JUDICIARY OF
ENGLAND AND WALES

MR JUSTICE HAYDEN
VICE PRESIDENT OF THE COURT OF PROTECTION

Dear Director,

In the early days of the covid-19 pandemic health crisis, the Court of Protection established a group of practitioners, ('the Hive') whose task is to monitor and respond to the strains on the court system which, inevitably, arise in consequence of the social isolation requirements that we all face. Hospitals, Care Homes, families and people self-isolating alone all face different challenges, with varying degrees of hardship and distress. Those who are subject to litigation in the Court of Protection (P) are amongst those most vulnerable to the privations which arise in consequence of the need to protect public health.

The protection afforded to this group of people by the Mental Capacity Act 2005 is constructed in a way which promotes autonomy, guards liberty and seeks to identify best interests. It requires to be said, in terms which permit of no ambiguity, that these principles have, if anything, enhanced importance in times of national emergency. The Court of Protection has adapted to the exigencies of remote hearings with an alacrity that few would have thought possible only months ago. This has been achieved by the concerted efforts of all involved.

I am very conscious that those on the front line and particularly those in the Care Home system, have come under great pressure on many fronts. I am aware, from a variety of sources, that many carers have given selflessly and unstintingly of their time and energy. In some circumstances carers for those with dementia and other cognitive impairments have become their primary source of stability and, to use the phrase which I have heard so frequently, evolved in to "a substitute family". I have heard of Care Homes devising compassionate and humane arrangements to facilitate contact between P and family members in various creative and resourceful ways which adhere to the need for social distancing. Equally, I am alert to the fact that individuals in these circumstances may often react badly. I have been told that this can take many forms but commonly manifests itself either in depression and withdrawal from the world or alternatively in highly agitated behaviour. Both these presentations may provoke the necessity for medication. It is self-evident that this changed dynamic requires a constant evaluation of 'best interests'. Deprivation of liberty will always require strong and well-reasoned justification. The obligation to keep this in review has not diminished in any way in the present circumstances.

I am very clear that assessments of capacity can be conducted 'remotely' with both competence and fairness in the vast majority of cases. Key to this is the involvement of carers and family in the process. The incorporation of these important sources of information will, I strongly suspect, be a feature of the assessment process long after

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the present public health emergency has passed. I have been greatly impressed with the protocol put in place by Ms Lorraine Currie, professional lead for Shropshire Council. Ms Currie is a visiting lecturer at Wolverhampton and Keele Universities and chairs the national DoLS leads groups. I anticipate that she will be well known to you. I have appended her protocol to this letter, in the hope that it may be considered and perhaps developed to formulate a consistent national approach. I emphasise that I pass it on to you because it strikes me as an effective way of respecting the autonomy of people in Care Homes and the continuing application of the fundamental principles of the Mental Capacity Act 2005 in what will be, at times, challenging circumstances.

It was expressed to me, at the Hive group, that there appear to be some who believe that careful adherence to proper legal process and appropriate authorisation may now, at times, be required to give way to other pressing welfare priorities. I understand how this view might take hold in establishments battling to bring calm and reassurance to intensely distressed people, both in the Care Homes and within their wider families. It is important, however, that I signal that whilst I am sympathetic to the pressures, I am very clear that any such view is entirely misconceived. **The deprivation of the liberty of any individual in a democratic society, holding fast to the rule of law, will always require appropriate authorisation. Nothing has changed. The Mental Capacity Act 2005, the Court of Protection Rules and the fundamental rights and freedoms which underpin them are indispensable safeguards to the frail and vulnerable.**

There has been a 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. 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.

4th May 2020

Measures to manage DoLS authorisations during Covid -19

The following measures are proposed instead of face to face visits to ensure protection for those most at risk of Human Rights breaches, to maximise the Councils capacity to promote and safeguard the well-being of those who may be subject to a deprivation of liberty and to manage the potential spread of Covid -19

General points

Most/all care homes are likely to be implementing additional restrictions during this time. Many of these do **not** relate to deprivation of liberty due to unsoundness of mind but rather relate to preventing the spread of infectious diseases. We await clear guidance on the position for those who need to be isolated/restricted on this basis and how to protect their article 5 rights beyond the protection offered by DoLS.

Schedule A1 Mental Capacity Act describes how a best interests assessment is carried out.

The assessor must consult the managing authority of the relevant hospital or care home.

The assessor must have regard to all of the following—

(a)the conclusions of the mental health

(b)any relevant needs assessment;

(c)any relevant care plan.

There is no requirement for face to face assessment or even for consultation with P.

This is much more difficult with capacity and mental health assessments; hence the following measures seek pragmatic ways to provide such assessments.

Appeal to the Court of Protection is still available for people once an authorisation is issued, this is not available without an authorisation in force.

Consideration may need to be given for casual staff to have look up access to Liquid Logic if they are utilised during this period to allow them to carry out the checks referred to below.

It must be noted that these measures will ensure some degree of business continuity, but Public Health measures may make it impossible to complete many of the requests for DoLS Authorisations.

Form 1s – new applications

Screen as usual for priority

Urgent cases

1. If the situation is urgent DoLS Team Manager to consider whether a visit is possible or even an option.
2. If it is possible the first approach is to require the s12 doctor to visit and complete MHA and MCA. This limits the number of professionals visiting and the BIA will complete the rest of the assessments by phone interviews.
3. If significant restriction or objection is indicated, the BIA may need to visit to assess further; however, in such cases it is preferable to consider shorter authorisation periods with a

reassessment planned later, or a longer authorisation period but with a review planned e.g. within 2-3 months.

If no visit is possible

1. Can the MHA be completed from existing notes?
2. Is there a capacity assessment for the same or similar decision with adequate evidence to rely on, which can be utilised by the BIA?
3. Is the person nonverbal rendering it likely that capacity is lacking on this basis alone?
4. Is there evidence from other sources and previous assessments rendering it likely that capacity is lacking for most decisions other than day to day. Can this evidence be used?
5. If a capacity assessment can be completed by any of the above methods, then the remaining assessments to be completed by phone

Non-Urgent Form 1s

1. Screen for existing evidence.
2. Is communication nil and has capacity previously been assessed on more than one occasion with a lack of capacity evidenced through minimal to no communication.
3. Can you use this evidence to complete a valid capacity assessment, in conjunction with the social worker or person who knows P well?
4. There may be a recent capacity assessment e.g. for admission to care home but completed by social worker. Can the BIA verify details and use this as evidence for their own capacity assessment making it clear it is drawn from evidence from others due to not being able to visit.
5. If so, then proceed to do Best Interests by phone and speaking to relatives.
6. BIAs/Admin should record which care homes are preventing access and update their assessments with details of additional restrictions such as lack of access, visitor restrictions etc
7. BIAs can still commence new assessments by phone to care homes and families, identify specific restrictions and any particular issues, and complete as far as possible. These can be finalised with capacity assessments once visits are allowed again. In this way partial assessments can be completed in bulk by care home. To be finalised later.

Form 2s -Renewals

1. Screen for all up and coming renewals with capacity assessments in date
2. Use these along with MHA completed from previous assessment and do Best Interests by phone
3. Where visits are still allowed/advised s12 doctors to be required to complete mental capacity assessments, as well as MHA
4. Recently expired capacity assessments where the BIA confirms with the care home and the RPR that there is no change, could be used by the BIA repeating the information and updating with their phone call to verify nothing has changed. Don't forget there will be no time limit of use of assessments under LPS
5. In renewal cases where there has been some significant change, such as increase in dependency/restrictions, BIAs can still complete renewal assessments by phone, but if there is significant new information complete a Form 3 explaining in the recording the circumstances which prevented a visit.
6. If there is objection – either new or more markedly than previously - then BIAs may need to highlight the strength of objection and consider advising on an application to the Court of

Protection at the earliest opportunity. BIAs must still apply the guidance on where an appeal is required.

Renewals where the Form 2 is not received in time

1. A short window (up to two weeks) could be allowed whereby an expired authorisation can still treated as a renewal even though they have expired. Perhaps consider whether Form 9 is appropriate in these circumstances.
2. Generating Form 2s on time is useful for everyone in the current situation. Where a Form 2 is not received the BIA can still commence the renewal and ask for the Form two when they phone to begin assessing.

Summary

During this challenging time a pragmatic approach must be taken to ensure vulnerable people receive appropriate legal protection.

Locating capacity assessments which are still in time is key and can be carried out by admin

Locating renewals in time also can be supported by admin

Using a combination of the above measures will ensure the Council continues to meet its legal requirements.

BIAs and Authorisers should record some form of words to clarify how the assessments were completed. The following is suggested[1]

For the BIA report:

"This assessment occurred at a time when public health measures had been put in place by HM Government to contain the spread of the COVID-19 virus. Professionals were being advised only to carry out essential visits to care homes.

When completing this assessment, I had to balance the need to protect X's Article 5 rights against the need to protect him/her from transmission of the virus. COVID-19 infection would have posed a grave risk to X in view of his/her underlying health conditions.

In view of these concerns, I therefore decided to base my assessment on existing documents and on the views of X's carers and family/friends rather than visiting him/her in person."

For the authorisation document:

"I note that the BIA decided not to assess X face to face in view of the risk of COVID-19 transmission. I agree that this is the best way of promoting X's Article 5 rights whilst protecting him from serious illness. This authorisation will be reviewed when public health restrictions are lifted."

[1] Thanks to Martin Sexton and Salford DoLS Team