Browne Jacobson

Court of Protection update for local authority lawyers

08 January 2025 Sarah Erwin-Jones

It's all about the care plan

A couple of recent Court of Protection cases illustrate two key themes.

- The care plan is king – get that clear first.
- Openness, transparency and compliance with court directions is essential for local authorities.

Here's a summary of the two cases.

Bury Metropolitan Borough Council v EM and Others [2024] EWCOP 76(22)

EM had, from the age of six, a history of dysregulated behaviour. At around the age of 16 she was diagnosed with ADHD and later began a pattern of self-harm and attempts to end her own life. In June 2023 she was diagnosed with ASD.

Initially there were proceedings in the high court and interim orders were made. However by November 2023, EM was detained under the Mental Health Act and the court concluded it had no jurisdiction to make any Order. Proceedings were adjourned. Subsequently, two capacity assessments concluded that EM lacked capacity to make decisions in relation to her residence and care and proceedings were issued in the Court of Protection.

A suitable hospital placement had been identified and EM moved to it in March 2024. Incidents of self-harm declined following that move. The court made it clear that capacity and care planning was central to the case. The court needed to understand the nature of EM's fluctuating capacity since a consultant psychiatrist concluded that her capacity to make relevant decisions about her residence and care fluctuated. The court made it clear that in this particular case, its focus needed to be on what the care plan was and how that would best meet EM's needs. On the face of it, EM was still likely, at times, to act in a dangerously dysregulated way. The judge identified a lack of clarity on the part of professionals around EM. The Mental Capacity Act calls for a decision to be made for people who cannot make those decisions themselves where necessary. That includes issues over residence and care.

It enables decision makers to decide on care plans that meet the best interests of the person concerned and that care plan is the starting point. The care plan needs to be in the P's best interests. A plan that adopts the least restrictive option is what the decision maker must choose. If that plan involves or may involve the deprivation of P's liberties then it needs to be authorised. The court will authorise it if it is necessary and proportionate in furthering P's best interests.

The emphasis throughout this judgement was clearly on the care plan itself, and not on the legal status of the restrictions that might be used in order to implement it.

As the judge said "*the care plan to be used is still a decision to be made by the carer/clinician/MDT (as in Multi-Disciplinary Team) in charge on the basis of what they consider to be needed in the circumstances that arise, and what is in P's best interests*". However, where a court authorises a care plan that amounts to a deprivation of liberty, it should not be seen as mandatory; as if the court has imposed a prison sentence, the court will ask questions like:

- What is the care plan and how is it formulated?

- What other plans have been considered and risk assessed and what do all stakeholders including P think?
- Is it the least restrictive option that will address P's needs?
- What steps have been taken to reduce the needs for such intense care plan?

So, if a care plan is devised that means that P need not be deprived of the liberty, there will be no need for the court to authorise any deprivation of liberty. The judge noted that focusing on the court and the making and unmaking of a deprivation of liberty order would make P feel peripheral to the whole process.

In fact, the whole MCA/Court of Protection process is about ensuring care planning decisions are constantly re-evaluated to ensure that P's best interests are served with the least restrictive option.

In this particular case, the care plan was, in the court's view, a deprivation of EM's liberty, not because the *court* said it was a deprivation, but because the restrictions imposed under the plan were necessary, proportionate and in her best interests according to those involved in her care. They placed EM under continuous supervision and control and she was not free to leave the placement. The court made it clear that **its role was to approve the restrictions** on the basis of the evidence available to it. The court's role was not to **create** those restrictions.

A costs order

The judge found there were serial and unexplained breaches of directions by the local authority as a result of which a wasted hearing took place. Delays in making disclosure meant the OS was initially unable to represent their client by scrutinising the local authority's case or putting forward any other positive alternative cases.

There was no evidence the local authority kept the court informed or explained the reasons for its delay, alternative directions were not proposed with the other stakeholders nor was there any request for any hearings to be adjourned or re-listed.

In the circumstances, the judge concluded that there were wholesale breaches of the order and this non-compliance took place within the context of earlier delays and complaints about tardiness made by the OS. The judge made an order that the local authority would pay the OS's costs of and incidental to the wasted hearing and the additional costs of making an application for costs.

Oldham Metropolitan Borough Council v KZ and Others [2024] UWCOP72(T3)

KZ was profoundly deaf and had lived in a specialist placement since February 2024. By the time of the judgement, he was 20 years old and there had been a long history of his needs not being properly met when he lived with his family. He was reluctant to have contact with them as a result.

Proceedings were commenced in January 2022. In November 2023 questions were raised about a previous assessment that concluded KZ lacked capacity in all relevant areas, and so Dr O'Rourke, a consultant psychologist with specific expertise in assessing people with a hearing impairment, was instructed in early 2024. By contrast, Dr O'Rourke concluded, following three appointments with KZ when he was properly supported, that although he was unlikely to have capacity to manage his property and financial affairs, he did have capacity to make decisions about residence, care and support and contact with this family, save for occasions where he became dysregulated.

In this case, the local authority had, in advance, filed a detailed **care plan** setting out detailed arrangements for KZ's continuing care including the restrictions in place. This was underpinned by a structure of three-monthly reviews. The care plan accepted that there were times when the Claimant would have capacity to make his own decisions.

So, the case turned on whether an anticipatory declaration as to capacity could be made under Section 16 of MCA. The judge concluded that the court did have the power to grant anticipatory declarations. The evidence showed that for the majority of the time, KZ had capacity to make decisions regarding his residence, care and contact arrangements with his family. The behavioural incidents that would happen, and would result in loss of capacity, appeared to be time limited and the staff around him understood the triggers and warning signs and had the skills in resolving and de-escalating situations.

In those circumstances, the least interventionist approach to capacity that promoted his autonomy and capacity would be achieved by making an anticipatory declaration as compared to a longitudinal one. The care plan, which allowed staff to respond to a fluctuating position with the right balance between autonomy and freedom, made the right course of action plain for the court to understand.

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