ARTICLE

The Mental Capacity Act 2005 and autoerotic asphyxiation: pleasure versus the risk of harm

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SUMMARY

There has been a series of judgments in recent years emanating from the Court of Protection in England and Wales involving sexual relations. One such judgment is unique in that it is the first time the court has assessed capacity in the sexual practice of autoerotic asphyxiation in a person with a diagnosis of autism spectrum disorder. This article reviews the judgment and specifically the key section of the Mental Capacity Act 2005, section 27, which applies to capacity decisions in the context of family relationships, including sexual relationships. The practice of autoerotic asphyxia can be a complex and emotive subject and dangerous to individuals undertaking it. The judgment provides guidance and a framework for applying the Act to assess the capacity of someone practising autoerotic asphyxia that can be used in clinical practice for people with any mental disorder.

LEARNING OBJECTIVES

After reading the article you will be able to:

- understand how the Court of Protection approached the issue of someone being able to consent to autoerotic asphyxia
- understand the key application of section 27 of the MCA in relation to making certain decisions in the context of family relationships
- appreciate how previous case law influences and shapes Court of Protection decisions and judgments.

KEYWORDS

Autism spectrum disorders; consent and capacity; human rights; intellectual disability; psychiatry and law.

The Court of Protection (COP) in England and Wales considers issues concerning a person's capacity to consent to a variety of decisions under the Mental Capacity Act 2005 (MCA). This article reviews a COP judgment from December 2020 – *AA (Court of Protection: Capacity to Consent to Sexual Practices)* [2020]. It involved a 19-year-old man known as AA. The court was told he had been diagnosed with 'autism ('ASD') and Asperger's Syndrome' (generally referred to thereafter in the judgment as ASD – autism spectrum disorder). He was known to have interests in certain sexual practices, including autoerotic asphyxiation (AEA in the judgment) – the deliberate self-induction of cerebral hypoxia with the intent of causing heightened sexual arousal or orgasm. It has an inherent risk of severe physical injury and even death (Chater 2020). Deaths attributed to autoerotic asphyxiation are predominantly in males (Byard 2012). In DSM-5 (American Psychiatric Association 2013), autoerotic asphyxiation is recognised as a paraphilic disorder. The judgment is unique in that there has been no previous case law on making decisions about autoerotic asphyxiation.

This article describes the application of the MCA when assessing AA's capacity to consent to sexual practices and in particular autoerotic asphyxiation. It shows how the court used previous case law to help guide its decision-making and the depth of discussion from the relevant parties involved in the case on the narrow subject of autoerotic asphyxiation. In doing so, it provides an understanding of how such a complex and sensitive subject can be approached and assessed for use in clinical practice in similar cases.

Background to the case

The court described salient issues in AA's life. He was placed into the care of his father until the age of 15, having previously been removed from his mother's care. In 2017, AA alleged his father had asked him for oral sex. Although his father was arrested, the police took no further action. Following this, AA lived briefly with an aunt, but she was unable to cope with his behaviour. The local authority arranged for him to be voluntarily accommodated and placed in a children's home under section 20 of the Children Act 1989 (Provision of accommodation for children: general). AA was made the subject of a care order in 2018.

Previous COP proceedings had found that AA lacked the capacity to make welfare decisions and that it was in his best interests (section 4 of the

MCA) to move from the children's home into a supported living placement under an authorised deprivation of liberty. AA moved into his new property in August 2020. He was supported 24 h a day, 7 days a week. At the time of the court hearing, AA was attending a local college twice weekly to study an animal care course. He continued to have contact with some family members but was estranged from his father.

AA was described as engaging in, or having an interest in, various sexual practices apart from autoerotic asphyxiation, including cross-dressing and 'My Little Pony' (one assumes a sexual fetish, albeit not explained in the judgment). He had also posted material about himself on the dark web describing his wish to be a 'submissive partner' and his 'desire to be kidnapped and raped'. The judgment described the evolution of AA's sexual practices involving autoerotic asphyxiation. His interest in autoerotic asphyxiation had started at the age of 13 or 14. When he was living with his father, he was found to have videos of the practice on his phone, and on one occasion had fallen asleep with a plastic bag over his head. His aunt had observed red marks around his neck on occasion. In March 2018, while under the care of the children's home, AA was noted to have made a noose from swimming goggles. AA reported that he had been 'dizzy' when engaging in autoerotic asphyxiation and how cutting off his circulation was 'just a nice feeling to have'. He felt he was addicted to this activity. The judgment described how he had put a bag over his head until 'getting to a point I couldn't breathe and masturbating … didn't know the real reason I was doing it'.

Important evidence was noted from AA's social worker, who described a 'good working relationship' with AA. She described the extensive efforts the local authority had made to support AA in relation to his engagement in autoerotic asphyxiation, albeit 'all to no avail'. The care arrangements and restrictions on AA's liberty were:

- one-to-one staffing at all times, with visual checks every 10 min throughout the day and every 15 min when he was asleep
- no unsupervised access in the community or social time
- his mobile phone was checked every evening by a member of staff
- his bedroom was searched by the staff twice a day.

When the judge met AA prior to the hearing, AA described finding such restrictions too invasive and wished for them to be removed or reduced. The judge was informed by the social worker that the care provider would not be able to maintain the placement if the restrictions were reduced, owing to the perceived risk of AA harming himself or unintentionally causing his own death. However, if AA engaged in therapeutic support, the social worker would be encouraged to consider steps to reduce the support/restrictions in place.

How the case came to court

The parties in the case were:

(a) the applicant – being the local authority, which was represented by instructed legal counsel
(b) the respondent – being AA, who was represented by his litigation friend, the Official Solicitor, who was represented by separate instructed legal counsel.

The Official Solicitor acts as a litigation friend when the person involved has been assessed as lacking the capacity to engage in court proceedings and there is no one else suitable or willing to be a litigation friend, e.g. parent or guardian, a family member or friend, a solicitor, a professional advocate such as an independent mental capacity advocate (IMCA), a COP deputy or someone who has a lasting power of attorney.

The local authority submitted that because of AA's 'autism', his sexual interests were at 'risk of becoming all consuming'. It further contended that without appropriate intervention and support for AA, there was a 'high risk of unintentional death'. It was also noted by the court that AA's family were understandably concerned that AA might not only be a victim of sexual abuse and assault, but also become a perpetrator. It was the concern regarding such sexual behaviour that prompted the local authority to bring the case to court.

Although this article concentrates on autoerotic asphyxiation and sexual relations, the judge outlined the issues to be determined:

(a) AA's capacity to conduct proceedings, make decisions regarding autoerotic asphyxiation, internet and social media use, consent to sexual relations, and contact with others
(b) AA's best interests in those domains where he lacked the capacity to decide
(c) whether he should authorise AA's deprivation of liberty.

Application of the Mental Capacity Act 2005

As is usual in COP cases, the application of the MCA is sequentially considered, invariably concentrating on sections 1–4 of the Act, which are key to any capacity assessment. In applying the MCA in this case, the judgment drew heavily on previous COP jurisprudence and specifically the case of *A Local Authority v TZ* [2014], which 'encapsulated' the MCA principles to be applied when determining whether a person had the capacity or not to make

a decision. The case involved 'TZ', a 24-year-old man with mild intellectual disability (referred to as 'learning disabilities' in the judgment), atypical autism and hyperactivity disorder. One aspect was the assessment of his capacity to consent to and engage in sexual relations. The judge quoted several paragraphs from *TZ* pertinent to the application of the MCA and fully concurred that these were applicable in AA's case.

The *TZ* case provided guidance in that when assessing capacity 'the court must consider all the relevant evidence'. In doing so, evidence and opinion from an independently instructed expert were 'likely to be of very considerable importance'. However, in COP cases there will 'invariably' be evidence from other professionals who are familiar with treating and working with the person, and sometimes from friends and family, and vitally on occasion from the person involved themselves. It was further observed in *A Local Authority v K, D and L* [2005] that the court 'must' indeed consider all evidence and not merely the views of the independent expert and that:

- 'the roles of the court and the expert are distinct'
- 'it is the court that is in the position to weigh the expert evidence against its findings on the other evidence'
- 'the judge must always remember that he or she is the person who makes the final decision'.

The final part of the *TZ* judgment reiterated previous case law (*PH v A Local Authority, Z Ltd and R* [2011] and *CC v KK* [2012]) that in cases involving a vulnerable adult there was a risk that professionals involved with treating and supporting the person – 'including, of course, a judge in the COP' – could be 'drawn towards an outcome that was more protective of the adult and thus, in certain circumstances, fail to carry out an assessment of capacity that is detached and objective', i.e. an inherent propensity to a paternalistic approach. It was also observed that it was not 'necessary for the person to comprehend every detail of the issue […] it is not always necessary for a person to comprehend all peripheral detail' (*LBL v RYJ & Anor* [2010]). The key question was whether the person involved could 'comprehend and weigh the salient details relevant to the decision' being made.

Expert evidence

Two experts, Dr X (a psychologist) and Dr Y (a specialist psychiatrist), were asked to provide reports to the court about various capacity aspects of the case (most COP cases contain various capacity-based decisions to be assessed). Dr X, who was instructed first, noted that AA did not have an intellectual disability but did have 'autistic spectrum disorder, Asperger's syndrome, and paraphilic disorder'. He further explained that he felt autoerotic asphyxiation should be considered 'as a specific decision and a domain separate from engagement in sexual relations' and that AA '[did] not fully appreciate the dangerousness of engaging in AEA [autoerotic asphyxiation]'. Dr X and Dr Y concurred that the information relevant to making decisions regarding autoerotic asphyxiation included:

(1) the concept of AEA;
(2) the manner in which AA engaged in AEA;
(3) the range of risks and harm associated with the practice of AEA and their likelihood; and
(4) knowledge and use of safety strategies and their effectiveness (recognising that AEA is an inherently dangerous practice and potentially life threatening).'

As part of his evaluation, Dr X had also included knowledge and experience of other strategies for obtaining sexual gratification. Dr Y, while agreeing with this proposition, considered it was more complicated for AA owing to issues relating to his diagnosis, which at that time were unassessed. Dr Y considered that AA lacked the capacity to make decisions regarding autoerotic asphyxiation because:

(1) he had no knowledge of the risk of partial hypoxia and acquired brain injury;
(2) he was unable to cross-transfer skills and knowledge because of his autism;
(3) although he [had] a basic understanding of the risks in relation to plastic bags, he [could not] transfer this knowledge to other similar mechanisms; and
(4) AA could not retain information related to specific breathing techniques and similar information provided to him with the educative work undertaken with him.'

These can be regarded as four-limbed criteria by which to assess capacity to consent to AEA.

The judgment elucidated Dr Y's in-depth reasoning by quoting excerpts from written submissions in relation to the juxtaposition of AA's autism and his practising of autoerotic asphyxiation (Box 1). Dr Y noted that AA had not undergone a sensory profile assessment. He considered this a 'crucial assessment' that would 'enable a much clearer understanding of the impact of ASD on AA's life and his capacity to make decisions' and was 'key to his whole life'. A particular focus of Dr Y's evidence was whether AA's engagement in autoerotic asphyxiation was a feature of his ASD or a personal preference to achieve sexual gratification. In the absence of a sensory profile, Dr Y tended to the view that it was indeed a manifestation of his ASD, but in any event AA's inability to weigh relevant

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BOX 1 Dr Y's written submissions regarding AA's autism spectrum disorder (ASD) and practising of autoerotic asphyxiation (AEA)

'9.5.3. In the case of [AA] the aetiology of his presentation is also worthy of consideration given that – and as set out within the previous diagnostic criteria – he further presents with the relevant circumscribed and specific interests as a component of his ASD.

9.5.4. It is additionally worthy to note his early upbringing and – similarly – the relevance of sensory factors and the possibility/likelihood that he experiences a degree of 'low registration' in that he has a pattern of sensory processing in which he has a high threshold to sensory stimulus, and either does not detect changes within the range of stimulus, or requires a higher level of sensory stimulus to achieve the same outcome – both of these scenarios would be hugely pertinent in this case given the risks related to either a greater need for hypoxia for the same level of arousal or the failure to recognise changes in consciousness levels and the risk of hypoxic brain injury or death.

9.6.10. Accordingly, I do not believe that [AA] truly understands the inherent risks related to all relevant practices, can transfer his knowledge between each practice (be it breathing techniques, use of dog collars, ligatures, plastic bags or other implements) and – further – does not have a broad knowledge of the ancillary risks aside from death, i.e. hypoxia, cognitive damage or the associated issues of being "found" within such a position and – thus – the emotional and social impact upon others due to the behaviour itself rather than specifically his death.

9.6.11. As previously stated, it is also my view that there remains therapeutic assessment work that may firstly give a better understanding of the relevant aspects of AEA as a concept within [AA]'s sensory profile and – thus – alternative mechanisms by which interventions can be employed. I am also mindful that he referred to his interest in AEA as 'an addiction' and – whilst sublimated to more socially acceptable (and I use that as a concept accordingly) practices – I again refer to the intrinsic compulsion related to the restrictive and circumscribed interests and – thus – the likelihood that they will be, in isolation, particularly difficult to extinguish.

9.6.12. As such, overall, it is my opinion that [AA] fails to understand and weigh the information relationship to the decision and – thus – lacks capacity to make decisions with regard to his engagement in AEA and associated practices for sexual gratification.'

(Reproduced from *AA (Court of Protection: Capacity to Consent to Sexual Practices)* [2020])

information regarding autoerotic asphyxiation, combined with his inability to cross-transfer skills and knowledge, was due to his ASD (one of the consistent characteristics of people with autism/ASD is that they have difficulty with generalisation – the process of transferring skills or concepts taught in one set of conditions to other conditions).

Dr X concurred that it was important that AA underwent a sensory profile assessment to better inform an understanding of his ASD and its impact on his life. He considered there was a lack of clarity about AA's needs and requirements and that 'AA underestimated his need for support', explaining that AA

> 'needed the support of a well-led multidisciplinary team to:
> (1) formulate an intervention plan;
> (2) provide therapeutic support;
> (3) psychological education; and
> (4) a risk management plan.'

Submissions of the parties involved

The parties each made their own submissions to the court, giving insight into the intricacies of legal aspects of autoerotic asphyxiation from various viewpoints.

The local authority

The local authority counsel pertinently noted the provisions of section 27 of the MCA (Box 2) – this precludes the court from making a decision on behalf of someone in the context of family relationships, i.e. where someone has been assessed as lacking the capacity to make a decision within the section 27 remit, the MCA does not allow for a best interest decision to be made. Applicable to this case was section 27(1)(b) – consenting to sexual relations. Hence, counsel submitted that if AA was found to lack capacity to engage in autoerotic asphyxiation, then owing to section 27, there was no best interest decision to be made.

The Official Solicitor

Counsel for the Official Solicitor noted that there had been no previous reported case law on capacity to make decisions about autoerotic asphyxiation. The judgment noted 'helpful' submissions and 'specific points' from the Official Solicitor on the issue of capacity to engage in autoerotic asphyxiation – in essence, assessment of the balance of 'pleasure versus risk of harm' (Box 3).

The judgment noted that the Official Solicitor had considered its position in terms of being a 'matter of public policy and statutory construction' as to whether the applicant and the COP actually had 'any proper role to conduct a capacity assessment of [AA]'s decision making in respect of AEA'. An argument was propagated that, unlike sexual relations, which needed to involve another person, the

BOX 2 Section 27 of the Mental Capacity Act 2005

Section 27 comes within a section of the Act entitled 'Excluded decisions'. The MCA Code of Practice (Department for Constitutional Affairs 2007: paras 1.9 and 1.10) advises that there are certain decisions that can never be made and actions that can never be carried out on behalf of a person who lacks the capacity to make such specific decisions, whether by family members, carers, professionals, attorneys or the Court of Protection. This is because they are so personal to the individual concerned, or governed by other legislation.

Section 27 reads as follows:

'27 – Family relationships etc.

(1) Nothing in this Act permits a decision on any of the following matters to be made on behalf of the person –

(a) consenting to marriage or civil partnership,

(b) consenting to have sexual relations,

(c) consenting to a decree of divorce being granted on the basis of two years' separation,

(d) consenting to a dissolution order being made in relation to a civil partnership on the basis of two years' separation,

(e) consenting to a child's being placed for adoption by an adoption agency,

(f) consenting to the making of an adoption order,

(g) discharging parental responsibilities in matters not relating to a child's property,

(h) giving consent under the Human Fertilisation and Embryology Act 1990 (c. 37),

(i) giving consent under the Human Fertilisation and Embryology Act 2008.

(2) 'Adoption order' means –

(a) an adoption order within the meaning of the Adoption and Children Act 2002 (c. 38) (including a future adoption order), and

(b) an order under section 84 of that Act (parental responsibility prior to adoption abroad).'

BOX 3 Submissions and specific issues from the Official Solicitor on the issue of capacity to engage in autoerotic asphyxiation in the case of *AA*

- In as much as AA had unusual sexual interests and derived pleasure from those, as long as they remained within the law, these were private matters for him and all professionals must approach him and his interests in a non-judgemental fashion.
- All adults, whether capacitous or not, are entitled to a zone of private life in which they can explore their sexuality and seek solitary pleasure, whether from masturbation, other self-stimulatory behaviour, watching pornography or using sex toys. Failure to respect this boundary was 'a gross incursion into the dignity and humanity' to which all adults were entitled to live their lives.
- In the vast majority of self-stimulatory sexual practices, there is no role for capacity assessment and best interest decisions.
- The state must be vigilant to afford those who are considered to be of borderline capacity, to have autism or intellectual disability, a clear zone of privacy in respect of solitary sexual practices. The state has a very limited role to assess capacity or make best interest decisions in these areas: every incursion is an affront to human dignity and private life, i.e. there is an inherent risk of discrimination against those with intellectual disability and others with incapacity should 'private practices become the subject of public assessment' as could occur in the COP.
- If AA's 'intimate, private sexual life' was analysed in such a way, then this would amount to a violation of his right to respect for a private life under Article 8 of the Human Rights Act.
- Professionals must be alive to the fact that unusual sexual practices may be difficult to assess from the perspective of capacity, because the mechanics of such acts and the pleasures derived from them are unchartered and/or unknown territory.
- The court should not step into AA's shoes to make a best interest decision for him, i.e. the court could not weigh up and use the relevant information ('pleasure versus risk of harm') on AA's behalf as the court could not weigh up 'highly subjective factors of sexual pleasure and risk in an objective way' to reach a decision.
- Such an approach was consistent with section 27 of the MCA, which 'imposes a statutory prohibition' on best interest decisions being made in respect of a person's consent to sexual relations, i.e. a 'solitary sexual practice' was 'very different' from sexual relations.
- Autoerotic asphyxiation is dangerous and AA is at risk of injury or death should he continue to practise it.
- It is very important, whether he has or does not have the capacity, that AA is offered and helped to accept a package of sexual education that embraces his sexual interests and safe(r) autoerotic asphyxiation practices.
- AA was currently being deprived of his liberty because of the risks to his health from autoerotic asphyxiation – these were significant restrictions for a young man about to turn 19.

(Summarised from *AA (Court of Protection: Capacity to Consent to Sexual Practices)* [2020])

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state's role in this assessment of autoerotic asphyxiation should be 'limited and circumscribed'. On this issue, the judgment noted that 'on balance, the risk of death/hypoxia of AEA leads to the conclusion that unlike most other self-stimulatory practices, a capacity assessment is not inconsistent with public policy and the language of the Act'.

Analysis of the court

The judgment accepted that issues around practising autoerotic asphyxiation engaged the most private and personal of AA's rights under Article 8 of the Human Rights Act (HRA) – the right to respect for private and family life – and that the state should be 'very slow and cautious to interfere with the same'. It was clear that capacitous people engaged in autoerotic asphyxiation 'notwithstanding that it is an inherently dangerous practice which carries a very real risk of acquired brain damage or unintentional death'. The judgment emphasised that capacitous people are entitled to make unwise decisions (MCA, section 1(4)) – and many people engage in contact with strangers on the internet/social media, which may put them at risk of physical, sexual, emotional or psychological harm. The judge was outspoken in reminding himself that he 'must not adopt an approach based on a moral judgment about AEA or on contacting strangers on the internet or social media'. Similarly, he noted he must not 'adopt a protective stance towards a person when determining whether they have capacity to make a decision to engage in AEA notwithstanding that they are very likely to make an unwise or risky decision'.

The judge accepted evidence from Dr Y and in particular:

- the impact of AA's diagnosis of ASD was still largely unassessed and a sensory profile assessment was required to enhance this understanding;
- because of ASD, AA was 'more likely to be preoccupied with and obsessively engage in AEA than would otherwise be the case';
- AA's engagement with AEA was a manifestation of ASD (diagnostic test) which rendered him unable to weigh relevant information about AEA and from cross-transferring information from one specific situation to another (functional test);
- owing to ASD, AA did not have capacity in relation to contact with people he met online and subsequent ability to weigh information and to cross-transfer information;
- AA potentially had a high threshold to sensory stimulus, which may require a higher level of stimulus to achieve the same outcome;
- AA's 'addiction and intrinsic compulsion' to engage in autoerotic asphyxiation was likely to make it difficult to change his behaviour.

The judge was 'particularly concerned' by the last two opinions. He concluded that AA was at 'high risk of being unable to regulate his engagement with AEA and therefore at greater risk of serious harm or death'.

An interesting point was noted in that neither expert witness felt able to offer an opinion on whether AA had the capacity to consent to support when engaging in autoerotic asphyxiation. They considered the issue and the concept to be difficult. In light of this, the judge proposed to 'park' this but to return to it in due course if 'clear and cogent evidence' became available to help determine the issue. Another poignant issue that the judge considered was the impact on others, and especially close family members, where an acquired brain injury or death resulted from autoerotic asphyxiation, and whether this was a relevant overall factor in this case – he concluded that it was not. He accepted this 'would set the bar too high in comparison to capacitous adults who engage in the practice of AEA'.

Conclusions of the court

The judgment concluded on the balance of probabilities that AA lacked the capacity to make decisions about engaging in autoerotic asphyxiation. In light of this, the court considered that section 48 of the MCA (Interim orders and directions) was satisfied such that interim orders could be made.

The judge accepted the agreed position of the parties, that in relation to AA's engagement in autoerotic asphyxiation, no best interest decision could be made as it would be contrary to section 27(1)(b) or at least 'the philosophy of this provision for the court to make a decision in respect of AEA on AA's behalf'. The judgment emphasised that it was 'crucial' that a sensory assessment of AA was undertaken as soon as possible, following which, the local authority must then draft a detailed care and support plan. It specifically noted that AA needed to be provided with an education programme to enable him to understand different ways of obtaining sexual gratification other than engaging in autoerotic asphyxiation. In advising that it was 'essential' that therapy was made available to AA to 'deal with his past experiences and to explore how his ASD has an impact on his day-to-day life', the judge had no doubt that AA would 'readily engage in this therapeutic process'.

The final part of the judgment acknowledged the 'burdensome and invasive' restrictions under which AA lived primarily due to his interest in autoerotic asphyxiation. Such restrictions were deemed still to be necessary and in his best interests to continue to 'protect him and to ensure his life is not

unnecessarily endangered'. However, the judge hoped the local authority and the care provider would give 'anxious consideration' to the degree, if at all, to which some of these restrictions could be reduced while awaiting the outcome of the assessments, education and therapy advised. In doing so, it was noted that such reductions, if able to be achieved safely, would continue to not only recognise AA's right to private life but also increase his autonomy.

Discussion

Predictably, given the probable low rates of autoerotic asphyxiation in the general population, there is a dearth of research or publications in the more specific area of autoerotic asphyxiation and autism/intellectual disability (Kolta 2018). Of the publications there are, most (three) are case studies (Box 4). The proposal to help AA was to develop a behavioural intervention plan including psychoeducation. Further to the three cases in which such interventions were implemented, a person-centred psychoeducational approach from a rights-based perspective enabled a person with autism and mild intellectual disability to make important changes in his life and sexual risk based on his sexual fetish of using nappies and baby paraphernalia (Cambridge 2013). Davis et al (2016) undertook a large review of studies that had evaluated behavioural treatments to reduce inappropriate sexual behaviour in people with developmental disabilities. They report strengths and weaknesses of various treatments but also provide a model for treatment selection. Larger reviews of studies reviewing sexuality research in people with ASD (Kellaher 2015) including hypersexual and paraphilic behaviour (Schöttle 2017) have been undertaken.

In terms of the MCA framework for assessment of capacity to consent to autoerotic asphyxiation, the salient issues were twofold. First, the key sections 1–3 of the MCA to establish capacity or not (using the criteria elucidated by the expert witnesses for making autoerotic asphyxiation decisions) should be sequentially applied. Second, and what naturally follows, is that autoerotic asphyxiation is automatically subsumed by section 27(1)(b), which does not allow for a best interest decision to be made where a person is assessed as lacking capacity. Thereafter, the court can make directions under section 15 (Power to make directions) or section 48 (Interim orders and directions), as occurred in this case.

In recent years, there has been a glut of court cases on the issue of consenting to sexual relations. Section 27 of the MCA was central to a seminal case from the Court of Appeal (*A Local Authority v JB* [2020]). This involved a 36-year-old man with a complex diagnosis of ASD and impaired cognition. It produced a list of information relevant to a decision as to whether someone has the capacity to engage in sexual relations that may include:

> '(1) the sexual nature and character of the act of sexual intercourse, including the mechanics of the act;
> (2) the fact that the other person must have the capacity to consent to the sexual activity and must in fact consent before and throughout the sexual activity;
> (3) the fact that a person can say yes or no to having sexual relations and is able to decide whether to give or withhold consent;
> (4) that a reasonably foreseeable consequence of sexual intercourse between a man and woman is

BOX 4 Three case studies examining autoerotic asphyxiation in people with autism spectrum disorder and/or intellectual disability

Thompson & Beail (2002) describe a case study of an 18-year-old man with autism and severe intellectual disability. He engaged in autoerotic asphyxiation on an almost daily basis at home, where he lived with his family. He had been undertaking this behaviour for around 2 years. His parents reported that they often found him breathless and on the point of collapse. A single case study methodology was implemented to assess the effectiveness of a treatment involving a behavioural and psychoeducational programme. This intervention produced learning of new adaptive behaviour – autoerotic asphyxiation ceased and the person's masturbatory behaviour also changed to reduce the risk of death. The authors also importantly found a qualitatively significant reduction in the level of stress experienced by the individual's family. They concluded that behavioural and educational techniques may be effective in the management of such cases.

Williams et al (2000) describe a multidisciplinary assessment and intervention for a 20-year-old man with mild to moderate intellectual disability who engaged in autoerotic asphyxiation. The intervention, which concentrated on developing a greater range of social opportunities, led to an overall decrease in the frequency and severity of the behaviour that was maintained over time.

Faccini & Alezey Saide (2012) reported the coexistence of autoerotic asphyxiation and asphyxiophilia (performed by a partner) in a man with mild intellectual disability which would predictably add another layer of risk assessment to that of just autoerotic asphyxiation alone. His comprehensive treatment plan included environmental restrictions, close monitoring and social skills training, as well as social opportunity lifestyle enhancements.

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BOX 5 Key learning points from the case of *AA* that can be used in clinical practice

- Cases heard in the COP often involve multiple capacity issues to assess and decide upon.
- The COP will draw on previous relevant MCA case law to apply to and guide the current case.
- The COP will invariably appoint independent expert witnesses to provide evidence for a case.
- The COP must, however, consider all evidence, for example from other sources, and not just the views of the independent expert.
- Where a person involved in a COP case lacks the capacity to engage in court proceedings, they will be represented by the Official Solicitor.
- Section 27 of the MCA precludes the COP from making a decision on behalf of a person who has been assessed as lacking the capacity to make decisions in the context of family relationships; applicable to the autoerotic asphyxiation case in *AA* was section 27(1)(b) – consenting to have sexual relations.
- Where someone is found to lack the capacity to make specific decisions under section 27, the Act precludes best interest decisions from being made.
- The judgment in *AA* has developed criteria for assessing capacity to engage in autoerotic asphyxiation which can be used in clinical practice – each case, whatever the mental disorder, will of course be individually contextually different when applying the MCA.
- The person would need to understand all four limbs of these criteria and be able to retain the relevant information, use or weigh this information and be able to communicate it to have the capacity to make decisions about practising autoerotic asphyxiation.

(After *AA (Court of Protection: Capacity to Consent to Sexual Practices)* [2020])

that the woman will become pregnant;
(5) that there are health risks involved, particularly the acquisition of sexually transmitted and transmissible infections, and that the risk of sexually transmitted infection can be reduced by the taking of precautions such as the use of a condom.'

Recent case law affirms that this is the current approach to be applied for such decisions (*Liverpool City Council v CMW* [2021]). The JB judgment pertinently noted the issue of capacity and sexual relations was of 'great importance to people with LD or acquired disorders of the brain or mind'. It explained it required the court 'to balance three fundamental principles of public interest':

(1) The principle of autonomy – this lies at the heart of the MCA case law. It underpins the purpose of Article 1 of the UN Convention on the Rights of Persons with Disabilities 2006: 'to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity'.
(2) The principle that vulnerable people in society must be protected – it was observed in *B v A Local Authority* [2019] that 'there is a need to protect individuals and safeguard their interests where their individual qualities or situation place them in a particularly vulnerable situation'. There was a balance to be struck between the first and second principles, which was often the most important aspect of decision-making in the Court of Protection. The MCA Code of Practice notes that: 'It is important to balance people's right to make a decision with their right to safety and protection when they can't make decisions to protect themselves' (Department for Constitutional Affairs 2007: para. 2.4).
(3) The principle that sexual relations between two people can only occur with the full and ongoing consent of both parties (this is the core issue the Court of Appeal addressed) – in relation to this principle, it noted that the MCA and COP did 'not exist in a vacuum'; they were part of a wider system of law and justice. As a public authority, the COP had an obligation under the HRA to act in a way that was compatible with the European Convention on Human Rights when considering the rights of both an individual and the rights of others.

Section 27(1)(b) was an important aspect of a case involving a 27-year-old man with Klinefelter's syndrome and ASD (*A Local Authority v C & Ors* [2021]). He was assessed as having the capacity to consent to sex but did not have the capacity to determine contact with others, including sex workers. Although the court could not consent on behalf of the person in relation to having sexual relations, as per section 27(1)(b), it could make best interest decisions regarding contact where he lacked capacity. Similarly, in the case of AA, it was found that he lacked the capacity to make decisions in relation to contact with people he met online; the judgment advised the local authority to develop a best interest framework to underpin a draft care plan for the court's approval on this issue.

Although this case involved a person with ASD, autoerotic asphyxiation may be a complicating issue for people with other mental disorders and

MCQ answers
1 c 2 e 3 d 4 d 5 d

Box 5 summarises key learning points from this case that can be used in clinical practice. As with any case law, although this case is unique in being the first to consider assessment of capacity to consent to auto-erotic asphyxiation, case law in this area may well evolve in future cases reviewed in the COP.

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*These cases can be accessed for free at: https://www.bailii.org

MCQs

Select the single best option for each question stem

1 Section 27 of the Mental Capacity Act 2005 does not apply to:

a consent to marriage
b consent to civil partnerships
c consent to contact with others
d consent to making an adoption order
e consenting to a decree of divorce being granted on the basis of 2 years' separation.

2 In the case of *AA*, the information that the expert witnesses agreed on relevant to making decisions regarding autoerotic asphyxiation did not include:

a the concept of autoerotic asphyxiation
b the manner in which someone engaged in autoerotic asphyxiation
c the range of risks and harm associated with the practice of autoerotic asphyxiation and their likelihood
d knowledge and use of safety strategies and their effectiveness
e that it will always involve a best interest decision where a lack of capacity is found.

3 Regarding the Court of Protection:

a cases heard in the COP can only address one issue of capacity
b the COP does not draw on previous relevant case law to apply to and guide a case
c the COP cannot appoint independent expert witnesses to provide evidence for a case
d the COP must consider all evidence, e.g. from all available sources pertinent to the case
e where a person involved in a COP case lacks the capacity to engage in court proceedings, they can only be represented by a lasting power of attorney.

4 Information relevant to a decision to engage in sexual relations may include:

a the fact that a person can say yes or no to having sexual relations but is unable to decide whether to give or withhold consent
b that a reasonably foreseeable consequence of sexual intercourse between a man and woman is not that the woman could become pregnant
c the fact that the other person must have the capacity to consent to the sexual activity but only consent before the sexual activity
d the sexual nature and character of the act of sexual intercourse, including the mechanics of the act
e that there are no potential health risks involved.

5 With regard to autoerotic asphyxiation:

a it is not regarded as a paraphilia in DSM-5
b it does not have any inherent risks, including death
c deaths attributed to autoerotic asphyxiation are predominantly in females
d practising autoerotic asphyxiation engages a person's most private and personal rights under Article 8 of the Human Rights Act
e autoerotic asphyxiation needs to involve another person to perform the act.