned for further capacity evidence. There being no dispute over the new expert's conclusions, the judge held that AG lacked capacity to make decisions about the conduct of litigation, residence, care, and property and affairs including termination of the tenancy for the following reasons:

14 ... AG does not have insight into her own limitations, or her need for care and assistance. Her very simplistic belief is that since she was previously able to care for herself, find accommodation, and manage her affairs, she can do so in the future. She does not understand that she has dementia or that her cognitive functioning is impaired. Therefore, she expresses herself with confidence, even though her beliefs are patently ill-founded. She has no ability to process information relevant to more complex decision making such as would be involved in deciding where to live, the conduct of litigation, ways of providing

the care she needs, or the advantages and disadvantages of different ways of managing her property or affairs. Her ability to retain anything more than basic information is severely impaired, and she is unable to weigh and use information relevant to these decisions.

Contrary to the previous expert, Dr Mynors-Wallis' view was that AG had capacity to make decisions to engage in sexual relations and to have contact with others. Perhaps illustrating the need to calibrate the sexual capacity test when assessing someone aged 69, Dr Mynors-Wallis said, "I asked whether she thought she was at risk of becoming pregnant. She laughed and said "I'm too old. There's just as much a chance of him becoming pregnant as me" and laughed again." In relation to contact with others, the expert explored AG's understanding by reference to contact with people about whom she would have to make decisions, including her family, and her partner CI. She demonstrated understanding of the advantages and disadvantages of contact, and of what to do if she wanted to be alone. The judge agreed with the expert's conclusions and accordingly the care plan would need to be changed to reflect her decision-making ability in these two regards:

24 ... The previous position that AG did not have capacity to engage in sexual relations had significant consequences for AG, for CI, and for the management of the care home. Restrictions were put in place to prevent AG entering CI's room for example. Any form of physical intimacy between them could potentially have been viewed as an assault upon AG given the view and interim findings that there was reason to believe that AG lacked capacity to consent to sexual relations. Those restrictions will now be reconsidered and the safeguarding adults protection plan will be withdrawn.

The care home will follow the CQC's guidance on "Relationships and Sexuality in Adult Social Care Services."...

One tricky area concerned AG's capacity to marry. The expert was satisfied that AG demonstrated a basic understanding of the marriage contract but not the more complex information relevant to decisions about marriage and divorce, such as the financial implications. Having considered the previous case law, Poole J held:

21. In the light of this guidance, it is important not to apply too stringent a test for capacity to make decisions about marriage or divorce. Nevertheless, s 3(4) of the MCA 2005 provides that information relevant to a decision includes the reasonably foreseeable consequences of deciding one way or another, or not making a decision. A person with capacity to enter into a marriage may choose to disregard those consequences, but they must be able to understand and weigh such relevant information. A person may lack capacity in relation to decisions about residence, care or their financial affairs, but have capacity to make decisions about marriage. However, in this case, when determining capacity to marry, some consideration is required of AG's capacity in relation to decisions about care, residence, and financial affairs. AG herself sees marriage as a way of changing her care and residence. Furthermore, although previous authorities may have focused on the necessity for P to understand information relevant to marriage, it is important also to consider P's ability to retain, use and weigh such information.

22. Dr Mynors-Wallis reports that AG said

she wished to marry CI because they loved each other. She said that one difference between being married and not being married would be that on becoming married she would be able to go out to work to support CI. She said that once married they would share their money and would find a bungalow in which to live but she did not know anything about her own finances, or CI's finances, did not know in what town she currently lives, could not recall the fact that she is currently married, and had no idea what would happen to money and property after any divorce, and so did not appear to understand that divorce may bring about a financial claim. She told Dr Mynors-Wallis, as recorded at paragraph 12.5 of his report, that she would have no difficulty living independently with CI because she had always been able to look after herself. She believes that becoming married would enable her to work, to look after CI, and to be fully independent. In fact, she is clearly unfit to work, and she was admitted to the care home because she was utterly unable to look after herself in the community even with considerable assistance. AG has no insight into her cognitive limitations or her physical health needs, and no real understanding of the financial and other implications of her entering into marriage so that she and her spouse could live together as she envisages. AG's view of her status as a married person is not at all grounded in reality.

23. I remind myself that the test is status specific not person specific, and that the wisdom of any particular marriage decision is irrelevant. However, applying the capacity tests from the MCA 2005, I agree with Dr Mynors-Wallis and the parties that AG lacks capacity to make decisions about marriage, and about

divorce. Due to her inability to understand, retain and weigh information, she has fantastical beliefs that the act of getting married will result in her living independently in the community, free her of the need for care, and enable her to work. This is what married life was like for her in the past, and her impairments due to her frontal lobe dementia result in an inability to understand that marriage in the future will not return her to that same level of functioning and independence. AG is unable to retain information about her present married status – she does not consistently recall whether she is married, divorced or widowed. She cannot weigh or use relevant information to allow her to consider the advantages and disadvantages of marriage so as to make a decision about marriage. Dr Mynors-Wallis reminded himself, as I do, that the test for capacity for marriage should not be over-complicated, but he considers that AG's dementia "means that she doesn't have capacity to fully weigh up the pros and cons of a marriage" and she is "unable to retain key necessary information to make a decision about marriage". I agree that AG does not have capacity to enter into marriage. I am also satisfied that she has no understanding of what divorce would entail financially or in relation to her status, not even in broad terms. In my judgment it is necessary to make a finding on AG's capacity to enter marriage because the finding that she has capacity to engage in sexual relations may well bring the contemplation of marriage, already remarked on by both respondents, into sharper focus.

The local authority was directed to consider

what options were available to AG in terms of accommodation and care and support packages, including the possibility that she and CI could reside together under some arrangement whereby sufficient care can be provided. A best interests meeting is to be convened in February 2021 after which the matter will return to court when, if reported, we might find out how the story of this couple ends.

Comment

This case illustrates the importance of getting the sexual and contact capacity assessments right, particularly when someone is already confined to an institutional setting where sometimes intimacy is one of the few things left. As these facts demonstrate, there is a fine line between consensual intimacy and a safeguarding alert and capacity defines where that line is drawn:

25. It is regrettable that delay in resolving her case has prevented AG and CI from sharing intimacy when, as the court has now found, AG does have capacity to engage in sexual relations. However, the need for a new expert to look at this case afresh, has been proven.

Capacity enthusiasts will also note the reference to AG's lack of "insight" into her limitations and needs. But this case illustrates those scenarios where a lack of insight overlaps with a lack of capacity, with full reasoning given as to why insight was found wanting and how it was affecting her capacity, as recommended for practitioners by the [NICE guidelines](#) at para 1.4.24.

Interim treatment authority

University Hospitals of Derby and Burton NHS Foundation Trust & Derbyshire Healthcare NHS

Foundation Trust v MN [2021] EWCOP 4 (Hayden J)

Best interests – medical treatment

Summary

This case concerned the medical treatment of MN, a 60 year old man with suspected bladder cancer. Having co-operated with an ultra-sound, he subsequently stopped co-operating with any further investigations or treatment. In particular he would not co-operate with the Trust's initial investigation and treatment plan to undertake a CT scan and if clinically appropriate perform a cystoscopy procedure with surgery performed via telescope (transurethral resection of bladder tumour (TURBIT)). Without such treatment (and in the event that MN had bladder cancer) there was a risk that he would suffer a painful deterioration due to blood clots forming in his bladder and could be prevented from urinating. The surgery would excise or debulk the tumour enabling MN to urinate painlessly.

The treating Trust together with the Trust responsible for meeting MN's mental health needs in the community (MN having a diagnosis of paranoid schizophrenia), sought orders from the court authorising them to take steps to investigate the cause of MN's difficulties by way of a CT scan and if appropriate perform a TURBIT under general anaesthetic. These steps would likely require a degree of restraint which the applicant's considered would amount to a deprivation of MN's liberty.

Which (if any) of the longer term treatment options for bladder cancer would be appropriate for MN was unknown, and no orders were sought in respect of this at the interim hearing (the options being radiotherapy, surgery to

remove the bladder, chemotherapy or palliative care). It was however made clear that radical treatment was unlikely to be offered to him if he was unwilling to comply with it.

Hayden J was satisfied that it was appropriate to make a s.48 declaration that there was reason to believe that MN lacked capacity to both conduct the proceedings, and to make decisions about the investigations and treatment of his identified kidney obstruction. The more difficult question for the court was whether it should authorise the 'emergency' treatment plan in advance of the final hearing (namely the CT scan and TURBIT). Hayden J emphasised that MN had not been informed of these proceedings and so had not had an opportunity to express his wishes and feelings in relation to receiving pain-relieving emergency treatment for blood clots, as distinct from the primary treatment for his suspected bladder cancer.

The applicants recognised that they could rely on:

- Section 6(7)(a) MCA 2005 (which allows a person to provide life sustaining treatment while a decision is sought from the court)
- Section 6(7)(b) (which allows a person to do 'any act' which they reasonably believe to be necessary to prevent a serious deterioration in MN's condition while a decision is sought from the court)
- Section 4B MCA 2005 (which authorises steps to be taken which would deprive MN of his liberty if the steps consist wholly or partly of giving MN life-sustaining treatment or doing any vital act whilst a decision is sought from the court).

Nevertheless, despite the potential legal cover that this would provide them, the applicants pressed for authorisation of their treatment plan on the basis that there was an 80% chance that the emergency treatment would be required before the final hearing, and it was far preferable for an order to be made now rather than during an emergency hearing (which might result in delay of the treatment being provided to MN).

Hayden J held (at paragraph 24) that "*it would be inconsistent with the principles of the MCA 2005 for the Court pre-emptively to authorise the deprivation of MN's liberty in circumstances where both the nature of the potential emergency situation could be anticipated (the foreseeable impact of blood clotting related to bladder cancer), and where MN's wishes and feelings might be sought and recorded in advance.*"

Hayden J directed that the interim order sought by the applicants would only be operative (pending the final hearing) if a number of conditions were met:

- MN was in pain and/or discomfort and/or was unable to urinate;
- MN's views had been canvassed regarding having emergency treatment (it having been explained to him that such treatment would release him from pain and/or discomfort and/or would enable him to urinate);
- The emergency treatment would include releasing any blood clots in his bladder (or other clinically indicated and operable obstruction) preventing him from urinating;
- MN continued to express a resistance to emergency treatment.

Comment

This judgment shows the critical importance (and rightly so) of obtaining P's wishes and feelings about any treatment plan being put before the court. Had the Trust known what MN's wishes and feelings about the proposed emergency treatment were, Hayden J might have acceded to the request to authorise the emergency treatment absent the conditions.

"Incomplete and non-final" LPS impact assessment

Despite its caveats, provisos and intention to undertake a more detailed version after public consultation, this latest impact assessment provides an insight into how the government thinks LPS might operate. It applies to both England and Wales and is based on 2018-19 demand levels but does not take account of the government's [decision](#) to abandon the different procedure for care home managers. As a result, we should expect some of the costs to change during the current course of implementation planning.

It is predicted that doctors, social workers, AMCPs and advocates will be the professionals taking on the largest role in the new system and the following points caught our eye:

- **Numbers:** It is estimated there will be 257,984 LPS applications per year. This is based on the 2018-19 DoLS figures plus 53,000 (community settings) and 6600 (16-17 year olds).
- **Assessments:** A new medical assessment (costing £115 each) will be required in 20% of cases (the remainder having an established diagnosis). A new capacity assessment (costing £162) will be needed in 40% of cases. The necessity and proportionality assessment will be required in all cases but this can be streamlined where care-planning is taking place under the Care Act or NHS continuing healthcare. This leaves 154,790 applications (60%) requiring a standalone necessity and proportionality assessment (costing £152 each).
- **Training for assessments:** 100% of adult social workers and 20% of doctors, children's social workers and other social workers will require full LPS training. The remainder will need awareness training.
- **AMCPs:** 26% of the LPS applications will require an AMCP (67,076 per year). There are 2720 best interests assessors to convert to the AMCP role (8-hour conversion course at £615) and an extra 107 new AMCPs will need to be recruited.
- **IMCAs:** it is thought that 95% of those under LPS will have representation. Of that number, 75% will have an appropriate person (for which 40% will need IMCA support) and 25% will have direct IMCA support. Training will be required for 10,602 new IMCAs.
- **Legal representation:** 0.5% of LPS authorisations (1290 per year) will be challenged in the Court of Protection. Each case costs £8400 (legal aid), £12,000 (responsible body), and £12,000 (Official Solicitor acting in 25% of cases).
- **Regulation:** annual cost will be £13.5 million (CQC) and £600,000 (Ofsted).

Comment

These figures are clearly going to change as the government works through the implementation stage. Many are best estimates, or derive from the Law Commission estimates, and there are some known unknowns. For example, whether the estimated demand for AMCPs is accurate will depend upon how the AMCP trigger is interpreted by the courts and applied in practice. When will it be 'reasonable to believe' that the cared-for person 'does not wish' to reside in, or receive care or treatment at, the place? The figures also assume the enhanced care home manager role which the government will not be introducing, so there will be additional costs on responsible bodies. It is a worry though that 12,899 (5%) of people are not expected to have an appropriate person or IMCA to represent and support them. This 5% includes those who have (with capacity) declined support; more problematically, it will also include those who are 'unbefriended,' and for whom representation is in their best interests, but where the responsible body is unable to appoint one, having taken all the reasonable steps required of them under the Act. At that point, a serious problem will arise because will be without the representative required as a key human rights safeguard.

Short note: an update on the RS saga

The deeply disturbing saga in the case of RS we reported upon in the January Report (see [here](#)), saw the case return one last time to the Court of Protection, and Cohen J roundly reject an argument that the impact of the Vienna Convention on Consular Relations required him to enable the Polish Consul to visit RS in hospital as his birth family wished but in circumstances his wife could not support, RS being very close

to the end of his life. In *Re RS* [2021] EWCOP 6, Cohen J found that that the right for consular officers to visit those in prison, custody and detention, "plainly" did not extend to those in hospital, noting that to hold "*the Consul General is under a duty or has the right to check the treatment of every citizen of his country in a NHS hospital would clearly be unsustainable.*" Cohen J found that it was not in RS's best interest for the visit to take place when, if not the sole, at least a primary purpose of the visit would be to obtain a remote assessment from a doctor which would carry little weight:

1. *To force this visit upon his unwilling wife with the attendant stay, whether described that way or not, is in my judgment the very opposite of what he would want and the opposite of what would be in his best interests. In my judgment, the hospital would be acting in his best interests not to accede to that. In reaching that decision, I do not accept that I am impeding the Republic of Poland or the Consul General in the execution of or complying with his Vienna Convention rights/obligations in any way.*

We have [previously commented](#) upon the limited relevance of the Vienna Convention in this context.

RS has subsequently died, but not before some further steps taken in Poland which we do not address here as we only have limited information about them (that limited information, on its face, painting a disturbing picture of how the position in England was being characterised before the courts there).

Short note: *B v A Local Authority*

Via the [Mental Health Law Online website](#), we note that the Supreme Court (Lord Hodge, Lady Black and Lord Kitchen) refused permission to appeal from the decision of the Court of Appeal in *B v A Local Authority* [2019] EWCA Civ 913 on 13 October 2020 on the basis that *"the application does not raise a point of law of general public importance which ought to be considered at this time bearing in mind that the issue has already been the subject of judicial decision and reviewed on appeal."*

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Katie advises and represents clients in all things health related, from personal injury and clinical negligence, to community care, mental health and healthcare regulation. The main focus of her practice however is in the Court of Protection where she has a particular interest in the health and welfare of incapacitated adults. She is also a qualified mediator, mediating legal and community disputes. To view full CV click [here](#).

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Rachel has a broad public law and Court of Protection practice, with a particular interest in the fields of health and human rights law. She appears regularly in the Court of Protection and is instructed by the Official Solicitor, NHS bodies, local authorities and families. To view full CV click [here](#).

**Stephanie David:** stephanie.david@39essex.com

Steph regularly appears in the Court of Protection in health and welfare matters. She has acted for individual family members, the Official Solicitor, Clinical Commissioning Groups and local authorities. She has a broad practice in public and private law, with a particular interest in health and human rights issues. She appeared in the Supreme Court in *PJ v Welsh Ministers* [2019] 2 WLR 82 as to whether the power to impose conditions on a CTO can include a deprivation of liberty. To view full CV click [here](#).

**Simon Edwards:** simon.edwards@39essex.com

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](#).

**Adrian Ward:** adw@tcyoung.co.uk

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

**Jill Stavert:** j.stavert@napier.ac.uk

Jill Stavert is Professor of Law, Director of the Centre for Mental Health and Capacity Law and Director of Research, The Business School, Edinburgh Napier University. Jill is also a member of the Law Society for Scotland's Mental Health and Disability Sub-Committee. She has undertaken work for the Mental Welfare Commission for Scotland (including its 2015 updated guidance on Deprivation of Liberty). To view full CV click [here](#)

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 March. 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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