Dear all

During the recent seminar on hoarding and covert medication I was asked whether the Court of Protection ("CoP") must always be involved where there is covert medication of elderly people in care homes and I said I would look further at the issue so I thought I would let you know my view. In summary, there is no easy answer on whether you should go to court. Each case must be considered on its merits.

Professionals, carers and family must always consider the Mental Capacity Act and the following guidance, (i) NICE guidance, (ii) the CoP Vice President's guidance on covert medication and (iii) any local authority or organisations own policy on CM.

What can be said is that if the doctors, family and other professionals all agree then after proper assessment and consultation with appropriate people, an application is not generally required; but if there is a lack of agreement between those consulted, then an application to court should be made. The Vice President of the CoP issued guidance in January 2020 on medical treatment. It says that if a proper decision-making process under the MCA has taken place including consideration of any guidance and the Code of Practice and it leads to an agreement then an application is not always necessary, but there should always be consideration as to whether an application is required and a decision not to apply should be made in writing. Any decision to covertly medicate must be explicitly recorded in a care or treatment plan and in any DOL authorisation and there must be a management plan for periodic review.

In *NHS v Y* [2018] UKSC 46 in the Supreme Court in a case concerning life sustaining treatment, Lady Black confirmed that an application to the court is not necessary in every case. So we can say that if there is concern by any professional or family member about whether covert medication is right then an application to court is appropriate. Also, if the family say they agree to covert medication, but ask for independent consideration of the decision, then there should be an application to the court, or at least serious consideration to doing so [see case of *NHS Trust and XB and others* [2020] EWCOP 71, Mrs J Theis].

In *AG (by her litigation friend, the OS) v BMBH and SNH* [2016] EWCOP 37 District Judge Bellamy provided some general guidance. He was considering a wider issue of capacity but it emerged during the evidence that the elderly person was being covertly medicated; however no family member, social worker or relevant person's representative (RPR) had been involved in the decision. It was a GP decision. Also it had

not been addressed when a DOL authorisation was made. Everyone agreed that AG had dementia and a risk of serious harm through self-neglect, night-time wandering and becoming unwell without medication, but DJ Bellamy criticised the process of arriving at the decision to covertly medicate. Process is important and in this case there was a lack of consultation, regular reviews and safeguards. The court said that there could be no covert medication until a best interests assessment in line with NICE guidelines had taken place and only after a management plan had been agreed on consultation between healthcare professionals and family. At paragraph 43 of his judgment, DJ Bellamy provided some the useful guidance for wider cases where there is a DOL authorisation:

"(*a) Where there is a covert medication policy in place or indeed anything similar there must be full consultation with healthcare professionals and family.*

(b) The existence of such treatment must be clearly identified within the assessment and authorisation.

(c) If the standard authorisation is to be for a period of longer than six months there should be a clear provision for regular, possibly monthly, reviews of the care and support plan.

(d) There should at regular intervals be review involving family and healthcare professionals, all the more so if the standard authorisation is to be for the maximum twelve month period.

(e) Each case must be determined on its facts but I cannot see that it would be sensible for there to be an absolute policy that, in circumstances similar to this, standard authorisation should be limited to six months. It may be perfectly practical and proportionate provided there is a provision for reviews(or conditions attached) for the standard authorisation to be for the maximum period.

(f) Where appointed an RPR should be fully involved in those discussions and review so that if appropriate an application [to court] *for part 8 review can be made.*

(g) Any change of medication or treatment regime should also trigger a review where such medication is covertly administered.

(h) Such matters can be achieved by placing appropriate conditions to which the standard authorisation is subject and would of course accord with chapter 8 of the deprivation of liberty safeguard's code of practice.…."

I'm sorry that the answer to the question does not provide clarity for all cases. Each case needs to be assessed individually. Nonetheless, I hope the above helps.

Mike O'Brien KC