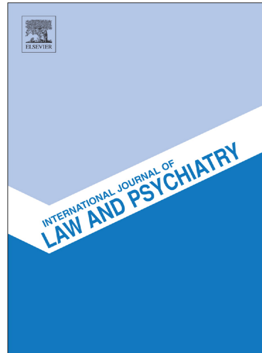
Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Elsevier hereby grants permission to make all its COVID-19-related research that is available on the COVID-19 resource centre - including this research content - immediately available in PubMed Central and other publicly funded repositories, such as the WHO COVID database with rights for unrestricted research re-use and analyses in any form or by any means with acknowledgement of the original source. These permissions are granted for free by Elsevier for as long as the COVID-19 resource centre remains active.

Journal Pre-proof

Capacity in the time of Coronavirus



Alex Ruck Keene Barrister

PII: S0160-2527(20)30019-4

DOI: https://doi.org/10.1016/j.ijlp.2020.101560

Reference: IJLP 101560

To appear in: *International Journal of Law and Psychiatry*

Received date: 6 April 2020

Revised date: 8 April 2020

Accepted date: 8 April 2020

Please cite this article as: A.R.K. Barrister, Capacity in the time of Coronavirus, *International Journal of Law and Psychiatry* (2020), https://doi.org/10.1016/j.ijlp.2020.101560

This is a PDF file of an article that has undergone enhancements after acceptance, such as the addition of a cover page and metadata, and formatting for readability, but it is not yet the definitive version of record. This version will undergo additional copyediting, typesetting and review before it is published in its final form, but we are providing this version to give early visibility of the article. Please note that, during the production process, errors may be discovered which could affect the content, and all legal disclaimers that apply to the journal pertain.

© 2020 Published by Elsevier.

Capacity in the time of Coronavirus

Alex Ruck Keene Barrister alex.ruckkeene@39essex.com

39 Essex Chambers Wellcome Research Fellow and Visiting Lecturer at the Dickson Poon School of Law, King's College London Visiting Senior Lecturer, Institute of Psychiatry, Psychology & Neuroscience, King's College London Research Affiliate, Essex Autonomy Project, University of Essex

Abstract

In the course of a few short weeks, many of the established legal frameworks relating to decision-making in England & Wales in respect of those with impaired decision-making capacity have been ripped up, or apparently rendered all but unusable. Although the Mental Capacity Act 2005 itself was not amended, the impact of other legislation (especially the Coronavirus Act 2020) means that duties towards those with impaired decision-making capacity have been radically changed. This article reflects the experience of a practising barrister in England & Wales grappling with the impact of COVID-19 upon the Mental Capacity Act 2005 across a range of fields in the weeks after the world appeared to change in mid-March 2020

Introduction

This paper is avowedly a report from the front line, rather than an abstract academic disquisition. It is, further, at best, a first draft of history. It reflects the experience of a practising barrister in England & Wales grappling with the impact of COVID-19 upon the Mental Capacity Act 2005 ('MCA 2005') across a range of fields in the weeks after the world appeared to change in mid-March 2020.[1] In the course of a few short weeks, many of the established legal frameworks relating to decision-making in England & Wales in respect of those with impaired decision-making capacity were ripped up, or apparently rendered all but unusable. Although the MCA 2005 itself was not amended, the impact of other legislation (especially the Coronavirus Act 2020) meant that duties towards those with impaired decision-making capacity were radically changed. Questions of isolation and social distancing raised stark questions about protection – and the ends of protection – with particular difficulties in the context of those who could not understand what they were being asked or required to do. The intense pressure upon hospitals, and, in particular intensive care units, meant that best interests decision-making as the choice between available options suddenly took on a new and very stark character, and advance care planning started – in some cases – to appear to be a threat rather than an opportunity. And the Court of Protection itself, the statutory court charged with oversight of the MCA 2005, had in a matter of weeks to transform itself into a virtual court, raising deep questions about the functions of justice and participation.

This article surveys each of these areas and provides some initial reflections – and predictions – in relation to them.

Section 1: Context

For those not familiar with the law of England and Wales, a brief overview may be of assistance.

[1] The world had, of course, changed some time ago in other countries, from China in late 2019.

Journal Pre-proof

Journal Pre-proof

This article discusses both England and Wales. Devolution means that there are similarities and differences between the two.[2] The MCA 2005 applies in England & Wales as the framework through which decisions are made (most often informally) about capacity and best interests, on the basis of a functional model of mental capacity. The MCA 2005 also provides an administrative route for deprivation of liberty for purposes of enabling care and treatment of adults in hospitals and care homes, the so-called Deprivation of Liberty Safeguards ('DoLS'). Outside hospitals/care homes, or in relation to those aged under 18, court authorisation will be required. Separately, and long-predating the MCA 2005 the Mental Health Act 1983 ('MHA 1983'), which applies in both England & Wales, provides for the assessment and treatment of mental disorder, by compulsion if required. Challenges to authorisations under DoLS are to the Court of Protection, a statutory court established to oversee the MCA 2005;[3] challenges to detention under the MHA 1983 are to the Mental Health Tribunal/Mental Health Review Tribunal for Wales.

The MCA 2005 does not provide any mechanism to compel the delivery of health or social care to an individual. The Court of Protection has a duty to act in the best interests of the person before it, as do others (outside the court room arena) making best interests decisions on their behalf. But the Court of Protection:

> *35.* […] *only has power to take a decision that P himself could have taken? It has no greater power to oblige others to do what is best than P would have himself. This must mean that, just like P, the court can only choose between the 'available options.'*
>
> […]
>
> *37. Other service-providing powers and duties* [outlined immediately below] *also have their own principles and criteria which do not depend upon what is best for the service user, although that will no doubt be a relevant consideration. Decisions can, of course, be challenged on the usual judicial review principles. Decisions on health or social care services may also engage the right to respect for private (or family) life under article 8 of the European Convention on Human Rights, but decisions about the allocation of limited resources may well be justified as necessary in the interests of the economic wellbeing of the country (see McDonald v United Kingdom [2015] 60 EHRR 1). Here again, therefore, the legal considerations, both for the public authority and for the court, are different from those under the 2005 Act.*[4]

Challenges by way of judicial review are to a different court, the Administrative Court, for which it is more difficult (as a generalisation) to get public funding to pay for legal assistance,[5] and are more limited in scope, focusing on the **process** of decision-making much more than the **outcome** of the decision.

The National Health Service Act 2006 sets out the powers and duties of the National Health Service to provide healthcare; the Care Act 2014 (in England) and the Social Services and Well-Being (Wales) Act 2014 sets out the powers and duties of local authorities to provide social care to individuals.[6] If an

---

[2] I do not address these in detail, but keen observers will no doubt wish to keep an eye upon whether and how devolution means that the paths taken in the two differ.

[3] For more detail, see Ruck Keene, A. R., Kane, N. B., Kim, S. Y., & Owen, G. S. (2019). Taking capacity seriously? Ten years of mental capacity disputes before England's Court of Protection. *International journal of law and psychiatry*, *62*, 56-76.

[4] See *MN v ACCG* [2017] UKSC 22, per Lady Hale. See also *PW v Chelsea And Westminster Hospital NHS Foundation Trust & Ors* [2018] EWCA Civ 1067, in the context of medical treatment.

[5] Where, importantly, it is more difficutl

[6] Separate regimes exist in relation to children, which are not discussed in this article.

Journal Pre-proof

individual's needs are such as to amount to a 'continuing healthcare' need, then it is the responsibility of the NHS to meet them, and to do so for free. Social care is means-tested, such that a charge can be made for the provision of such care by local authorities. In very broad terms, in relation to both healthcare (outside hospital) and social care, the relevant public body is under a duty to assess the needs of the person, determine whether they are eligible needs, and then meet them.

Finally, the Public Health (Control of Diseases) Act 1984 contains an extensive range of powers (in Part 2A) in relation to public health protection, including, most materially, the power to the Secretary of State (in England) and the Welsh Ministers (in Wales) to make 'health protection regulations' "for the purpose of preventing, protecting against, controlling or providing a public health response to the incidence or spread of infection or contamination in England and Wales (whether from risks originating there or elsewhere)."[7]

Section 2: Health and social care outside hospital

If decisions are made under the MCA 2005 between the options that are actually available to the person, then changes made in relation to the powers and duties upon the state to secure the needs of individuals with impaired decision-making capacity will have a dramatic – knock-on – effect upon the scope of those options. This is precisely what the Coronavirus Act 2020 ('CA 2020') has done, and I go into the changes it has introduced in some detail for two reasons:

(1) for the benefit of those within England & Wales who are grappling with (for whatever reasons) the new landscape;

(2) as a case study for those concerned more broadly with the UN Convention on the Rights of Persons with Disabilities ('CRPD'), to make the point that examining whether persons with disabilities are able to 'enjoy legal capacity on an equal basis with others in all aspects of life'[8] in any jurisdiction requires examination not just of the laws that on their face govern legal capacity, but also the wider framework within which those laws are placed.

The CA 2020 was introduced into Parliament on 19 March 2020, and received Royal Assent under a week later, on 26 March 2020. Its long title "An Act to make provision in connection with coronavirus; and for connected purposes" does not adequately convey its scope. Reflecting the impact of COVID-19 across all aspects of society, the Act includes provisions ranging from emergency registration of health professionals, to the power to require information relating to food supply, to powers relating to the temporary closure of educational institutions and childcare premises, to postponement of elections to the General Synod of the Church of England. For present purposes, I focus upon the duties upon public bodies to assess and meet the continuing healthcare and social care needs of individuals, the latter because of their profound, indirect, impact upon decision-making in relation to those within the scope of the MCA 2005.

Even prior to the introduction of the Coronavirus Bill, it had become clear that local authorities would become hugely stretched. On the day that the Bill was introduced into Parliament, the Government published on 19 March 2020 an unprecedented document, *Responding to COVID-19: Ethical*

[7] PH(CD) A 1984, s.45C.
[8] UNCRPD, Article 12.

Journal Pre-proof

Journal Pre-proof

Framework for Adult Social Care.[9] This document, in essence, transposed principles that had been developed in relation to triage for inpatient medical treatment in the context of pandemic flu[10] to the social care setting:

> *Recognising increasing pressures and expected demand, it might become necessary to make challenging decisions on how to redirect resources where they are most needed and to prioritise individual care needs. This framework intends to serve as a guide for these types of decisions and reinforce that consideration of any potential harm that might be suffered, and the needs of all individuals, are always central to decision-making.*

It was not just local authorities, but also the NHS, which would be stretched. I deal at section 6 below with decision-making in hospital. Here, I focus on the position outside hospital where, as noted above, the NHS (through – in England – Clinical Commissioning Groups) has both powers and duties to meet continuing healthcare needs.[11] The CA 2020, with immediate effect, suspended[12] the duty on the NHS in England to carry out assessments of whether a person is in need of continuing healthcare. Crucially, such continuing healthcare needs are free to access, unlike social care provision for which charges can be made. The Explanatory Notes to the Act rather coyly suggested this section "changes the procedure for discharge from an acute hospital setting for those with a social care need […] It allows NHS providers to delay undertaking the NHS Continuing Healthcare (NHS CHC) Assessment and pending that assessment, the patient will continue to receive NHS care."[13] The provisions of the CA 2020 in this respect were not, in fact, so limited. Although s.14 CA 2020 does not **stop** Clinical Commissioning Groups carrying out such assessments, the (temporary) repeal of the duty mean that, overnight, individuals with profound health care needs lose any entitlement to assessment of those needs as a precursor to the potential for those needs to be met, for free. Those of such individuals with impaired decision-making capacity therefore lose – in many cases – the potential for options to be made available for them in terms of their residence and care arrangements.

Further, given the abolition of the duty to assess, recourse to judicial review to challenge a failure to carry out an assessment becomes a high-on impossible task (and the Court of Protection can offer no assistance[14]). Given that there is a considerable overlap between individuals with impaired decision-making capacity and those with continuing healthcare needs, their options have been immediately and dramatically narrowed by this legislative change.

The CA 2020 also introduced what the Government (but not the Act) described as 'easements'[15] to the governing legislation relating to social care provision in England (the Care Act 2014) and Wales (the

[9] Department of Health and Social Care, 19 March 2020: https://www.gov.uk/government/publications/covid-19-ethical-framework-for-adult-social-care/responding-to-covid-19-the-ethical-framework-for-adult-social-care (accessed 4 April 2020).
[10] By the Committee on Ethical Aspects of Pandemic Influenza in 2007: see Department of Health 'Responding to pandemic influenza—the ethical framework for policy and planning (London: Department of Health, 2007).
[11] Under, in particular, the National Health Service Act 2006.
[12] CA 2020s.14.
[13] Coronavirus Act 2020 Explanatory Notes, http://www.legislation.gov.uk/ukpga/2020/7/contents/enacted (accessed 4 April 2020), paragraphs 229-230.
[14] *MN v ACCG* [2017] UKSC 22 at paragraph 35, per Lady Hale.
[15] See (for England), Department of Health and Social Care 'Care Act easements: guidance for local authorities' (31 March 2020), available at https://www.gov.uk/government/publications/coronavirus-covid-19-changes-to-the-care-act-2014/care-act-easements-guidance-for-local-authorities (accessed 4 April 2020).

Journal Pre-proof

Journal Pre-proof

Social Services and Well-Being (Wales) Act 2014).[16] Both came into force shortly after the CA 2020 was passed.[17] For present purposes, I focus upon the English position.

Statutory guidance published[18] on 31 March 2020 makes clear that there was a process through which local authorities have to go before they can take advantage of the 'easements' provided by the Act, and, in particular, that:

> *A Local Authority should only take a decision to begin exercising the Care Act easements when the workforce is significantly depleted, or demand on social care increased, to an extent that it is no longer reasonably practicable for it to comply with its Care Act duties (as they stand prior to amendment by the Coronavirus Act) and where to continue to try to do so is likely to result in urgent or acute needs not being met, potentially risking life. Any change resulting from such a decision should be proportionate to the circumstances in a particular Local Authority.*

At the time of writing, no local authority has yet gone through this procedure, but such is only a matter of time. At that point, any local authority would not have to comply with the following duties in terms of assessment: (1) the duty to assess needs under s.9;[19] (2) the duty to assess the needs of a carer under s.10;[20] (3) the duty to give written records of an assessment under s.12 (3) and (4);[21] (4) the duty to determine whether needs meet the eligibility criteria under s.13 (or regulations made under s.13);[22] (5) the duty to assess financial resources consequent upon a determination that needs meet the eligibility criteria under s.17 if it is intending to charge for the provision of services.[23] Further, the local authority's duty and powers to meet needs under ss.18 and 19 of the Care Act 2014 were essentially re-written. Section 18 was rewritten[24] so as to impose a duty upon a local authority to meet an adult's needs for care and support if (and only if): (1) the adult was ordinarily resident in the authority's area or was present in its area but of no settled residence; (2) the authority considered that it was necessary to meet those needs for the purpose of avoiding a breach of the adult's rights under the European Convention on Human Rights and; (3) there was no charge (under s.14) for meeting those needs or, in so far as there was, condition 1, 2 or 3 was met.[25] The power under s.19 to meet an adult's needs for care and support was expanded, so as to take effect without any prior requirement for a needs, eligibility and/or financial assessment, s.19(1) for instance being re-written to read "[a] *local authority may meet an adult's needs for care and support if (a) the adult is ordinarily resident in the authority's area or is present in the area but of no settled residence; and (2) the authority is*

[16] CA 2020 s. 15 and Parts 1 and 2 respectively of Sch. 12 to the CA 2020.
[17] By Coronavirus Act 2020 (Commencement No. 2) Regulations 2020 (SI 2020/388) and The Coronavirus Act 2020 (Commencement No. 1) (Wales) Regulations 2020 (SI 2020 No. 366 (W. 81)).
[18] CA 2020 Sch. 12 para 18.
[19] CA 2020 Sch. 12 para. 2(1)(1). This also means that there is no duty to comply with regulations made relating to such assessments under s.11 CA 2014 Sch. 12 para. 2(1).
[20] CA 2020 Sch. 12, para. 2(1)(b). This also means that there is no duty to comply with regulations made relating to such assessments under s.11 CA 2014 (Sch. 12 para 2(1).
[21] CA 2020 Sch 12, para 2(1)(c).
[22] CA 2020 Sch. 12, para. 2(2).
[23] CA 2020 Sch. 12, para. 3(1) of Schedule 12. However, a local authority could not charge for services unless such an assessment had been carried out:CA 2020 Sch. 12.,para. 3(2).
[24] CA 2020 Sch. 12, para. 4.
[25] These are, respectively, (1) the local authority is satisfied on the basis of the financial assessment it carried out that the adult's financial resources are at or below the financial limit; (2) the local authority is satisfied on the basis of the financial assessment it carried out that the adult's financial resources are above the financial limit, but the adult nonetheless asks the authority to meet the adult's needs; and (3) the adult lacks capacity to arrange for the provision of care and support, but there is no person authorised to do so under the Mental Capacity Act 2005 or otherwise in a position to do so on the adult's behalf.

Journal Pre-proof

satisfied it is not required to meet the adult's needs under section 18." The statutory guidance did not explain when and how such power was to be used. Section 20 of the Care Act 2014 is also (when 'eased') watered down[26] so that that the duty to meet a carer's need for support is to be tied to the necessity to avoid a breach of the carer's rights under the ECHR.

The CA 2020 does not suspend **every** duty upon local authority where an 'easement' was in force: as the statutory guidance[27] noted

> *Duties in the Care Act to promote wellbeing and duties relating to safeguarding adults at risk remain in place.* […]
>
> *Duties in the Mental Capacity Act 2005 relating to Deprivation of Liberty Safeguards (DoLS) remain in place.* […]
>
> *Duties imposed under the Equality Act 2010 also remain, including duties to make reasonable adjustments, the Public Sector Equality Duty and duties towards people with protected characteristics. These should underpin any decisions made with regard to the care and support someone receives during this period.* […]

I return to Deprivation of Liberty Safeguards at section 4 below.

The ECHR to the rescue?

It will be clear that the watering down of duties under the Care Act 2014 to a 'bare bones' approach, so as to avoid a breach of the ECHR,[28] means that in many cases the options available for individuals with impaired decision-making capacity are dramatically reduced.

That having been said, and as a possible – and very tentative – silver lining to the cloud, the sudden and very immediate focus upon the ECHR may mean a renewed focus by the English courts upon the **positive** aspects of rights under the ECHR, and what those aspects mean in the context of those who cannot make their own choices.

The statutory guidance, itself identifies as of importance the right to life under Article 2 of the ECHR, the right to freedom from inhuman and degrading treatment under Article 3 and the right to private and family life under Article 8.[29] In order for these rights to be effective, the courts have over time identified that they contain not just injunctions upon the state **not** to things, but also to take positive steps to ensure that the right is enjoyed.[30]

---

[26] CA 2020 Sch. 12, para. 6.
[27] Department of Health and Social Care 'Care Act easements: guidance for local authorities' (31 March 2020), available at https://www.gov.uk/government/publications/coronavirus-covid-19-changes-to-the-care-act-2014/care-act-easements-guidance-for-local-authorities (accessed 4 April 2020).
[28] In Wales, the position was arguably even starker: local authorities were only under duties to meet needs under the Social Services and Well-Being (Wales) Act 2014 where " the local authority considers it necessary to meet the needs in order to protect the adult from abuse or neglect or a risk of abuse or neglect" (CA 2020 Sch. 12, para. 27, amending s.35 Social Services and Well-Being (Wales) Act 2014.
[29] Department of Health and Social Care 'Care Act easements: guidance for local authorities' (31 March 2020), available at https://www.gov.uk/government/publications/coronavirus-covid-19-changes-to-the-care-act-2014/care-act-easements-guidance-for-local-authorities
[30] For an overview, see Jean-François Akandji-Kombe, 'Positive obligations under the European Convention on Human Rights,' A guide to the implementation of the European Convention on Human Rights (Council of Europe, Human Rights Handbook No.7, 2007).

Journal Pre-proof

The ECHR has been 'domesticated' through the Human Rights Act 1998, such that individuals can rely upon the rights it contains before the courts, and public bodies are required to comply with it in the discharge of their functions, so, on one view, the changes introduced by the CA 2020 do nothing other than repeat a commitment which already exists. However, traditionally, ECHR rights have played only a relatively limited part in consideration of Care Act 2014 duties and powers. A useful summary can be found in the judgment of Michael Fordham QC in *R (Aburas v London Borough of Southwark).*[31] Ordinarily, as that judgment makes clear, "*Convention rights which relate to 'looked-after needs', if not met through the section 18 duty and "eligible needs" , must be secured through the exercise of the section 19 power*."[32] In other words, recourse will only rarely be required to the ECHR as opposed to the terms of s.18 Care Act 2014 itself. Further, only very limited recourse would be had to the ECHR in order to leverage the provision of social care to a person. Such could explain the majority decision of the Supreme Court *in R (McDonald) v Royal Borough of Kensington and Chelsea*,[33] in which it was found that the decision of a local authority to meet the claimant's needs in relation to incontinence by way of incontinence pads rather than overnight support did not even engage her rights under Article 8(1).[34]

Indeed, to date, almost the only situation in which recourse had routinely had been to the ECHR to ground a **duty** to support[35] was in the immigration context, in which s.54 and Paragraph 1 of Schedule 3 to the Nationality, Immigration and Asylum Act 2002 ('NIAA 2002') prevents local authorities from providing support under the provisions listed in the Schedule (including, now, the provision of care and support under the Care Act 2014) to those subject to immigration control. Paragraph 3 of Schedule 3 to the NIAA 2002 provides that this exclusion:

> "*does not prevent the exercise of a power or the performance of a duty if, and to the extent that, its exercise or performance is necessary for the purpose of avoiding a breach of—*
>
> *(a) a person's Convention rights, or*
>
> *(b) a person's rights under the Community Treaties*."

The case-law decided in relation to this paragraph sets the bar high, for instance. It was usefully summarised by Deputy High Court Judge Peter Marquand in *R (GS) v Camden London Borough Council*,[36]the key passages being as follows:

> *… In Limbuela's case [2006] 1 AC 396 , paras 7–8, Lord Bingham of Cornhill reviewed the principles of article 3 … "Treatment is inhuman or degrading if, to a seriously detrimental extent, it denies the most basic needs of any human being. As in all article 3 cases, the treatment, to be proscribed, must achieve a minimum standard*

[31] [2019] EWHC 2754 (Admin).
[32] [2019] EWHC 2754 (Admin),para. 10.
[33] [2011] UKSC 33
[34] See [2011] UKSC 33 paras. 15-19 in the judgment of Lord Brown, with whom the other members of the majority agreed (they also agreed with his conclusion that even if her rights were engaged, any interference with them would have been justified by reference to Article 8(2) "*on the grounds that it is necessary for the economic well-being of the respondents and the interests of their other service-users and is a proportionate response to the appellant's needs because it affords her the maximum protection from injury, greater privacy and independence, and results in a substantial costs saving*" (para. 19)).
[35] As opposed to framing the exercise of a power, as per *R(Aburas v London Borough of Southwark)* [2019] EWHC 2754 (Admin)..
[36] [2016] EWHC 1762 (Admin)

Journal Pre-proof

of severity, and ... in a context such as this, not involving the deliberate infliction of pain or suffering, the threshold is a high one. [….] *When does the ... duty ... arise? The answer must in my opinion be: when it appears on a fair and objective assessment of all relevant facts and circumstances that an individual applicant faces an imminent prospect of serious suffering caused or materially aggravated by denial of shelter, food or the most basic necessities of life.*

And this passage, in which the judge made clear that Article 8 is, to date, rarely seen as adding anything to Article 3:

In Anufrijeva's case [2004] QB 1124 , para 43, which concerned allegations that there was a failure to take positive action to avoid breaches of article 8 rights by denying benefits to the claimants, the Court of Appeal (Lord Woolf CJ, Lord Phillips of Worth Matravers MR and Auld LJ) stated: "We find it hard to conceive, however, of a situation in which the predicament of an individual will be such that article 8 requires him to be provided with welfare support, where his predicament is not sufficiently severe to engage article 3. Article 8 may more readily be engaged where a family unit is involved. Where the welfare of children is at stake, article 8 may require the provision of welfare support in a manner which enables family life to continue.[37]

In the context of immigration control, the fiction (and it is frequently a fiction) is that the individual concerned could always return to the country from where they came from, so it is not surprising that the courts have interpreted the ECHR as providing a minimalist safety net designed to ensure that the UK does not breach its obligations to those individuals under the Convention. No such fiction could now operate across the piece. It seems to me, therefore, that (as perhaps presciently *Aburas* might be said to recognise[38]), the context is very different because, in effect, the ECHR is being required to do the heavy-lifting across the piece.

Long experience before the courts means that I do not underestimate the difficulty in persuading either a local authority or – in due course – a court that it should not follow the very high bar set by the cases discussed above, which include jurisprudence up to and including the Supreme Court.

That having been said, it seems to me that there are good arguments that courts should be more willing to place weight upon Article 8 ECHR alone as opposed to the general position that (absent where a family is involved[39]) Article 8 does not add to Article 3 ECHR. Article 8 is a qualified right – i.e. interference with it can be justified under the circumstances provided for under Article 8(2)[40] – so that it does not have the same leverage as the absolute right under Article 3 ECHR. However, if the Government has (by the Coronavirus Act 2020, amplified by the guidance) squarely invited public

---

[37] [2016] EWHC 1762 (Admin) at paragraphs 64-70

[38] Note this passage: "*authoritative guidance as to the relevant level of severity of the implications for the individual [in order to engage Article 3 ECHR, and hence require the s.19 power to be exercised under the Care Act 2014] can be discerned from the passages citing Limbuela and Anufrijeva . No alternative line of authority was cited to me and no alternative formulation of relevant standards was contended for. The observations in Limbuela can, in my judgment, aptly inform the 'looked-after needs' context,* ***if that context is borne in mind***." (emphasis added).

[39] This is how subsequent decisions have distinguished *R (Bernard) v Enfield London Borough Council* [2002] EWHC 2282 (Admin), in which the situation was found to have breached Article 8 ECHR even though it did not breach Article 3 ECHR, because the entire family were in such dire straits as a result of the local authority's actions.

[40] Art. 8(2) applies. where the interference is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

bodies, and in due course, the courts to proceed by reference to Article 8 ECHR, then there is undoubtedly an argument that it should be asked to do more work to address the middle ground where the person's circumstances are not so dire as to cross the very high threshold of Article 3 ECHR, but positive steps are nonetheless required so as to secure their physical health[41] or, importantly, "psychological integrity."[42]

I would also suggest the courts should be willing to have regard to the recent jurisprudence from Strasbourg relating to Article 5 which – oddly – does not seem to have been considered domestically before the courts in England.[43] I note, in particular, the decision of the Grand Chamber of the European Court of Human Rights in *Rooman v Belgium*, in which it held, after a review of its case-law relating to Article 5 ECHR that:

> *the current case-law clearly indicates that the administration of suitable therapy has become a requirement in the context of the wider concept of the "lawfulness" of the deprivation of liberty. Any detention of mentally ill persons must have a therapeutic purpose, aimed specifically, and in so far as possible, at curing or alleviating their mental-health* condition*, including, where appropriate, bringing about a reduction in or control over their dangerousness. The Court has stressed that, irrespective of the facility in which those persons are placed, they are entitled to be provided with a suitable medical environment accompanied by real therapeutic measures, with a view to preparing them for their eventual release*.[44]

and also the decision in *Hiller v Austria*[45] in which the court held that:

> *today's paradigm in mental health care is to give persons with mental disabilities the greatest possible personal freedom in order to facilitate their re-integration into society. The Court considers that from a Convention point of view, it is not only permissible to grant hospitalised persons the maximum freedom of movement but also desirable in order to preserve as much as possible their dignity and their right to self-determination.* ***It also follows from the case-law on Article 5 of the Convention that a deprivation of liberty must be lifted immediately if the circumstances necessitating it cease to exist or change*** […] ***or must be scaled down to the extent which is absolutely necessary under the given circumstances*** […][46] (emphasis added)

Transposed to the social context, these cases could be used to found arguments that the environment in a particular care home (or another placement) is so unsuitable that to continue to require the person to live there (by exercising their functions under s.18 Care Act 2014) would be to either give rise to or perpetuate a breach of their Article 5 rights. It would, in other words, be an argument that the local

[41] *Botta v Italy* (1998) 26 EHRR 241.
[42] On the scope of this concept, see, for instance, *Dordevic v Croatia* [2012] ECHR 1650: "*152. The Court has previously held, in various contexts, that the concept of private life includes a person's psychological integrity. Under Article 8, States have in some circumstances a duty to protect the moral integrity of an individual from acts of other persons. The Court has also held that States have a positive obligation to ensure respect for human dignity and the quality of life in certain respects (see L. v. Lithuania, no. 27527/03, § 56, ECHR 2007-IV, and, mutatis mutandis, Pretty, cited above, § 65).*"
[43] The Court of Protection, in particular, having understood Article 5(1)(e) in principle not to relate to the suitability of the conditions under which the person is deprived of their liberty. See *North Yorkshire County Council & Anor v MAG & Anor* [2016] EWCOP 5, in particular the discussion of the jurisprudence relating to Article 5(1)(e) at paragraph 26, which predates both this decision and the decision in *Rooman*.
[44] [2019] ECHR 109 at para.286.
[45] [2016] ECHR 1028.
[46] *Hiller v Austria* [2016] ECHR 1028 at paragraph 54.

authority was exercising its (revised) powers under s.18 Care Act 2014 incompatibly with the ECHR, and hence unlawfully for purposes of s.6 Human Rights Act 1998.

Finally, and given what became rapidly and tragically clear was the very real risk to life posed by COVID-19 **within** care homes,[47] it could also be argued that, within the specific context of COVID-19, there would be cases in which the state's positive duty to secure life under Article 2 would mandate moving an individual from a care home into a place where they could benefit from better protection.

In these arguments, the CRPD can no doubt be deployed,[48] and this may be a circumstance in which the English courts' reluctance to engage substantively with the CRPD – as an unincorporated international treaty – may be amenable to challenge. To date, the approach of the courts to the CRPD in the context of the Care Act 2014 can be seen in the decision of the Court of Appeal in *R (Davey) v Oxfordshire County Council & Ors*,[49] where Bean LJ noted (and endorsed) the fact that:

> *the UNCRPD could be resorted to as a construction of a particular provision of the 2014 Act in case of ambiguity or uncertainty. However, great care must be taken in deploying provisions of a convention or treaty which set out broad and basic principles as determinative tools for the interpretation of a concrete measure such as a particular provision of a UK statute.* ***Provisions which are aspirational cannot qualify the clear language of primary legislation.***(emphasis added)[50]

In other contexts, the courts have been willing to accept that the CRPD can be of assistance in interpreting the application of the ECHR.[51] If the statute **itself** now directs the courts to consider the provisions of the ECHR (and, by extension, the CRPD), then the approach in *Davey* may no longer seem quite so tenable. Put another way, if the statute itself asks the ECHR to do more work as the safety net for those with disabilities, it is legitimate to ask those applying the statute to look to the CRPD to assist in ensuring that safety net has as few holes in as possible.

Whether advocates and – in due course – the courts will be willing to run with arguments such as those set out above is, at the time of writing, an open question. But if they do, they may, ironically, have further blurred the distinction between the civil and political rights traditionally seen as the core of the ECHR and socio-economic rights (i.e. rights which actually require states to spend money). They would, therefore, have potentially served as a Trojan Horse for making enforceable, at an

Journal Pre-proof

[47] As powerfully identified by the statement of the Council of Europe's Commissioner for Human Rights of 2 April 2020, 'Persons with disabilities must not be left behind in the response to the COVID-19 pandemic' (https://www.coe.int/en/web/commissioner/-/persons-with-disabilities-must-not-be-left-behind-in-the-response-to-the-covid-19-pandemic).

[48] A helpful summary of the extensive range of pronouncements from international human rights bodies in relation to the application of the CRPD and other instruments in the context of COVID-19 can be found in Oliver Lewis, Disability, coronavirus and international human rights, https://insights.doughtystreet.co.uk/post/102g27s/disability-coronavirus-and-international-human-rights (accessed 4 April 2020).

[49] *R (Davey) v Oxfordshire County Council & Ors* [2017] EWCA Civ 1308.

[50] [2017] EWCA Civ 1308 at para. 62.

[51] See, in particular, *Burnip v Birmingham City Council* [2012] EWCA Civ 629 (obiter, in the context of interpretation of Article 14 ECHR). See also Lawson, A. and Series, L. 'United Kingdom' in Waddington, L., & Lawson, A. (Eds.). (2018). *The UN Convention on the Rights of Persons with Disabilities in Practice: A Comparative Analysis of the Role of Courts*. Oxford University Press.

Journal Pre-proof

individual level, the rights to independent living and to health enshrined in the CRPD.[52] Such would be of inestimable benefit to those with impaired decision-making capacity.

Section 3: Public Health Restrictions

The lives of those with impaired decision-making capacity have also directly, and, as will be seen, disproportionately, been affected by the public health measures taken to respond to the COVID-19 crisis.

In the same week as the CA 2020 came into force, regulations made under the Public Health (Control of Disease) Act 1984 radically changed the legal landscape in England & Wales, effectively placing the population under severe restrictions (which the Daily Mail might even characterise as house arrest) for their good, and the good of society.

Health Protection (Coronavirus, Restrictions) (England) Regulations 2020

The Health Protection (Coronavirus, Restrictions) (England) Regulations 2020[53] are set to expire in 6 months' from the date of their coming into force on 26 March 2020,[54] although with reviews by the Secretary of State every 21 days.[55] Whilst the regulations are in force however, there are statutory restrictions on every person in England from leaving the place where they are living "without reasonable excuse."[56] The regulations provided for statutory steps which could be taken to enforce this, including the power for a relevant person[57] to direct the person to return the place to where they were living or remove them to the place where they are living (including by the use of reasonable force). The person would also be also committing a criminal offence (which can be discharged by way of the issue of a fixed penalty notice).[58] What constituted a "reasonable excuse" for these purposes is set out in Regulation 6(2). This included taking exercise, as well as 'to avoid illness or injury or to escape a risk of harm.'[59]

There are some very interesting questions that arose as to whether the Regulations were ultra vires the Act under which they were made (the Public Health (Control of Disease) Act 1984). I do not address them here, but David Anderson QC wrote a stimulating blogpost on the question.[60] Interesting questions also arise as to whether they gave rise to the deprivation of liberty of the entire population of England & Wales for purposes of Article 5(1) ECHR (and, if so, whether it is justified under Article 5(1)(e) for purposes of the "prevention of the spreading of infectious diseases"). These are both interesting questions, my tentative thoughts being, respectively (1) probably not;[61] but (2) if they

[52] As recognised under CRPD Articles 19 and 25 respectively.
[53] SI 2020/350. The counterpart in Wales (which were nearly, but not quite, identical – limiting by statute the reasonable excuse relating to exercise to once a day) were the Health Protection (Coronavirus, Restrictions) (Wales) Regulations 2020 (SI 2020/308 (W.68).
[54] Regulation 12.
[55] Regulation 3(2).
[56] Regulation 6(1).
[57] Defined in regulation 8(12) as including police officers, police community support officers, and other people to be designated (either by a local authority, for specific purposes, or the Secretary of State).
[58] Regulations 9 and 10.
[59] Regulation 6(2)(m).
[60] David Anderson QC, 'Can we be forced to stay at home?' (26 March 2020) https://www.daqc.co.uk/2020/03/26/can-we-be-forced-to-stay-at-home/ (Accessed 5 April 2020).
[61] Because the Supreme Court has held that, for purposes of the law in England & Wales, deprivation of liberty requires not only that a person not be free to leave, but also that they are under continuous supervision and control: see, in the context of deprivation of liberty on the basis of 'unsoundness of mind,' *Surrey County*

Journal Pre-proof

do, it would be challenging to justify the position by reference to Article 5(1)(e), at least without further clear evidence that this was both necessary and proportionate.[62]

For present purposes, I focus on the fact the Regulations did not make any provision in relation to those with impaired decision-making capacity. The question arises, therefore, as to how they should be applied to someone who lacks the capacity (applying the MCA 2005, or any common law test that might be said to apply) to understand: (1) that they are required not to leave the place where they are living without a (statutory) reasonable excuse); or (2) the consequences of so doing without such a reasonable excuse? And should they be subject to criminal sanction if they do so?

One would like to think that it would be very unlikely that any prosecution would be brought against a person who did not – because they could not – understand what it is that they should or should not have been doing. The guidance issued by the Crown Prosecution Service[63] in relation to prosecution of offences under the Regulations provided that:

> *Given that the offences in the Regulations are related to measures imposed to prevent the spread of infection throughout the UK, and potentially high incidences of serious illness and death, they should be considered serious. A prosecution will therefore likely be required in the public interest in the majority of cases.*

The guidance made no reference to the presence of impaired decision-making capacity as a factor. It is also, equally, troubling that it would even be possible for a criminal prosecution to be in contemplation in such circumstances.

It may, perhaps, be that the answer is to be found in the wording of Regulation 6(2), which is not **exclusive** in terms of reasonable excuses. Rather, it provides that "a reasonable excuse **includes**." That a person lacks the capacity to understand what it is that the new regime requires would appear, on its face, to be a reasonable excuse. Whether any of the near constant stream of guidance coming out (but not, so far, relating to the MCA specifically) will address this issue is not known, but I would hope it would.

I should note that, under Regulation 8(4), it would undoubtedly be possible for a person to be returned to the place where they are living by the use of reasonable force whether or not they had the capacity to agree to the steps being taken. Interestingly, and undoubtedly by a side-wind, this suddenly given a previously missing power[64] to police offices, and other authorised people to return individuals subject to DoLS authorisations in care homes[65] where they have 'wandered' (a term I put in parenthesis because in many cases, it is very far from purposeless wandering on the part of a person with

---

Council v P, Cheshire West and Chester Council v P [2014] UKSC 19 at paragraph 49. See also, earlier, and in the context of 'control orders' relating to terrorism, *Secretary of State for the Home Department v JJ & Ors* [2007] UKHL 45 at paragraph 57, per Lady Hale.

[62] On these points, see also Tom Hickman QC, Emma Dixon and Rachel Jones, 'Coronavirus and Civil Liberties in the UK' (6 April 2020), https://coronavirus.blackstonechambers.com/coronavirus-and-civil-liberties-uk/ (Accessed 8 April 2020).

[63] Crown Prosecution Service, Coronavirus: Health Protection (Coronavirus, Restrictions) (England) Regulations 2020 (26 March 2020), https://www.cps.gov.uk/legal-guidance/coronavirus-health-protection-coronavirus-restrictions-england-regulations-2020 (Accessed 5 April 2020).

[64] See for a discussion of this, Law Commission (2017), *Mental Capacity and Deprivation of Liberty* (Law Com 372), at 7.10 and 7.13.

[65] I am excluding hospitals here, the other place where a person can be subject to a DoLS authorisation, but a hospital would falls within this power if (on the facts of the case) the person could be said to 'be a place where they are living.').

dementia). But this was undoubtedly not the purpose for which Regulation 8(4) was enacted. It would also leave anyone who does take steps to return an individual to somewhere **other** than a care home in a difficult position. The Regulations did not provide the power for the person returning the person to where they live to prevent them from leaving their home; any such power would have to (legally) be found in another source, and (practically) be exercised by someone. And what if the person lived in their own home, and did not appear to have anyone there to 'receive' them?

Finally, I note that those caring (formally or informally) for those with impaired decision-making capacity are left in a very invidious position. Should they be seeking to prevent the individual from leaving home so as not to breach the Regulations, or should they let them do so in the hopes that the individual does not then encounter an unsympathetic relevant individual. It is very likely that many carers will feel (rightly or wrongly) that they have to take steps to stop the person leaving. In many cases, this is likely then to mean that the individual then meets the 'acid test' of not being free to leave the place they live and also being subject to continuous supervision and control.[66] If they cannot consent to that confinement, then it is very likely that they are then to be seen as deprived of their liberty for purposes of Article 5 ECHR.[67] I return to this issue below having looked at the further powers that the CA 2020 introduced in the public health sphere.

CA 2020

Section 51 and Schedule 21 CA 2020 contain powers relating to potentially infectious persons. Part 1 relates to England; Part 2 to Scotland and Part 3 to Wales. They are materially identical, and for present purposes I will only give references to the paragraph numbers in Part 1 (for England).

Schedule 21 provides public health officers, constables and (in some circumstances) immigration officers with the means to enforce public health restrictions, including returning people to places that they have been required to stay. Where necessary and proportionate, constables and immigration officers are able to direct individuals to attend, remove them to, or keep them at suitable locations for screening and assessment. Where a person has been screened and assessed and either tested positive, or the screening is inconclusive, paragraph 14 of Schedule 21 enables a public health officer to impose requirements including to remain at a specified place (which may be a place suitable for screening and assessment) for a specified period; and/or to remain at a specified place in isolation from others for a specified period. ('a requirement to remain'). The public health officer has when imposing a requirement or restriction to inform the person of the reason for doing so, and that it was an offence to fail to comply with the requirement or restriction. A person can only be required to remain at a place for a maximum of 28 days,[68], although can be required to remain in isolation indefinitely (although with a review every 24 hours after 28 days). A failure to comply with the requirement to remain at a place or in isolation is a criminal offence.[69] A public health officer, constable or immigration officer can give reasonable instructions to a person in connection with

[66] The 'acid test' being the phrase used by Lady Hale to capture the objective element of deprivation of liberty – confinement – in *Surrey County Council v P, Cheshire West and Chester Council v P* [2014] UKSC 19 at paragraph 47.
[67] Deprivation of liberty requiring (1) confinement; (2) a lack of valid consent; and (3) state imputability. The last limb will be satisfied wherever the state knows or ought to know of the confinement: *D (A Child)* [2019] UKSC 42 at paragraph 43.
[68] CA 2020 Sch. 21, para. 15.
[69] CA 2020 Sch. 21, para. 23.

Journal Pre-proof

Journal Pre-proof

removing someone to or keeping the person at a place under the powers identified here;[70] failure to comply with a reasonable instruction is a criminal offence.[71] A constable or immigration officer (but not a public health officer) can use reasonable force, if necessary, in the exercise of the powers outlined here.[72] The recourse against the exercise of the draconian (if justified) imposition of a requirement to remain is by way of appeal to the magistrates' court.[73]

None of the provisions outlined above make any reference to the position of persons with impaired decision-making capacity. The closest that they come are in paragraph 14, where a public health officer is required in deciding whether to impose a requirement to remain "must have regard to a person's wellbeing and personal circumstances." "Personal circumstances" here could – and arguably should – include whether they have capacity to understand what it is that they are being required to do, and the consequences if they do not.

In the event that a requirement to remain was imposed, it was not obvious from the face of the CA 2020 how it is that a person with impaired decision-making capacity is to make any appeal to the magistrates' court. So as to comply with the provisions of Article 6 and 8 ECHR (read alone or in conjunction with Article 14 ECHR), it is clear[74] that the appeal provisions in paragraph 17 will have to be interpreted (1) as placing the threshold for bringing an application extremely low (as per the approach before the Mental Health Tribunal or the Court of Protection[75]); and (2) where the person does not meet that threshold, enabling another person to act on their behalf to bring the application.

Deprivation of liberty

It was entirely possible that there are those who **do** have impaired decision-making capacity and pose a public health risk because they are either potentially or actually infectious with COVID-19. Precisely what legal powers could be exercised to require them to remain either in a place or (within that place, within isolation) is a question that has exercised many commentators.[76] Four key issues are:

1. Whether a person already subject to a DoLS authorisation at a particular care home or hospital (or, indeed, a patient detained in hospital under the MHA 1983) was then subject to sufficient additional restrictions in consequence of being kept in isolation within that facility so as to give rise to an **additional** deprivation of their liberty (requiring additional authorisation);[77]

2. Whether it was legitimate to use DoLS to authorise deprivation of liberty for purposes of preventing the spread of infection from the person given the statutory requirement that a DoLS

[70] CA 2020 Sch. 21, para. 20(1).
[71] CA 2020 Sch. 21, para. 20(1), 20 (2) and 23.
[72]CA 2020 Sch. 21, para. (4)
[73] CA 2020 Sch. 21, para. 17.
[74] And it was anticipated at the time of writing that statutory guidance would confirm this position.
[75] See *RD & Ors (Duties and Powers of Relevant Person's Representatives and Section 39D IMCAS)* [2016] EWCOP 49at paragraph 86(a), where Baker J held that the capacity to ask to issue proceedings "simply requires P to understand that the court has the power to decide that he/she should not be subject to his/her current care arrangements. It is a lower threshold than the capacity to conduct proceedings."
[76] For an early discussion, see 39 Essex Chambers, 'Rapid Response Guidance Note: COVID-19, Social Distancing and Mental Capacity' (31 March 2020), https://www.39essex.com/rapid-response-guidance-note-covid-19-social-distancing-and-mental-capacity/ (Accessed 5 April 2020).
[77] See, by analogy, *Munjaz v United Kingdom* [2012] ECHR 1704

authorisation is only lawful where deprivation of liberty was not only in the best interests of the person, but also necessary and proportionate to the likelihood and seriousness of the harm that they would suffer otherwise.[78]

3. The interaction between DoLS/the MHA 1983 and the powers granted under Schedule 21 to the CA 2020 to public health officers to require individuals to remain in isolation – did they extend to directing isolation **within** a facility?

4. The practicality of obtaining judicial authorisation where no administrative route could be used – for instance in the person's own home – especially given the pressures under which the courts were under (see further section 5 below). In this, it was also of relevance that, whilst s.4B MCA provides authority to deprive a person of their liberty upon the **making** of an application to court and pending its determination, it is only authority where the actions are being taken in the context of either providing life-sustaining treatment or preventing a serious deterioration in the person's condition. It is not obvious that preventing transmission of illness to **others** could fall within this.

The Department of Health and Social Care is expected to produce guidance upon the MCA and DoLS (see further section 4). However, it is likely that, even with such guidance, practitioners and professionals remain in considerable doubt as to how to proceed and with a distinct unease as to the operation of pragmatism.

Section 4: the MCA under strain

So far, I have primarily examined the context within which decisions under the MCA 2005 are now being made, as opposed to the MCA 2005. I now turn to look at the MCA 2005 itself. Attempts were made to introduce amendments to address the near impossibility of complying with the requirements of DoLS in the context of COVID-19,[79] but without avail.[80] At Second Reading of the Coronavirus Bill in the House of Lords on 24 March 2020, Lord Bethell on behalf of the Government:

> *recognise*[d] *that we have to strike a careful balance between the need to protect some of the most vulnerable in our society with preventing the spread of the virus. Therefore, we have decided not to alter deprivation of liberty safeguards in primary legislation. However, we think that we can achieve significant improvement to the process through emergency guidance. That will include making clearer when a deprivation of liberty safeguards authorisation is necessary, and the basis on which an assessment can be made, including, for example, phone or video calling for assessment. We are especially grateful to the noble Baroness, Lady Finlay, and other experts, who have worked with us on this.*[81]

Although that emergency guidance had yet to be published at the time of writing, it is clear that it will essentially rip up much of the DoLS Code of Practice in terms of the approach to be adopted,[82] but

[78] Paragraph 14 of Schedule A1 to the MCA 2005.
[79] Personal knowledge of the author.
[80] Changes were, however, made to the provisions of the Mental Capacity Act (Northern Ireland) 2016 relating to deprivation of liberty which had recently been brought into force: s.10 and Schedule 11 to the CA 2020. These came into force on 2 April 2020: The Coronavirus Act 2020 (Commencement No.1) Order (Northern Ireland) 2020 (Northern Ireland Statutory Rules 2020 No. 58)
[81] Hansard, HL, 24 March 2020, Vol 802, col. 1734 (the author being one).
[82] And, in the process, ironically laying bare the fact that the primary legislation does not, itself, require such things as face-to-face assessment of capacity.

Journal Pre-proof

Journal Pre-proof

significant doubts remain as to the thickness of legal ice upon which professionals are standing. Had the Mental Capacity (Amendment) Act 2019 been in force, professionals would have had the ability to rely upon a revised version of s.4B MCA 2005 making clear the basis upon which they were able to deprive an individual in need of care and treatment in an emergency, and then pending completion of the relevant statutory processes.[83] However, the likelihood of implementation of that Act, requiring a substantial amount of work on the part of local authorities and NHS bodies, which was already looking unlikely for 1 October 2020, receded rapidly into the distance.

Very shortly after 'lockdown' started, the Court of Protection had cause to consider how DoLS was working in the context of a care home which – as with many others – had barred visitors. In *BP v Surrey County Council & Anor*[84] the Vice-President of the Court of Protection, Hayden J, was already considering an application under s.21A MCA 2005, by which a man, known as BP, was seeking to challenge the deprivation of liberty to which he was subject. On 20 March 2020, however, the care home decided to suspend all visits from any family members to BP and indeed to the others living in the home. The restriction also extended to any other visitors. As Hayden J noted,

> 9. […] *there can be no doubt that the change to BP's quality of life from 5 o'clock on Friday 20th March 2020 was seismic. Additionally, the restriction extended to the Mental Capacity Assessor visiting.*[[85]] *Thus, there is need for heightened vigilance to ensure that BP's fundamental rights are not eclipsed by the exigencies of the Coronavirus pandemic. Fundamental to any consideration of the issues presented by this case is Article 11 UN Convention of the Rights of Persons with Disabilities ('CRPD') which provides:*
>
> > *"Article 11 – Situations of risk and humanitarian emergencies*
> > *States Parties shall take, in accordance with their obligations under international law, including international humanitarian law and international human rights law, all necessary measures to ensure the protection and safety of persons with disabilities in situations of risk, including situations of armed conflict, humanitarian emergencies and the occurrence of natural disasters."*
>
> *10. The COVID-19 pandemic plainly falls within the circumstances contemplated by Article 11 and signals the obligation on the Courts, in particular, and society more generally to hold fast to maintaining a human rights based approach to people with disabilities when seeking to regulate the impact of this unprecedented public health emergency.*

By his litigation friend, his daughter FP, BP brought an emergency application for a:

> *a) A declaration that if, within 72 hours of SH Care Home being served with a copy of the relevant order it has failed to take steps to facilitate the attendance of Dr Babalola and to reinstate daily family visits to BP, then it is not in BP's best interests to reside in the interim at SH Care Home;*
> *b) An order that if the above has not been complied with by SH Care Home, the order*

[83] For an overview of this Act, see Alex Ruck Keene, 'LPS – where are we, and where are we going?' (March 2020, updated February 2020), https://www.mentalcapacitylawandpolicy.org.uk/lps-where-are-we-and-where-are-we-going/ (Accessed 5 April 2020).
[84] [2020] EWCOP 17, heard on 25 March 2020.
[85] For purposes of assessing and reporting to the court as to BP's capacity to decide upon his residence and care arrangements.

Journal Pre-proof

dated 6 March 2020 extending the standard authorisation be revoked and the standard authorisation shall terminate at the expiry of that 72-hour period;
c) A declaration that the total ban on visits is a disproportionate interference with BP's rights under Articles 5 and 8 (read with Article 14) of the European Convention on Human Rights;
d) An interim declaration that whilst the restrictions on visits remain in place it is in BP's best interests to return home with a package of care.[86]

BP, who was diagnosed with Alzheimer's disease in December 2018, was deaf, but able to communicate through a "communication board." Hayden J considered that:

his age and with his underlying health problems BP is vulnerable to the most serious impact of the Coronavirus. In my view, it is necessary to state the risk BP faces, were he to contract the virus, in uncompromising terms: there would be a very real risk to his life. Manifestly, there are powerful and competing rights and interests engaged when considering this application.[87]

Having considered decisions of the European Court of Human Rights, the statement of principle of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment relating to the treatment of individuals deprived of their liberty in consequence of the COVID-19 pandemic,[88] and Article 25 of the CRPD (the right to health), Hayden J rejected the application brought on FP's behalf, noting that:

The case is, in any event, listed for further directions on 3rd June 2020. Accordingly, the interim declarations relating to BP's lack of capacity to conduct these proceedings and to make decisions concerning his residence and care remain valid. The focus of the arguments is therefore on whether it remains in BP's best interest to stay in the care home. It is in that context that I must consider the relevant rights and freedoms that all agree are engaged.[89]

Although the judgment does not expressly provide this, it is clear that the consequence was that the application was dismissed, although with clear judicial approval of the plan drawn up to seek to maintain as much contact as possible between BP and his family. However, Hayden J outlined the plans that were being developed – under his encouragement – to seek to secure continuing contact, including:

for BP's education in to the world of Skype with creative use of a communication board and the exploration of concurrent instant messaging. Additionally, the family can, by arrangement, go to BP's bedroom window which is on the ground floor and wave to him and use the communication board. All this will require time, effort and some creativity. I am clear that there is mutual resolve by all concerned..[90]

Importantly, Hayden J also held that:

---

[86] [2020] EWCOP 17 at para.11.
[87] [2020] EWCOP 17 at para. 12.
[88] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, 'Statement of principles relating to the treatment of persons deprived of their liberty in the context of the coronavirus disease (COVID-19) pandemic,' CPT/Inf(2020)13 (20 March 2020), https://rm.coe.int/16809cfa4b (Accessed 5 April 2020).
[89] [2020] EWCOP 17 at para. 26.
[90] [2020] EWCOP 17 at para. 36.

Journal Pre-proof

> *Accordingly, though I recognise the challenges, I consider that the outstanding assessment* [of mental capacity] *by Dr Babalola can be undertaken via Skype or facetime with BP being properly prepared and supported by staff and, to the extent that it is possible, by his family too.*[91]

The outcome of the application was, not, perhaps entirely surprising, although reflective of the changes that had been wrought by COVID-19 – only a few weeks prior, a care home that sought to impose such draconian restrictions would have been the subject of fierce criticism by a court. The judgment does have its oddities, including that Hayden J sought[92] himself to derogate from the ECHR under Article 15,[93] when such is not a course open to a judge as opposed to the relevant authorities of the Member State.

It is also striking (but perhaps reflective of the haste with which the application was brought on and considered) that Hayden J did not address the fact that the DoLS regime does not, itself, provide authority to restrict contact,[94] so it is not immediately obvious upon what legal basis contact could be restricted **except** by going to court.

Finally, it is also, perhaps, striking that no arguments were addressed to Hayden J (or raised by Hayden J of his own motion) as to the risk posed to individuals **within** the care home by COVID-19. On one view it could have been argued (see further section 2) above that BP's Article 2 rights in fact pointed not to the cessation of contact between him and his family, but for his rapid move to his daughter's house, and the provision of such support to her there as required to ensure he could be kept safe there.

Section 5: The Court of Protection

A word about the Court of Protection.[95] In the space of little more than a week, it became clear that it could not be business as usual for the court (as with all the other courts in England & Wales), and a rapid transition had to begin into, in essence, a virtual court, sitting remotely and proceeding either by video or audio. The pace of the transition can be seen in the number of guidance documents that the Vice-President had to issue, culminating in (the first iteration of) a document published on 31 March 2020 entitled *Remote Access to the Court of Protection Guidance*,[96] in which he noted that

> *The present viral pandemic presents real and obvious challenges to the effective and fair operation of the Court of Protection. Remote access to the Court has become a necessity and it is the responsibility of all involved to ensure that such hearings continue to provide proper access to justice. These arrangements are driven by the inevitable restrictions on freedom of movement that have been put in place to protect public health. Remote hearings, i.e. by Skype or alternative versions of video link, will sometimes fall short of providing the opportunities that are available in a live hearing in a court room. Recognising this, it is important to keep in focus that the procedure should seek to ensure that those who lack capacity do not become more disadvantaged than their capacitous counterparts. It remains the obligation of all*

[91] [2020] EWCOP 17 at para. 38.
[92] [2020] EWCOP 17 at para. 27.
[93] He did this by sending notice of his judgment to the Council of Europe.
[94] See, inter alia, *SR v A Local Authority & Anor* [2018] EWCOP 36.
[95] For an overview of the Court of Protection and its work, see Ruck Keene, A. R., Kane, N. B., Kim, S. Y., & Owen, G. S. (2019). Taking capacity seriously? Ten years of mental capacity disputes before England's Court of Protection. *International journal of law and psychiatry*, *62*, 56-76.
[96] Most easily accessible at time of writing at https://www.mentalcapacitylawandpolicy.org.uk/wp-content/uploads/2020/03/Remote-Hearings-COP-31-March-2020.pdf (accessed 5 April 2020).

Journal Pre-proof

> *involved and at all stages of the hearing, to continue to evaluate whether fairness to all the parties is being achieved. Fairness cannot be sacrificed to convenience.*

Prior to this guidance, an all Skype hearing (over 3 days) had been conducted remotely to determine whether life-sustaining treatment should be continued for a man named AF.[97] Counsel involved in the case and the judge himself were very positive;[98] the man's daughter had a very different perspective, stating that it

> *It felt like a second-best option. It didn't feel professional. It didn't feel like justice. It felt like a stop gap to ensure a box was ticked – rather than a serious and engaged attempt to make decisions about my Dad.*[99]

Not only would the Court of Protection have to find ways in which to ensure that family members and/or informal carers did not feel excluded by the arrangements, the court would have to find ways in which to ensure that sometimes painful progress towards the greater participation of the subject of proceedings – 'P' – was not lost.[100] The guidance noted above from Hayden J actively solicited "[i]*maginative ideas* […] *to ensure that P participates in their proceedings where they are able to so do safely and proportionately*."[101] But given that "[w]*here judicial meetings with P are* ***necessary*** *for a determination of the issues then remote conferencing technology to facilitate that meeting is the only likely mechanism*,"[102] immediate hurdles towards an important way in which such participation could take place were clear. The energy and commitment of those concerned with the court to ensure that it could continue both to offer a service, and to serve P was clear, but the task at the time of writing appeared formidable.

Section 6: Medical decision-making, the MCA and scarce resource

Space precludes a detailed consideration of the issues that arise in the context of the effect of COVID-19 upon the scarce critical care resource within England & Wales, and also the scarce resource of ventilation.[103] However, they do need to be touched on briefly as radically changing the framework for medical decision-making. In a series of cases starting in 2013,[104] the Court of Protection had developed an increasingly sophisticated notion of best interests in this context in which even interventions with a very small chance of success could be said to be in the best interests of the patient

Journal Pre-proof

---

[97] *A Clinical Commissioning Group v AF & Ors* [2020] EWCOP 16
[98] See Nageena Khalique QC & Sophia Roper, 'Skype in the Court of Protection' (23 March 2020): http://ukmedicaldecisionlawblog.co.uk/rss-feed/115-skype-in-the-court-of-protection-the-courts-in-the-time-of-coronavirus (Accessed 5 April 2020). Note, as the blog itself makes clear, it was revised subsequently to reflect the views of the man's daughter. As to the judge's perspective, see Catherine Baksi, 'Pioneering Skype trial 'went without a hitch', says judge,' The Law Society Gazette, 31 March 2020 (https://www.lawgazette.co.uk/practice/pioneering-skype-trial-went-without-a-hitch-says-judge/5103698.article) (Accessed 5 April 2020).
[99] See Celia Kitzinger, 'Remote justice: a family perspective' (29 March 2020), http://www.transparencyproject.org.uk/remote-justice-a-family-perspective/ (Accessed 5 April 2020).
[100] For an overview of how the court had been seeking to improve participation, see Mr Justice Charles, 'Facilitating participation of 'P' and vulnerable persons in Court of Protection proceedings,' (3 November 2016), https://www.familylaw.co.uk/docs/pdf-files/Practice_Guidance_Vulnerable_Persons.pdf (Accessed 5 April 2020).
[101] *A Clinical Commissioning Group v AF & Ors* [2020] EWCOP 16 at para. 73.
[102] *A Clinical Commissioning Group v AF & Ors* [2020] EWCOP 16 at para. 74.
[103] For a discussion of the issues more widely as they stood at the start of April 2020, see Dominic Wilkinson, 'ICU triage in an impending crisis: uncertainty, pre- emption and preparation,' (1 April 2020), *Journal of Medical Ethics* online first, http://dx.doi.org/10.1136/medethics-2020-106226 (Accessed 5 April 2020).
[104] With *Aintree v James* [2013] UKSC 67.

Journal Pre-proof

if it was clear that this is what they wanted.[105] This did not – quite – cross the line into holding that approaching matters through the prism of best interests could require that clinicians provide treatment that they did not consider clinically appropriate,[106] but on occasion came very close.[107]

The impact of COVID-19, however, means that it appears clear that decision-making in the case of those with impaired decision-making (and whether or not they have COVID-19) might have to be undertaken on the basis not of what was in their best interests, but on a utilitarian basis in order to save the maximum number of lives. What had been a perennial question for ethicists and the subject of planning that had never had to be moved into anything close to an operational phrase[108] has become an ever more pressing issue.

However, national bodies (in particular national NHS bodies) have been notably slow to produce guidance addressing the issues, perhaps because of political (including health service political) concerns as to the public reactions that would be engendered by the recognition of the reality of the position. They are also perhaps aware of how guidance produced under speed in countries that had been affected ahead of England (most notably that produced by in the Italian context by SIAARTI, which suggested that there might need to be a simple age cut-off for admission to ICU[109]) would look if transposed directly into the English context.

Further, an early – and very high-level – attempt to provide guidance (the NICE 'rapid response' guideline NG159[110]) was the subject of threatened judicial review proceeding within hours because of the perception that its reliance upon a tool known as the Critical Frailty Score would discriminate against individuals with learning disability or other 'stable' cognitive impairments.[111] It was perhaps not a coincidence that it took another 10 days before any other body (this time the British Medical Association) put its head above the parapet,[112] that time to press coverage including the headline "Virus patients more likely to die may have ventilators taken away").[113] Guidance from the Chief

[105] For an overview, see Ruck Keene, A & Lee, A. (2019). Withdrawing life-sustaining treatment: a stock-take of the legal and ethical position. *Journal of medical ethics*, *45*(12), 794-799.
[106] Which *Aintree* reinforced could not happen: see paragraph 18.
[107] For a good example, see *University Hospitals Birmingham NHS Foundation Trust v HB* [2018] EWCOP 39, I which Keehan J, considering the submission that CPR would not be in the best interests of the person, noted that "key to the decision must be the wishes and feelings of HB and it is plain that administering CPR in the event of a further collapse and giving her, albeit a very, very small chance of life, is what she would wish. In my judgment, at the moment, it remains in her best interests for that treatment to be provided to her" (paragraph 36).
[108] The closest previous shadow had been during the 2009 swine flu outbreak. For an overview of the legal and ethical issues that arose in that context (together with the framework within planning had started), see Alex Ruck Keene, 'The Legal and Ethical Principles of Rationing Critical Clinical Services - Particularly in Relation to Swine Flu' (2009) (https://www.mentalcapacitylawandpolicy.org.uk/wp-content/uploads/2020/03/Pandemic-Rationing-Talk-August-2009-Final.pdf) (Accessed 5 April 2020)
[109] SIAARTI (Italian Society of Anaesthesia, Analgesia, Resuscitation and Intensive Care): Clinical Ethics Recommendations for the Allocation of Intensive Care Treatments in exceptional, resource-limited circumstances - Version n. 1 (March, 16th 2020). The age cut-off was proposed in paragraph 3.
[110] *COVID-19 rapid guideline: critical care in adults NICE guideline* (20 March 2020) www.nice.org.uk/guidance/ng159 (Accessed 5 April 2020)
[111] https://www.independent.co.uk/news/health/coronavirus-nhs-treatment-disabled-autism-nice-covid-19-a9423441.html?fbclid=IwAR0T_53QtZG8axyfRs78tUYGfaT3seLd2FJf9PhSeoWTg64A_0XdkdkoEq8 (Accessed 5 April 2020)
[112] https://beta.bma.org.uk/advice-and-support/covid-19/ethics/covid-19-ethical-issues (1 April 2020) (Accessed 5 April 2020)
[113] The Guardian, 'Virus patients more likely to die may have ventilators taken away' (1 April 2020, https://www.theguardian.com/society/2020/apr/01/ventilators-may-be-taken-from-stable-coronavirus-patients-for-healthier-ones-bma-says (Accessed 5 April 2020)

Journal Pre-proof

Medical Officers (who appeared frequently in the 17:00 press conferences that became such a feature of the crisis) was still not forthcoming at the time of writing.

Whilst there was limited 'off-the-shelf' material that could be drawn upon, much of that material did not, in fact, provide the sort of detailed operational detail as to either procedures or criteria that was really required. This meant, therefore, that clinicians have bene left at a vital period in the run up to the peak essentially trying to make it up as they went along, frequently seeking to do so whilst juggling heavy, and increasing, clinical loads at the same time. They have also been left unclear – and in many cases in real moral distress in consequence – as to the point at which they were supposed to stop applying ordinary principles of medical decision-making and instead to start operating in a world governed by some form of utilitarianism. A further consequence of the slowness of national bodies to give direction was that NHS Trusts have not been not given either the 'push' or the tools to start creating the governance structures which would be crucial to ensure that triage decisions take place within structures that could provide both oversight of the process and support to clinicians operating within it.

This has had one particularly pernicious consequence in the case of those with disabilities, including those with impaired decision-making capacity. Whether out of a misplaced excess of zeal in attempting to undertake advance care planning, a misunderstanding of the law,[114] or otherwise, it appeared that significant numbers of individuals were having decisions made as to resuscitation without any form of consultation; in other cases, it appeared that individuals were being pressured into signing their own DNACPR notices.[115] Many such individuals were elderly, but did not have specific disabilities. In other cases, it appeared that judgments were being made that (e.g) CPR should not be attempted because they had, for instance, a learning disability. This prompted an urgent letter from the National Director for Mental Health NHS England and NHS Improvement, the National Clinical Director - Learning Disability and Autism NHS England and NHS Improvement and the Medical Director for Primary Care, NHS England and NHS Improvement to remind Trusts and GPs that:

> *The health of some people who have a learning disability and / or a diagnosis of autism may be at risk from the presence of co-existing physical conditions and also from inequities in access to and delivery of appropriate and timely assessment and treatment for physical health conditions.*
>
> *It is imperative that decisions regarding appropriateness of admission to hospital and for assessment and treatment for people with learning disabilities and / or autism are made on an individual basis and in consultation with their family and /or paid carers, taking into account the person's usual physical health, the severity of any co-existing conditions and their frailty at the time of examination. Treatment decisions should not be made on the basis of the presence of learning disability and / or autism alone.*[116]

[114] Which was absolutely clear as to the requirement to involve the patient or (where they lacked capacity) those appropriately concerned with their welfare: see *R (Tracey) v Cambridge University Hospitals NHS Foundation Trust & Anor* [2014] EWCA Civ 33 and *Winspear v City Hospitals Sunderland NHS Foundation Trust* [2015] EWHC 3250 (QB).

[115] See e.g. BBC News, 'Coronavirus: GP surgery apology over 'do not resuscitate' form' (1 April 2020), https://www.bbc.co.uk/news/uk-wales-52117814 (Accessed 5 April 2020). Requiring someone to complete their own DNACPR was, in fact, legally impossible unless they were being asked to make advance decisions to refuse CPR, which would then require compliance with the statutory provisions of the MCA (including that they be witnessed): see s.25 MCA 2005.

[116] 'Dear Colleagues' letter dated 3 April 2020, https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/C0166-Letter-DNACPR.pdf (accessed 5 April 2020).

At the time of writing, it remained unclear whether this letter would produce a material effect.

Section 7: Mental health law

The focus of this article has been upon mental capacity, rather than mental health law. However, for completeness, and because of the overlap between individuals with impaired decision-making capacity and those falling within the scope of the MHA 1983, it is important to note that here, too, the landscape has been changed. This is not just because of the complexities of addressing public health concerns within psychiatric hospitals, which bring with them similar issues to those discussed above in relation to DoLS, but also because of changes to primary legislation.

The CA 2020 includes (in s.10 and Schedule 8) the power to make temporary changes to mental health and mental capacity legislation across the United Kingdom. Those powers include the ability drastically to strip back the procedural safeguards around admission and treatment under the Mental Health Act 1983;[117] it is perhaps odd, given how much more relevant the MCA 2005 is to the response to the pandemic, that the CA 2020 only addressed the MHA 1983 in primary legislation.[118]

At the time of time of writing, those powers have not been brought into force. However, the power under the Act[119] to enable changes to the composition of the Mental Health Review Tribunal for Wales was brought into force on enactment, mirrored by a Pilot Practice Direction[120] in England. At a stroke, tribunals were reduced to single judges (as opposed to a judge sitting with a medical member and a specialist lay member) sitting remotely, with hearings taking place largely by telephone. I do not dwell further upon these changes, except to say that the reader can easily imagine the practical impact upon all concerned, above all the patients.[121]

Conclusion

As noted at the outset, this tour d'horizon of the state of mental capacity law in England & Wales only a short time into the COVID-19 pandemic presents a challenging picture. Across the board, options are being removed, and constraints necessary for utilitarian goals being imposed with inadvertent, and often disproportionate consequences. But there are glimmers of hope – for instance in the potential for the ECHR to be a very much more powerful tool than it has been to date in terms of securing service provision.[122]

And in a world where nothing appears certain, and everyone, irrespective of disability, is seeking answers, it is arguably easier than it was ever before for supported decision-making to appear something of universal relevance. Whether and how the second draft of history to be written after the

Journal Pre-proof

[117] For an overview, see the 39 Essex Chambers Rapid Response Guidance Note: COVID-19 and the Mental Health Act 1983, available at https://www.39essex.com/tag/mental-capacity-guidance-notes/ (accessed 4 April 2020).
[118] It is quite possible that this was down to the fact that changes had had to be contemplated in relation to the MHA 1983 in 2009 in the context of swine flu, so, to some extent, there were legislative amendments which could be taken off the shelf.
[119] Section 10 of and Part 1 of and paragraphs 11, 12 and 13 of Schedule 8, by virtue of The Coronavirus Act 2020 (Commencement No. 1) (Wales) Regulations 2020 (SI 2020 No. 366 (W. 81))
[120] Pilot Practice Direction: Health, Education and Social Care Chamber of the First-Tier Tribunal (Mental Health), 19 March 2020.
[121] Linked also to this were the very substantial difficulties caused by the practicalities of complying with a legal aid system dependent upon a set of procedures that were not easily adaptable for remote working.
[122] There of course, a considerable irony to this given that the Conservative Government has repeatedly expressed hostility to the ECHR, and a desire to revisit how human rights are protected in the United Kingdom, including through a British Bill of Rights.

Journal Pre-proof

end of the pandemic makes a more or less cheering read than it does at present will depend, in very significant part, upon the actions taken by those who care about capacity law over the coming months, when it will be tested as never before.

Acknowledgements

The author thanks Mary Donnelly for her very rapid assistance with editing, and the two reviewers for their incisive, constructive, and exceptionally speedy responses. Any errors remaining are the responsibility of the author.

Journal Pre-proof