Court of Protection: update

Gemma Daly, Mary-Rachel McCabe and Sophy Miles look at the operation of the Court of Protection during the pandemic and case law on medical treatment, permission, cross-border cases, and capacity, plus guidance on medical treatment applications.

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Court of Protection in lockdown

The Coronavirus Act 2020 made no changes to the Mental Capacity Act (MCA) 2005, secondary legislation or statutory guidance. Instead, the Department of Health and Social Care issued guidance: *The Mental Capacity Act (2005) (MCA) and deprivation of liberty safeguards (DoLS) during the coronavirus (COVID-19) pandemic* (the MCA guidance) (9 April 2020, last updated 15 June 2020). While the MCA guidance reinforces the need to make decisions in accordance with the principles of the MCA 2005, it is perhaps unhelpful that it appears to truncate the 'best interests' checklist set out in MCA 2005 s4.[1] It further appears to condone failures to authorise deprivations of liberty in a timely fashion in its advice to care homes:

The department recognises the additional pressure the pandemic will put on the DoLS system. Fundamentally, it is the department's view that as long as providers can demonstrate that they are providing good-quality care and treatment for individuals, and they are following the principles of the MCA and code of practice, then they have done everything that can be reasonably expected in the circumstances to protect the person's human rights.

Alongside other jurisdictions, the Court of Protection has had to respond to the COVID-19 crisis. HM Courts & Tribunals Service published its family business priorities in April 2020.[2] Court of Protection work that 'must be done' includes urgent applications, applications under MCA 2005 ss16A and 21A, serious medical treatment cases, deprivation of liberty cases generally, statutory will applications when the testator is close to the end of life, and safeguarding applications initiated by the Office of the Public Guardian. Work that 'will be done' includes welfare cases, while property and affairs cases are in the category of work that 'we will do our best to do'.

On 23 March 2020, the vice president of the Court of Protection, Hayden J, set up a 'multi-disciplinary thinktank' of experienced practitioners, known as the HIVE group. Helpfully, the group's mailbox (hive@justice.gov.uk) is in the public domain and can be used to raise issues related to the court's operation during the pandemic.

The court rapidly expanded its ability to work remotely. On 31 March 2020, the vice president issued detailed guidance on remote access (the March guidance).[3] This is essential reading for Court of Protection practitioners. It sets out a 'primary aim' (para 4, page 2) to ensure access to justice for all parties to cases before the court, and goes on to provide that 'remote hearings are the default position until further direction' (para 6, page 2), subject to the court's permission. Attended hearings will only take place where there is genuine urgency and a remote hearing cannot take place.

The March guidance includes a draft remote hearing order, which needs to be approved in all cases. Importantly, the draft order includes a direction that future hearings will be in private. The order therefore disapplies Practice Direction 4C (which provides that hearings will normally be in public). If the court has already made a transparency order, then it is important that this is specifically discharged by the remote hearing order.

Although remote hearings in the Court of Protection will therefore remain listed as private, the March guidance states that the attendance of members of the press or public may be accommodated. This was supplemented in a letter dated 11 May 2020,[4] where the vice president suggested that when members of the public or press attend a remote hearing, the advocate for the applicant should begin the case with a short opening, to help any observers grasp what the case is about.

The March guidance asks for 'imaginative ideas' for the participation of P, noting that the attendance of P at a hearing is first a matter for P's legal representatives and/or litigation friend. When judicial meetings with P are necessary, this will only take place via a remote teleconferencing facility.

The vice president has also endorsed guidance on remote advocacy by the Court of Protection Bar Association.[5] For an appraisal of the move to remote hearings generally, see Sue James' recent article, 'Remoteness of justice' (May 2020 *Legal Action* 18).

Unusually, the Court of Protection has been willing to extend its reach to local authorities. On 4 May 2020, the vice president wrote to the directors of all adult social services expressing his concern at the 'striking and troubling drop in the number of section 21A (MCA 2005) applications which has occurred, in some areas, alongside a significant reduction in referrals to advocacy services'.[6] The letter continued:

It needs to be emphasised that where there has been a failure properly to authorise deprivation of liberty one of the consequences is that, in the absence of authorisation, there will be a loss of entitlement to public funding and inevitably an obstruction to the individuals' absolute right to challenge the deprivation of liberty. For the present I simply highlight my concern and restate the importance of the statutory requirements.

Case law

Medical treatment

A Clinical Commissioning Group v AF and others [2020] EWCOP 16, 27 March 2020, was an early example of a contested hearing conducted remotely by Skype. Evidence was heard over three days and Mostyn J heard from 11 witnesses. The conduct of this case has been the subject of trenchant criticism on behalf of one of the parties, SJ, who was AF's daughter.[7]

AF was in his 70s and had worked in the NHS for most of his adult life. In 2016, he suffered a stroke. It was not disputed that he lacked capacity as a result. AF was described as 'sentient, cognitively active, emotionally aware and possessed of motor functions, albeit grossly impaired physically and mentally' (para 20).

The question for the court was whether it was in his best interests to continue to receive clinically assisted nutrition and hydration, without which he would probably not survive. AF had maintained a strong sense of autonomy and dignity while he had capacity to make decisions. He had stated that he would not want to be kept alive as a 'body in a bed' (see para 18). SJ told the court that '[d]eath doesn't scare my Dad. What scared him was loss of dignity. He saw some of the worst situations people can be in and he would talk about that and say, "you shouldn't always keep people alive"' (see para 18).

AF had never made an advance decision, and Mostyn J said that even if he had done so, the judge doubted that it would have covered anything other than a descent into a vegetative or minimally conscious state, which was very different from AF's actual situation.

Mostyn J accepted that AF had, since losing capacity, expressed the wish to die but could not accept that 'he then expressed a fully rational and considered view that he wished to take the ultimate fatal step' (para 26). Mostyn J listed a number of physical and emotional stimuli that were known to give AF pleasure, including seeing children and listening to music and poetry, and found it 'unlikely that if he were granted a brief window of lucidity, he would reach the conclusion that he would be better off dead rather than to continue with the limited life that he presently enjoys' (para 31(ii)). The judge concluded that:

I have reached the very clear conclusion that it would be categorically contrary to AF's interests for him to be set on the path that will lead to his inevitable death from starvation. This may be a diminished life, but it is a life nonetheless which has, as I have said, intrinsic quality and from which AF derives pleasure and satisfaction (para 32).

Re Z [2020] EWCOP 20, 3 April 2020, concerned a young woman of 22 with a rare chromosomal abnormality syndrome, known as 'chromosome 17q12 microdeletion', as a consequence of which she suffered from cognitive impairment and a bicornate (or heart-shaped) uterus. She had a mild learning disability and had been assessed as having capacity to make decisions about her antenatal care and mode of delivery. She was 35 weeks pregnant and was booked to deliver her baby by caesarean section due to the risk associated with her condition.

This was Z's fifth pregnancy. One of her children had died at six days and the other three had been taken into care. The application concerned whether Z had capacity to consent to the insertion of an intrauterine contraceptive device at the time of the caesarean and, if not, whether this was in her best interests. Knowles J accepted the independent psychiatric evidence that Z lacked capacity to conduct the proceedings.

The parties agreed that the 'relevant information' in relation to the insertion included the high risk to Z's health of future pregnancies. In *The Mental Health Trust, The Acute Trust and The Council v DD and BC* [2014] EWCOP 13, Cobb J stated that '[i]n a case concerning medical treatment, the "relevant information" (sections 2(1) and 3(1)/(4)) is that which contains the "proximate medical issues", not the wider social consequences of the decision …' (para 15(iv); see para 22 of the instant judgment). Despite this, it was argued that the wider social consequences of future pregnancies were part of the relevant information for the purpose of the decision. Knowles J concluded that she did not need to resolve this, given the strength of the evidence that Z could not understand, retain, use or weigh information about the health risks to her of future pregnancies.

While Z had said she would accept long-term injectable contraception, there was evidence that she had not been willing to comply with this in the past. The judge held that while this option:

… accorded with Z's wishes and took account of the least restrictive approach set out in s1(6) of the Act, it did not in my view effectively achieve the purpose for which contraception was sought, namely to prevent the very serious risks to Z's physical health which further pregnancies would undoubtedly bring. Z's poor compliance with not only past injectable contraceptives but with medical treatment in this pregnancy militated against me endorsing Z's wish to have an injectable contraceptive (para 33).

Comment: This was another application that straddled the implementation of lockdown. It came before the judge on 20 March 2020 and an urgent hearing took place on 27 March 2020 (prior to the March guidance) and proceeded as a public hearing under a transparency order. The Official Solicitor's office had made contact with Z by telephone: she had wished to attend the hearing but no arrangements had been made by the time of the hearing. Z therefore telephoned the Trust, during the course of the hearing, asking to take part. One of the doctors called Z on his phone and placed the phone so that Z could hear the submissions. After hearing the judge tell her she had decided it was in Z's best interests to have the device fitted, Z rang off. Z was said to be self-isolating at the time, so it is not clear what support was available to her during and after the hearing.

Permission

Re D (a young man) [2020] EWCOP 1, 20 January 2020, concerned a contested application by D's mother for permission to make a substantive application in relation to her contact with D. D was 20 and had autism. There had been a history of litigation between his parents for many years during D's minority and this was the seventh application made by D's mother in relation to contact. MCA 2005 s50(3) provides that:

In deciding whether to grant permission the court must, in particular, have regard to –

(a) the applicant's connection with the person to whom the application relates,
(b) the reasons for the application,
(c) the benefit to the person to whom the application relates of a proposed order or directions, and
(d) whether the benefit can be achieved in any other way.

Mostyn J held that:

In my judgment the appropriate threshold is the same as that applicable in the field of judicial review. The applicant must demonstrate that there is a good arguable case for her to be allowed to apply for review of the present contact arrangements (para 5).

Mostyn J attached no weight to the fact that D was now an adult and said:

I do not agree that because this arbitrary chronological threshold has been passed that D is entitled to be afforded more respect to his right to autonomy than prevailed in the period leading up to his 18th birthday. The decision I have to make is whether a good arguable case has been shown that it is in his best interests for there to be a full welfare investigation of the current contact arrangements (para 10).

The judge concluded that circumstances had not changed to any material extent since the last decision and he could not see any benefit to D from permission being granted.

Cross-border cases

Re QD (Habitual Residence) (No 2) [2020] EWCOP 14, 25 March 2020, was the second judgment of Cobb J that concerned QD, who was in his 60s and had Alzheimer's disease. In brief, he had lived with his second wife, KD, in Spain for some years when his children from his first marriage flew him to the UK from Spain, placed him in a care home, and sought orders in the Court of Protection that he should reside at the care home, should not return to Spain and should only have supervised contact with KD.

In his first judgment (*Re QD (Jurisdiction: Habitual Residence)* [2019] EWCOP 56), Cobb J found that QD lacked capacity to make decisions about his residence, care and support needs, the move from Spain was a wrongful act perpetrated by his children and QD was habitually resident in Spain, and there were no reasons why the Court of Protection should assume jurisdiction under MCA 2005 Sch 3. This meant that it was for the Spanish courts to decide what should happen next.

By the time of the second hearing, the court had received a report from a Spanish lawyer who advised that the Spanish court could not accept jurisdiction unless and until QD returned to Spain. Therefore, there was no order of a foreign court that the Court of Protection could recognise and enforce under Sch 3 and no prospect of securing one while QD remained in the UK. Moreover, although QD was found to be fit to travel to Spain, the COVID-19 pandemic prevented all but essential travel and QD was one of the 'shielded' group who had been advised to self-isolate until the end of June 2020. Although Cobb J was invited to try to resolve the 'legal "deadlock"' (para 6) by making in principle decisions, he preferred to adjourn the case, making it clear QD's continued residence in the UK in the current circumstances would not contribute to a conclusion that he had acquired habitual residence in the UK.

Health Service Executive of Ireland v Ellern Mede Moorgate [2020] EWCOP 12, 11 March 2020, was the latest of a series of applications by the Irish High Court for the recognition and enforcement under MCA 2005 Sch 3 of protective measures (see, for example, *Health Service Executive of Ireland v PA, PB and PC* [2015] EWCOP 38).

SM was 19 and had a serious eating disorder. She was a ward of the Irish High Court, which had concluded she lacked litigation capacity, and was represented in the Irish proceedings by the General Solicitor, Ms Hickey. SM's transfer to Springfield University Hospital had been approved by the Irish High Court in February 2019 and was recognised by the Court of Protection on 8 March 2019. SM's mental health had deteriorated and Dr Galavotti, SM's consultant psychiatrist, requested that she be moved to another specialist placement as a matter of urgency.

On 4 February 2020, the president of the Irish High Court directed SM's move to Ellern Mede Moorgate, a specialist hospital with a high dependency unit in the north east of England. The Irish High Court directed the Health Service Executive of Ireland (HSE) to make an application for urgent interim provision for the enforcement and recognition of the order of 4 February 2020.

The vice president accepted that the application was urgent as 'it is manifest that SM's life will be put at risk by any delay to the proposed transfer to Ellern Mede' (para 18). The vice president accepted that the criteria were met for the recognition and enforcement of the Irish High Court's order to transfer SM.

Comment: SM was not a party to the application under Sch 3 following the reasoning in *Re PD* [2015] EWCOP 48. The vice president noted, however, that SM was represented in the Irish High Court proceedings, and that her parents attended each hearing and were given the opportunity to address the court. It is clear from the judgment that great efforts were made by the HSE to take a transparent approach and 'stress test' (see para 55) the Sch 3 regime.

There was no reference, however, to the comments of Baker J in *Re PD* to the effect that the appointment of an accredited legal representative might be an appropriate mechanism for those like SM to participate in these complex, legally technical cases. It is hoped that the courts will consider this option more frequently in future.

Capacity

Is a failure to believe a failure to understand?

Leicester City Council v MPZ [2019] EWCOP 64, 29 November 2019, concerned the mental capacity, or, alternatively, vulnerability in the context of the inherent jurisdiction, of a woman with a learning disability and personality disorders who had been subject to abuse since childhood. The decisions in issue related to the conduct of the proceedings, residence, care, contact, social media, and sexual relations.

HHJ George, sitting as a deputy High Court judge, found that MPZ had the relevant impairment or disturbance in the functioning of the mind or brain by reason of her learning disability and personality disorders, although her learning disability was not of a degree to interfere with her ability to make decisions.

Initially, jointly instructed consultant psychiatrist Dr Lawson had assessed MPZ as having capacity to make all decisions in issue but considered her capacity to be vitiated by the undue influence of others. He revised his position and assessed MPZ as unable to use or weigh information as, while it appeared she was making unwise decisions, in fact 'her ability to make genuinely autonomous decisions' has been vitiated due to her personality disorders (para 18).

Dr Lawson described MPZ as unable to use or weigh information to enable her to consider the risks associated with decision-making 'as the prism through which she makes decisions is abnormal, and is distorted by her personality disorders' (para 26). He gave evidence that a person 'does not just process decision-making cognitively, but also psychologically and emotionally', and MPZ was said to interpret information in the context of her 'abnormal emotional state'. He considered her unable to assess the truth of information, particularly from abusers.

While Dr Lawson initially assessed MPZ's decision-making as more likely to be vitiated in respect of known as opposed to unknown persons, he clarified that her personality disorders were so pervasive and ingrained, whether with someone she knew or not, 'because it comes from within and affects how she makes her decisions' (para 29). The evidence was ultimately that this affected her thought-making process with abusive men or those who supported her.

With reference to the decision of *Re MM (an adult)* [2007] EWHC 2003 (Fam), HHJ George held that 'the specific requirement of belief is subsumed into the more general requirements of understanding and the ability to use and weigh information' (para 32). In MPZ's case, Dr Lawson described her 'pathological dependence on abusive relationships which causes her to reject the truth of information given to her' (para 34). HHJ George accepted that 'a failure to believe is a failure to understand and use or weigh in the context of the specific decision-making exercise engaged' (para 34).

HHJ George determined that the local authority had rebutted the presumption that MPZ had capacity to make the range of decisions before the court. While the Official Solicitor had submitted that MPZ's capacity depended on the context in which she was making a decision, the court found:

So pervasive and distorting are the disorders on the operation of her mind, that even with those with whom she is in a therapeutic or benign and caring relationship, her fear of damaging that relationship is so great that her capacity to make a decision is vitiated (para 37).

Given this decision, limited attention was afforded to the alternative issue of the exercise of the inherent jurisdiction in MPZ's case, although HHJ George determined that MPZ was a vulnerable adult such that the High Court would have considered protective measures.

MPZ's capacity to consent to sexual relations was considered separately and the court determined that she lacked capacity to consent as she did not understand that she had a choice as to whether or not to have sexual relations.

Comment: The judgment endorses the approach that a failure to believe is a failure to understand and use or weigh relevant information. In this case, there was a clear causal nexus between MPZ's personality disorders and her distorted beliefs. The refusal to believe information relevant to a decision requires careful consideration; the veracity of that information and the reasoning behind the belief may be important in determining whether a person truly understands and is able to use or weigh.

Person-specific capacity decisions on contact

The case of *Re SF* [2020] EWCOP 15, 25 March 2020, concerned a 45-year-old married woman diagnosed with mild learning disability, type 2 diabetes, depression, and frontal lobe dementia.

The local authority and the Official Solicitor agreed that the presumption of capacity was displaced in respect of SF's capacity to litigate and make decisions about her care, residence, finances and property, and to enter and terminate a tenancy. Interestingly, it was agreed that she lacked capacity to make decisions about contact with others *except* where this related to her husband. The issues were therefore whether she had capacity to have contact with her husband, AF, and to consent to sexual relations. The local authority advocated that SF *had* capacity to make these two decisions and, by the end of the hearing, the Official Solicitor 'no longer actively opposed' (para 4) these outcomes.

The circumstances that led to this case were that while AF was working, a man known as 'Dennis' had been visiting the couple's home and 'taking advantage' (para 11) of SF by having sex with her. Dennis was firmly advised by the police not to pursue a sexual relationship with SF as it would be unlawful because it did not appear that she had capacity to consent to sexual relations. So far as is known, he had no longer visited SF.

This case presented almost the opposite scenario to the psychiatrist's assessment in *MPZ* above, as here Dr O'Donovan assessed SF as lacking capacity to make decisions about contact with strangers, but having capacity to make such decisions about her husband because of the distinction between 'episodic' as opposed to 'semantic' memory (para 20). The point being that the psychiatrist considered SF 'would need to have regular understanding of someone before she could reach a capacitous decision [about contact with them]' (para 20).

For this reason, and SF's 'semantic' memory for her husband, Dr O'Donovan considered she was able to know that she had feelings for him, how he made her feel, and if he was in a good or bad mood. The psychiatrist also assessed SF as having capacity to consent to sexual relations, despite being vulnerable to sexual exploitation outside of her marriage. Crucially, SF understood her right to give and withdraw consent. Her passivity and personality characteristics were, according to Dr O'Donovan, distinguished from her mental disorder in this regard:

Her view that males take the lead when in sexual relationships to decide about sexual relations and that women do not refuse to have sex with their partners, as this would negatively impact on the relationship, indicates that she is aware that she has a choice and has considered the perceived consequences of consent versus refusal. This in the context of her marriage does illustrate a degree of passivity. However, this is not unique to her mental disorder and pre-dates the onset of this. Furthermore, it is common view that is held in various relationships (see para 22).

Cobb J determined capacity in accordance with this assessment and made declarations that SF *did* have capacity to make these two decisions.

Comment: The capacity issues in this case were complex and the judgment provides an insight into what must have been a careful and detailed capacity assessment. Unusually, this was a case in which a person was found to have capacity in relation to a specific individual but not to make decisions about contact with others.

SF was described as 'passive', 'apathetic', and 'a biddable woman'; 'she is happy to be led by her husband' (see, for example, para 19). As a person only lacks capacity if they are unable to understand, retain, or use or weigh relevant information or communicate a decision *because of* a mental disorder, the court had to disentangle what was attributable to her innate passivity and what was attributable to her disorder of the mind. The extracts from the psychiatrist's assessment analyse this distinction and remind us of the importance of the causative nexus in assessing capacity.

Cobb J directed a review of SF's capacity in three months' time given the psychiatrist's view, supported by SF's husband, that her frontal lobe dementia was deteriorating reasonably rapidly. This implicitly acknowledged that capacity is time-specific and the importance of keeping such decisions under review.

The application of the Mental Capacity Act to a patient subject to a community treatment order

Sunderland City Council v AS and others [2020] EWCOP 13, 20 March 2020, concerned a 44-year-old man with a diagnosis of mild learning disability and acquired brain injury living in supported accommodation. AS was subject to a community treatment order (CTO) under Mental Health Act (MHA) 1983 s17A.

Cobb J's judgment concerned whether AS had capacity to make decisions as to the litigation, residence and care. The single joint expert, Dr Hill, described the case as 'very complex' both in relation to AS's 'mental health and general functioning' (see para 28). Dr Hill initially considered AS fell into the rare category of case where a person lacks subject matter capacity but has litigation capacity. She subsequently changed her view and the court determined that AS lacked capacity to conduct the proceedings.

There was no dispute between the parties as to AS's incapacity to make the subject matter decisions. Of note, Cobb J accepted the local authority and NHS trust's submission that 'structure and routine' were an integral part of the information relevant to a decision on residence, these characteristics marking the difference between supported and independent living (para 34). In relation to care decisions, AS could articulate that he needed support but 'did not do so consistently, and was unclear what support was needed overall' (see para 35).

Residence, care and 'silos'

In *Tower Hamlets LBC v A and KF* [2020] EWCOP 21, 23 April 2020, Senior Judge Hilder considered the tests for capacity to make decisions about residence and care. A was 69 years old and had Korsakoff's dementia. Following an admission to hospital in 2019, she was discharged to a care home. A desperately wanted to return home to her flat, where she had lived for over 20 years.

A jointly-instructed independent psychiatrist concluded that A lacked capacity to conduct the proceedings, to make decisions about her health and care and to manage her property and affairs, but had capacity to make decisions about residence. The parties accepted that A lacked capacity to make decisions about her care. The issue to be determined by the court was whether she had capacity to decide where she lived and, if so, whether returning home with a care package for a trial period was in her best interests.

In reaching her decision, Senior Judge Hilder recalled *LBX v K, L and M* [2013] EWHC 3230 (Fam), in which Theis J identified the (different) relevant information for assessing capacity to make decisions about residence and decisions about care. The Theis J 'checklist' of relevant information to make a decision about residence includes 'what sort of care [they] would receive in each placement in broad terms' (para 43; see para 42 of the instant judgment).

The court also considered the Court of Appeal's decision in *B v A Local Authority* [2019] EWCA Civ 913, in which the court found 'no principled problem' with Theis J's list 'provided that it is treated and applied as no more than guidance to be expanded or contracted or otherwise adapted to the facts of the particular case' (para 62; see para 44 of the instant judgment).

Senior Judge Hilder applied *LBX* and *B* in finding that decisions about residence and care require different factors to be understood, retained and used or weighed and should be assessed as individual domains of capacity (paras 62–63). It did not follow from such an approach, however, that residence and care are decisions that are made in separate 'silos' (para 64). While there are differences in the information relevant to each decision, there is also overlap: Theis J's list of relevant information to make a decision about where to live includes a 'broad understanding' (para 65) of the sort of care available in each of the places of residence potentially available, for example.

Overlap does not, however, imply that a decision in respect of residence incorporates a decision in respect of care: '[I]t is not necessary to make a capacitous decision about care in order to make a capacitous decision about residence' (para 65).

Senior Judge Hilder agreed with the submissions of the Official Solicitor that there was no inconsistency between the expert's conclusions on residence on the one hand and care on the other. The court accordingly left the decision to A as to whether she wished to return home for a trial period or remain in the care home (para 75).

Comment: Senior Judge Hilder's detailed decision in this case has highlighted, once again, the decision-specific structure required by the MCA 2005 when assessing capacity, and confirmed that decisions relating to residence and care should be considered separately, albeit not in separate 'silos' since there is a degree of overlap between the relevant information.

At the end of Senior Judge Hilder's judgment is a 'postscript' regarding the implications for the standard authorisation in respect of A's residence at the care home until the package of care for a trial return home could be put in place. Until the package of care for the trial return home was arranged, there was no choice for A, concluded Senior Judge Hilder, and so the only option before the court in respect of A's care was for it to be provided at the care home. It followed that, 'on an interim basis, the determination that A lacks capacity to determine the care that she should receive necessarily means that she lacks capacity within the meaning of paragraph 15 of Schedule A1' (para 79).

While this observation made sense in this case, it is in some ways difficult to reconcile a conclusion that a person has capacity to decide where they live with the conclusion that they nevertheless meet the criteria to be deprived of their liberty under DoLS.

The threshold for interim declarations

The case of *DA v DJ* [2017] EWHC 3904 (Fam), 29 November 2017, was decided in 2017 but only published in March 2020. The decision is relevant as Parker J considered the approach to interim declarations under MCA 2005 s48 and the conflicting judgments of HHJ Marshall QC (*Re F* [2009] EWHC B30 (Fam)) and Hayden J (*Wandsworth LBC v AMcC, AJ, CJ and JJ* [2017] EWHC 2435 (Fam)).

In *Re F*, HHJ Marshall QC had taken the approach that the:

*... evidence required to found the court's interim jurisdiction under [s48] must be something less than that required to justify the ultimate declaration [under s15]. What is required, in my judgment, is simply sufficient evidence to justify a reasonable belief that P **may** lack capacity in the relevant regard ... the 'gateway' test for the engagement of the court's powers under s48 must be lower than that of evidence sufficient, in itself, to rebut the presumption of capacity* (paras 35–37; see para 42 of the instant judgment; emphasis in the original).

Conversely, Hayden J in *Wandsworth* adopted a higher threshold:

... the presumption of capacity is omnipresent in the framework of this legislation and there must be reason to believe that it has been rebutted, even at the interim stage. I do not consider, as the authors of the 'Mental Capacity Assessment' did that a 'possibility', even a 'serious one' that P might lack capacity does justification to the rigour of the interim test ... (para 65; see para 60 of the instant judgment).

Furthermore:

'Reason to believe' that P lacks capacity must be predicated on solid and well-reasoned assessment in which P's voice can be heard clearly and in circumstances where his own powers of reasoning have been given the most propitious opportunity to assert themselves (para 69; see para 62 of the instant judgment).

Both parties invited the court in this case to prefer HHJ Marshall's approach, for risk that otherwise it 'makes the Act unworkable in practice and runs a high risk of imperilling the safety and wellbeing of those persons whom the Act and the judges are charged with protecting' (para 65).

Parker J disagreed that P's voice had to be heard in the evidence for s48 declarations, and disagreed with Hayden J's approach. Parker J held that both 'a possibility', particularly 'a serious one', and 'an unclear situation', which might 'suggest a serious possibility P lacks capacity' met the s48 test (see para 70). She considered the s48 test required evidence on which a belief is formed, and it 'probably needs to be prima facie credible, not in the sense that it is believed but in the sense that it is capable of belief' (para 71). '[A] substratum of truth is probably sufficient enough to fulfil s48 in any event' (para 73).

Guidance on applications relating to medical treatment

On 17 January 2020, the vice president published guidance on serious medical treatment applications in the Court of Protection ([2020] EWCOP 2). The guidance sets out the procedure to be followed where a decision relating to medical treatment arises and where thought requires to be given to bringing an application before the Court of Protection. It is intended to operate until such time as it is superseded by the revised MCA 2005 code of practice.

The guidance sets out the circumstances in which MCA 2005 s5 either will not or may not provide a defence against liability for medical professionals carrying out the relevant act. It states that, if s5 does not provide a defence, then an application to the Court of Protection will be required.

Paragraph 8 of the guidance states (emphasis in the original):

If, at the conclusion of the medical decision-making process, there remain concerns that the way forward in any case is:

(a) ***finely balanced****, or*
(b) there ***is a difference of medical opinion****, or*
(c) a ***lack of agreement*** *as to a proposed course of action from those with an interest in the person's welfare, or*
(d) there is ***a potential conflict of interest*** *on the part of those involved in the decision-making process*

(not an exhaustive list)

Then it is highly probable that an application to the Court of Protection is appropriate. In such an event consideration ***must*** *always be given as to whether an application to the Court of Protection is required.*

The guidance confirms that applications relating to medical treatment fall within the Personal Welfare Pathway and so the pre-issue steps contained in Practice Direction 3B should be followed. It also addresses who the parties to the proceedings are likely to be; allocation of the case; matters to be considered at the first directions hearing; urgent hearings and orders.

1 See Sophy Miles's post on the guidance, 'Coronavirus, mental capacity and deprivation of liberty', Doughty Street Chambers, 9 April 2020.
2 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/878144/Ops_update_-_family_court_business_priorities_6_April_2020_FINAL.pdf.
3 www.mentalcapacitylawandpolicy.org.uk/wp-content/uploads/2020/03/Remote-Hearings-COP-31-March-2020.pdf.
4 www.cpba.org.uk/wp-content/uploads/2020/05/Mr-Justice-Hayden-letter-11.05.pdf.
5 www.cpba.org.uk/wp-content/uploads/2020/04/CPBA-Effective-Remote-hearings-7.4.2020-Final-Clean.pdf.
6 https://courtofprotectionhandbook.files.wordpress.com/2020/05/letter-vp-to-adass-4-may-2020.pdf.
7 See Sue James, 'Remoteness of justice', May 2020 *Legal Action* 18. See also: 'Remote justice: a family perspective', Transparency Project, 29 March 2020.

Gemma Daly, Mary-Rachel McCabe and Sophy Miles are barristers at Doughty Street Chambers.

Housing benefit: update 2020

Bethan Harris, Desmond Rutledge and Kevin Gannon round up the past year's key developments in housing benefit policy, legislation and case law.

Bethan Harris

Desmond Rutledge

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Policy and legislation

Changes to housing benefit and universal credit housing costs in response to COVID-19

Increase in local housing allowance rates

Local housing allowance (LHA) is the maximum rate at which housing benefit (HB) or the housing costs element of universal credit (UC) is paid to claimants who rent their homes in the private rented sector. In 2013, LHA rates ceased to be linked to local market rents, and from April 2016, the rates were frozen completely for four years (*Frozen out: the real value of the local housing allowance in the final year of the benefit freeze*, Chartered Institute of Housing, November 2019, page 3). As a result, the number of properties available at or below the LHA rate has been less than the number of private renters claiming benefit, with the result that large numbers of people have been facing a shortfall between what they have to pay for their accommodation and the HB/UC housing costs element they receive, and having to meet that shortfall out of other income.

Since 30 March 2020, the Social Security (Coronavirus) (Further Measures) Regulations 2020 SI No 371[1] have brought a measure of improvement for claimants renting in the private sector by restoring the link between LHA and market rents, with LHA reset at whichever is the lower out of the 30th percentile of local rents and a national maximum LHA set for the category of dwelling. However, the housing charity Shelter has pointed out that the effect of the reform is undermined by the benefit cap (Jenny Pennington, 'The benefit cap is undermining the government's response to coronavirus (COVID-19)', Shelter blog, 11 May 2020). Unless the benefit cap is lifted, it will prevent some households benefiting from the increase in LHA.

Prisoners on temporary release

The Social Security (Coronavirus) (Prisoners) Regulations 2020 SI No 409, in force since 8 April 2020, amend the Housing Benefit Regulations 2006 SI No 213 to enable prisoners on temporary release from prison due to the COVID-19 outbreak to claim HB. The amendments are of temporary effect (reg 6; see also the Department for Work and Pensions' (DWP's) HB adjudication circular A8/2020[2]).

Further measures called for

The District Councils' Network (DCN) has reported evidence of a large number of households in the private rented sector being at risk of homelessness due to needing to spend over half their income on rent, and incomes falling due to the pandemic ('Coronavirus: half a million on brink of homelessness due to pandemic, councils warn', DCN press release). It has called for the permanent lifting of HB for private sector tenants:

Councils are working flat out helping those that need help to try and prevent a homelessness spike – through administering the hardship fund, helping people access benefits, working with landlords, supporting food banks and more.

But it is becoming more difficult as the demand increases and council incomes plummet, councils will need more tools and funding to help stave off a huge rise in homelessness in the coming months.

Homelessness charities, while commending the government's 'Everyone in' hotel and emergency accommodation operation and the lifting of LHA to link it to the bottom 30th percentile of rent, have made a series of recommendations for homelessness prevention during the pandemic (*Open letter to the prime minister on the next steps needed to protect people experiencing homelessness in the coronavirus outbreak*, 2 April 2020[3]). These include an increase in discretionary housing payments (DHPs), particularly needed in high-rent areas where the increase in the LHA rate will have limited impact, and lifting the requirement to repay advance payments of UC paid during the five-week waiting period.

In the *Government response to the Housing, Communities and Local Government Select Committee report on protecting rough sleepers and renters* (CP 248, 25 June 2020), the government announced that the increase in the LHA rate to the 30th percentile would remain in place until March 2021, and that decisions on LHA levels from April 2021 would be made through future fiscal events and DWP Rent Officers Orders in the normal way.