HILL DICKINSON

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Court of Protection

Welcome

First Edition, COP Newsletter, 2022

Court of Protection practitioners up and down the country remain busy as you will see from this edition's round up of cases, and the Court has had reason again to remind us all of the need to bring cases before it in a timely fashion as will be seen from two of the cases covered.

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Welcome

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As to what else is happening, we are seeing an increase in requests for advice on advance decisions as with treatment to patients who have chosen to exercise their right not to be vaccinated, some of which have resulted in urgent applications being made. Whilst NHS bodies we work with continue to seek to resolve conflicts between healthcare professionals and families, the question of mediation and the need to give greater consideration to this is addressed in this edition by none other than Dr Chris Danbury (Consultant Intensivist and Mediator) and Andrew Hannam (Mediator, Trust Mediation). We would be very interested to hear from our readers as to their experiences with mediation and what can be done to encourage this further.

As regards the Liberty Protection Safeguards, implementation by April 2022 will not be possible and no new target date has yet been set. The public consultation on the draft regulations and draft Code of Practice is due to be launched early this year, so continue to watch this space.

And a new capacity guidance website has been launched as part of Mental Health & Justice, for clinicians and social workers in England & Wales, which we are sure will be of interest to you: *https://capacityguide.org.uk/*

Finally, it would be remiss of us not to mention that the President of the Family Division, Sir Andrew McFarlane, appeared in front of the Justice Committee (the Committee) on the subject of "Open Justice: Court Reporting in the Digital Age" on 11 January 2022, during which he told the Committee that, "There must be a way of allowing openness so that people can see what we do, understand what we do, how we do it, why we make the decisions, and yet maintain the anonymity of the individuals involved", and, "The public has a legitimate interest in understanding what we do because we are doing this on behalf of society". This follows the publication of his report in October 2021, "Confidence and Confidentiality: Transparency in the Family Courts" (see: Confidence and Confidentiality: Transparency in the Family Courts (judiciary.uk). Our experience is that the practitioners are getting better at notifying the press of applications and there is much greater transparency than was previously. That said, we are equally aware of the frustrations of journalists who consider that greater reporting should be permitted. We await with interest the outcome of the inquiry.

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Capacity to Engage in Sex vs Capacity to Consent: The Supreme Court's decision in JB

Background

At the time of judgment, JB was a 38-year-old male with a complex diagnosis of Asperger's Syndrome and epilepsy. His care arrangements amounted to a deprivation of his liberty. The local authority filed an application with the Court of Protection (the Court) seeking declarations of JB's capacity in various areas, including his capacity to consent to sexual relations.

The key question that arose was whether, in order to have capacity to 'consent' to sexual relations, P (a protected party) must not only understand that he can give or withhold consent, but must also understand that the other person involved must be able to give consent, and give and maintain consent throughout the sexual activity.

The Court held that this was not necessary for determining whether a person had capacity to consent to sexual relations under the Mental Capacity Act 2005 (MCA). The Court determined therefore that JB had capacity in this domain. This decision was P-centric and appears to provide protection for those under the MCA who may be vulnerable to sexual coercion by focusing solely on P's ability to consent.

The local authority appealed the decision to the Court of Appeal (CoA). Here the question was reframed to whether JB had capacity 'to engage in' rather than 'consent to' sexual relations.

The CoA held that in order for P to have capacity to engage in sexual relations, P must be able to understand that the other person involved must be able to consent to sexual activity and give and maintain their consent. Thus the appeal was allowed.

The Official Solicitor, acting on behalf of JB, appealed the CoA decision to the Supreme Court. Respond (a charity providing services to children, young people and adults with learning disabilities), and Centre for Women's Justice (a charity seeking to combat male violence against women and girls) provided written submissions to the Supreme Court, as interveners in the appeal.

The Supreme Court's decision

The appeal was dismissed.

The Supreme Court (SC) considered decision-making capacity under the MCA and concluded that the approach to capacity is functional and not outcome-based. Section 2(1) of the MCA was considered the core determinative provision. This provides:

2) People who lack capacity

(1) For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.

The SC held that JB understood the ability to consent but not the ability to engage in sex and that consent transcended throughout the act. He was therefore unable to reasonably foresee consequences of his decision to pursue sexual relations where the other person no longer consented. Lord Stevens commented that this could extend to consequences for others, not just P.

This is the first time that case law has articulated in the context of the MCA that the act goes beyond the protection of P. This builds upon foundation ideas set in *City of York Council* (a case that was heard before the CoA in 2013, which considered the question of sexual relations between a husband and wife) where in a contact decision, factual background taken into account may include consideration of the other person, and not just P.

The MCA enables parity; it enables people to make decisions on behalf of those who lack capacity. However, where a person lacks capacity to consent to sexual relations, nothing in the MCA *(s.27)* permits a decision to be made on behalf of P on consenting to have sexual relations.

How will this affect our clients

Lord Stevens' judgment somewhat controversially rejected the submission of the Official Solicitor that the MCA is there to protect P and not others. He concluded that the MCA is 'not concerned solely with protection of P'. Therefore, regard should be had as to how this will apply to cases going forward. Further, restrictive care plans to protect the public are considered by those who work within the Court of Protection as not to be in tune with the MCA. Deprivation of Liberty Safeguards have a statutory limitation to 'reference and risk' to the person, **not others**. There is uncertainty as to how this decision will operate moving forwards and whether this creates incompatibility between the protection of P and additional duties to others.

Emily Tracey,
Trainee Solicitor

Caesarean sections and contingent declarations

Following on from our article relating to the importance of timing in caesarean section court applications in our previous COP newsletter, we consider the recent judgment in *North Middlesex University Hospital NHS Trust -v- SR [2021] EWCOP 58* handed down on 10 November 2021 which dealt with whether contingent declarations should be made should SR lose capacity in the future.

Synopsis of the case

SR had capacity to make decisions about her care in pregnancy and at birth and wanted a caesarean section. The judge did not determine whether a threshold test for contingent declarations was necessary but suggested (obiter) that the appropriate threshold would be "a real risk" that the person may lose capacity. There was such a risk, and it was in SR's best interests for a planned caesarean to take place, using force if necessary.

Background

SR is a woman in her thirties, single and 36 weeks pregnant at the time the court considered the application on 21 October 2021. She had a number of mental health difficulties. She had not given birth before and had a due date of 9 November 2021. She had been under the care of the applicant NHS trust and neighbouring mental health trust since June 2021, with the application to court made on 18 October 2021. A planned caesarean section was scheduled for 25 October 2021.

SR had a turbulent and traumatic childhood. She had a longstanding drug problem and at around age 26, had been diagnosed with paranoid schizophrenia. That condition was well controlled with anti-psychotic medication. However, she had become non-compliant with this for a period in 2020 and her mental health deteriorated. She went missing from her supported accommodation between December 2020 and April 2021 and conceived during that time.

More recently, SR had reunited with her family which had been a very positive development and they were supporting her in attending her antenatal appointments. SR had expressed her fear of a vaginal delivery and strong wish for a caesarean section. On 21 September 2021, she again expressed this as she had before, and was clear if given the choice, she would opt for a caesarean. SR continued to use drugs and the risks of this were fully explained to her. SR, her family and the health professionals all agreed a caesarean section was the safest delivery option.

From 26 September 2021 onwards, concerns relating to SR increased. She presented to hospital with bleeding, however left before examination and was later returned by police and only agreed to limited monitoring. Midwives reported that she started staying out overnight with no-one knowing where she was, she was focussed on obtaining drugs and her ability to comprehend information fluctuated. She was not engaging in all recommended observations/investigations required. Her drug use was daily and of significant amounts, with SR prostituting herself to get the money to fund her drug use.

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The court application

At the point that the application came before the court, SR had capacity to make decisions about her birth arrangements and there was agreement between her and the professionals involved that the right method of delivery was by way of caesarean section. However, there was a concern that she might lose capacity on or before the point she was to come to hospital for the surgical delivery. The application was therefore brought seeking 'anticipatory', or 'contingent', declarations with the judge citing the issues she needed to determine (paragraph 38) as:

- Does SR have capacity to make decisions about her care in pregnancy and birth;
- Is there a risk that she will lose that capacity;
- Is it appropriate to make a declaration, contingent on her losing capacity, identifying the medical treatment that is in SR's best interests;
- Is it appropriate to make an order permitting the use of physical and chemical restraint so that if the need arises, effect can be given to the treatment declaration.

The application was made on an urgent basis which led the Judge to note her concerns as follows (see our previous COP newsletter for further information relating to timing of applications):

27. The Guidance given by Keehan J in Re FG [2014] EWCOP 30, [2015] 1 WLR 1984 is not limited to pregnant women who lack capacity to make obstetric decisions as a result of a diagnosed psychiatric illness: it also applies to those with fluctuating capacity (see paragraph 9). It requires that application is made "at the earliest opportunity". In this case it was, or should have been, clear in September [i.e. at least a month before the application was made] that an application would be necessary because SR fell within two of the four categories identified in the guidance. Those were and are that there was a real risk that she would be subject to more than forcible restraint, and a real risk that she would suffer a deprivation of her liberty which, absent a court order, would be unlawful. It is necessary to draw attention to the guidance again because it is still not as widely observed as it should be.

28. Trusts and their advisors may be tempted to think that in a case where all concerned agree that P has capacity, and the medical treatment the clinicians propose to provide is in accordance with the patient's wishes and feelings, no harm is done by making a late application. That is not the case: the evidence may change, capacity may change requiring the involvement of the official solicitor who will struggle to assist if she has no time to prepare, points of complexity may emerge during the hearing, and a late application puts pressure on an already busy urgent applications list. Where, as here, an ongoing situation mandates an application, delay must be avoided.

As SR was assessed as having litigation capacity the official solicitor had not been notified of the application nor been invited to represent SR.

The psychiatric evidence at the time of the hearing was that SR had schizoaffective disorder and mental and behavioural disturbances due to substance misuse. Her mental health was relatively stable having been recommenced on anti-psychotic medication several weeks earlier. The psychiatrist was unsure how significant the impact of SR's drug use was on her capacity to make decisions relating to her medical care. The midwives in their evidence described a number of visits where SR was under the influence of drugs, or completely focussed on obtaining them such that she lacked decision making capacity at those times. If she presented in that way on 25 October, it was considered it would be very difficult to get her in to theatre, as she disliked lying down or being physically restricted in any way.

Outcome

The Judge, Katie Gollop QC, determined that there was a 'real risk' that SR may lose capacity to make decisions about her labour and the birth during what remained of her pregnancy. The judge preferred the evidence of the midwives on capacity and she considered the main risk arose from SR's mental health disorder arising from her drug use and that it could overwhelm her such that she would lack decision making capacity. This risk arose every day of her pregnancy due to the nature of her drug use. The judge also considered that notwithstanding the psychiatric evidence that SR was not suffering from tokophobia (the morbid fear of childbirth), her "irrational belief that she will die having her baby goes beyond the anxiety that many women giving birth for the first time will experience as the day approaches. It represents a disturbance in the functioning of her mind which renders her at times unable to retain, use and weigh information about labour and birth" (paragraph 46).

"I also find that it is necessary, justified and proportionate to make declarations which permit a caesarean section and restraint, and that SR's circumstances are exceptional. The combination of being at term, engaging in frequent prostitution and daily buying and taking of multiple illegal substances including crack cocaine, makes her extremely vulnerable and in need of the court's protection" (paragraph 47).

In terms of SR's medical treatment, the judge found her best interests were clearly in favour of the caesarean section – this was in accordance with SR's wishes and considered to be the safest option by the health professionals. The issue of whether it was in her best interests to implement restraint to bring SR to hospital to try and ensure a safe delivery was more nuanced. The judge found that there were three reasons why she considered it was in SR's best interests to make a declaration relating to restraint being in her best interests to ensure delivery on 25 October 2021 if so required (paragraph 50):

1. First, the carefully made, bespoke birth plan for delivery on 25 October maximises the chance of SR having the alert, calm, comforted experience with her chosen birth partners that she wishes and which is in her best interests. On any later date, the theatres may be busy causing delay, the staff she knows may not be on duty, family members may be uncontactable, and the prospects of restraint and an unwanted general anaesthetic being required will increase.
2. Second, if the baby is not delivered on Monday, the pregnancy will continue and the chance of SR going into spontaneous labour will increase. Labour is likely to exacerbate her already extreme fear of dying in childbirth and if labour is at an advanced stage when help is sought, a caesarean section may not be an option.
3. Third, the risks of pregnancy increase with further drug use. The foreseeability of circumstances in which restraint may be required to achieve the delivery that is in SR's best interests, also means that there is no less restrictive option available. For these reasons, I make the declarations sought.

As a postscript following judgment, the court was informed that despite some panic attacks during the process, SR's caesarean section delivery went ahead under a spinal anaesthetic, as planned on the morning of 25 October 2021. Mother and baby were both well.

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What is the threshold, if any, for making contingent declarations?

The judge was concerned to understand what the correct test was in law for making an anticipatory declaration or order. She did not consider she was in a position to determine whether a threshold test was necessary, nor what the test was if it was necessary. No legal authority on this point was able to be identified by counsel involved for the applicant. The judge made (obiter) some observations:

1. The making of contingent declarations will almost always be an interference with, or have the potential to interfere with, the Art 8 ECHR rights of the individual concerned to respect for their private and family life, including their autonomous decision making about what is done to them physically. Ideally, everyone should have access to the full range of options when the time comes to put into effect a decision about their private and family life but a contingent declaration or order, restricts that full range. It is for this reason that such relief should only be granted where it is necessary, justified and proportionate, and why the power to grant relief should be used sparingly, or only in exceptional circumstances.
2. Before deciding whether to make any declaration or order, the court must, in accordance with s1(6) MCA 2005, have regard to whether the purpose for which it is needed "can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action".
3. Given these safeguards, it is unclear whether an additional threshold test which must be crossed before an anticipatory order can be made is needed. It is possible that without one, a general requirement of "exceptional circumstances" or "sparing use", may risk the corrosion of rights that the Vice President warned against. On the other hand, a threshold test may limit the court's power unnecessarily.
4. If a threshold test is required, then it seemed to the judge that a balance of probabilities would be unduly restrictive i.e. she did not read the word 'likely' in previous judgments as meaning a contingent declaration should only be made where it is 'more likely than not' that P will lose capacity. An anticipatory order being final, the existence of a risk, and not merely the reasonable belief that there may be one, is required. The judge suggested that "a real risk" that P may lose capacity is the appropriate threshold, and noted that was the language used by Keehan J in *Re: FG*. "Real" means more than theoretical based on credible evidence rather than speculation, and the risk must, of course, be person specific and present at the time the relief is granted rather than historical.

Comment

Although the observations of the judge about whether to apply a test, and if so what test, in contingency planning cases were identified as obiter, this is helpful for practitioners to consider when thinking about the risk of a loss of capacity in expressing their opinion.

From a practical perspective, three other issues arise that are of note:

1. The reiteration of the need to bring cases of this nature before the court at the earliest opportunity;
2. The need for information sharing between health professionals involved in a patient's care, to facilitate joined up care. The judge noted expressly the GMC guidance 'Confidentiality: good practice in handling patient information' 2018 relating to this. This arose in the context of a lack of joint capacity assessments undertaken in this case, which on the face of the information available may have assisted in greater clarity of evidence in this regard, and a lack of sharing information relating to obstetric care with the mental health services working with SR, amongst other factors;
3. Finally, advance care planning. There was agreement in this case between SR and those treating her as to what care she should receive, at least in relation to a caesarean section and the preferred treatment associated with that. She could have expressed a willingness to be admitted and for the care she wished to receive should she come to lack capacity in the future in an advance statement. However, whilst this is something which must by law be given due weight and consideration in any best interests decision being made on behalf of the patient, it is not legally binding in the same way an advance decision to refuse treatment is under the MCA 2005. In this case, it is likely to have been concern over the potential for restraint being required, and that sections 5 and 6 of the MCA 2005 may not be sufficient in the circumstances to ensure the lawful delivery of the proposed care and restraint, that led to this case being put before the court. There may also have been issues of this aspect being more finely balanced, with the decision regarding restraint being noted by the judge as more nuanced relating to best interests. On the ground, we often find that whilst advance care planning is actively promoted with patients, and if not sufficiently before legal advice is sought then certainly after, the take up by patients is minimal notwithstanding being provided with the resources and support to make this as straightforward as possible.

As a reminder, the Vice President of the Court of Protection issued guidance relating to medical treatment applications in January 2020 and this assists practitioners in considering cases that should, or must, be brought before the court.

Louise Wilson
Legal Director

The role of mediation

Medicine over the last 70 years or so has developed and continues to develop evermore complex and effective treatments. Conditions that were untreatable or partly treatable are now dealt with in an almost offhand manner. An example of this is gastric ulcer diseases. Before H2 blockers such as Ranitidine, and proton pump inhibitors such as Omeprazole, it was common to see entire operating lists of patients undergoing gastric vagotomies to treat a potentially life-threatening problem. Now, doctors will prescribe a pill and surgical vagotomy is no longer considered to treat this condition. As medicine gets better, so expectations of what can be achieved increase. New specialties, such as intensive care medicine, develop.

Intensive care medicine has come into the public eye during the pandemic and arose from a previous pandemic – that of polio in the 1950s in Denmark. Technology has changed since then from an 'iron lung' to the modern ICU ventilator, which is capable of adapting in real time to an individual patient's changing respiratory physiology. We will use intensive care medicine as an example for the rest of the discussion as it is one of the author's medical specialty (CD) and anecdotally the sharpest of the sharp end of technologically driven medical world. It is important to note that most patients on ICU lack the capacity to make decisions for themselves, and thus treatment decisions are frequently based on necessity or the perceived best interests of the patient.

With the increased expectations, can come problems. Patients and their families often do not understand what medicine can and cannot deliver. Conflict in healthcare, particularly ICU, is more common than is commonly thought. As Azoulay[1] and colleagues have shown, up to 70% of intensivists reported conflict occurring in decision-making on ICU, with at least half being perceived as severe. Conflicts can occur within the healthcare team, between different teams or between teams and families. This study shows that conflict increases when there is an end-of-life (EoL) decision to be made, which is perhaps unsurprising.

Interestingly conflicts have arisen both in the situation where there was a perception that the EoL decisions were made too early and also in similar patients where the decision was made too late. These conflicts can cause long-lasting issues for those caught up in the problem. Families have not been studied, but staff members report significantly increased job strain, and it is likely to be associated with the issue of 'burnout' that is increasingly being reported. So, what is the solution?

Classically, if conflict disagreement continues then there is recourse to the courts. As Lady Black said in *An NHS Trust & Ors -v- Y & Anor (Rev 1) [2018]* UKSC 46, at 125:

"If, at the end of the medical process, it is apparent that the way forward is finely balanced, or there is a difference of medical opinion, or a lack of agreement to a proposed course of action from those with an interest in the patient's welfare, a court application can and should be made...".

In England and Wales this would be an application to the Court of Protection for adults or within the Inherent Jurisdiction of the High Court for those under the age of 18. The issue to be considered is whether the treatment being received by the patient remains in their best interests, and not, as has been seen by the authors, that *withdrawal of treatment is in P's best interests.*

Whatever the decision of the court, the question arises, what happens the day after the decision is made? The lawyers and judge will have moved on to other cases , but the family and clinicians are back at the patient's bedside. They are the people who have to follow through with the decision if the decision is not appealed, in which case there is further delay.

What is the alternative? As Lady Black said in *Re Y [2018] UKSC* 46:

"... If the provisions of the MCA 2005 are followed and the relevant guidance observed, and if there is agreement upon what is in the best interests of the patient, the patient may be treated in accordance with that agreement without application to the court..."

Agreement can be achieved through the process of mediation. Both authors have seen resolution of serious medical treatment matters through mediation, or where resolution is not possible, a narrowing of the issues. Andrew Hannam chaired, and Dr Chris Danbury was a committee member, in the Court of Protection Mediation pilot, which is now being written up.

Taking the example of Elder mediation[2], it seems to be the case that mediating these cases is cheaper and faster with more than 50% settling. One key metric is the fact that 90% of participants found the process helpful, even if the matter did not settle. It allows the issues to be narrowed in scope. Where agreement is achieved, then, as it is a consensus, it can be implemented without delay.

Finally, mediation is a parallel track to litigation. Within the medical community, certainly the ICU community, there is a desire to avoid litigation unless necessary. The possibility of mediation is widely discussed, but access to it harder to achieve. It is the experience of both authors that the outcome, for patient, family and clinical team, is much better following a mediation compared with a court decision.

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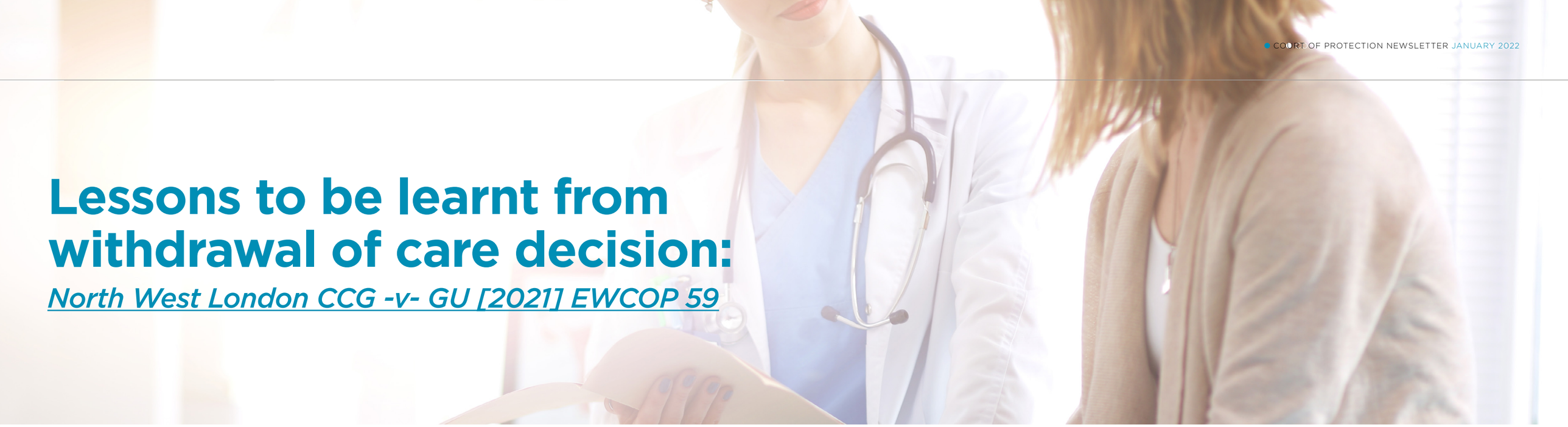
1 Azoulay, Elie, Jean-François Timsit, Charles L. Sprung, Marcio Soares, Katerina Rusinová, Ariane Lafabrie, Ricardo Abizanda, et al. 'Prevalence and Factors of Intensive Care Unit Conflicts: The Conflicus Study'. American Journal of Respiratory and Critical Care Medicine 180, no. 9 (2009): 853–60.

2* Report on Elder and Guardianship Mediation'. The Canadian Centre for Elder Law, 2012.



Lessons to be learnt from withdrawal of care decision:

North West London CCG -v- GU [2021] EWCOP 59

The facts

Following an accident while living in Thailand, GU was transferred to hospital in the UK in September 2014. He never regained consciousness following his accident.

In 2018, GU's brother raised the question of whether ongoing clinically-assisted nutrition and hydration (CANH) was appropriate and in GU's best interests. By this time, it was clear that GU was in a prolonged disorder of consciousness and there was no prospect of any future change. Based on a mistaken understanding that the rest of GU's family opposed withdrawal of CANH, the hospital continued with treatment, but no formal best interests' decision took place.

In December 2020, a second opinion expert was approached to provide an opinion as to GU's best interests in terms of withdrawal of CANH. The expert whose report was available in May 2021, concluded that it was not in GU's best interests to continue with CANH. The expert clarified that only GU's son dissented with this view, on the basis of a personal moral objection. The expert also confirmed that GU had no awareness of himself or his environment.

The decision

An application was made to the Court of Protection (the Court) by the local Clinical Commissioning Group (CCG). It is unclear from the judgment why the hospital did not apply to the Court itself, although the hospital in question is run by a charitable body and not an NHS trust.

Evidence before the Court was that GU had made it clear when he had capacity that he would not want to continue in the situation in which he found himself. GU's son's objection was carefully considered by the Judge, Hayden J. In June 2021, Hayden J ruled that continuation of treatment was not in GU's best interests, treatment was withdrawn and GU died peacefully on 26 June 2021.

Hayden J then gave the hospital an opportunity to explain the reasons for the delay in issuing proceedings, before handing down judgment. In his judgment, Hayden J gives significant consideration to the concept of human dignity and found that GU's dignity had been 'avoidably compromised'.

He said:

"GU was not provided with relief; he should have been. His treatment became both burdensome and futile and entirely contrary to what he would have wanted. His dignity was avoidably compromised. Even the most summary assessment of his best interests would have revealed this many years ago."

He was extremely concerned that GU's voice had remained unheard during a period of seven years when treatment had continued. No decision had been taken as to his best interests during this period. Treatment continued essentially by default.

The Official Solicitor (acting on behalf of GU) also criticised an 'inordinate and inexcusable delay' on the hospital's part in giving consideration to whether continued treatment was in GU's best interests and took the view that this should have been properly addressed in August 2018.

Comment

Delay is a common criticism in cases like this. It is clear that in cases involving the withdrawal of CANH, where there is doubt or a dispute as to the patient's best interests, the Court should be involved at the earliest opportunity.

While the hospital did not seek to justify the delay in bringing proceedings, it explained that the aim of the charity was to provide relief, rehabilitation and long-term care for patients and that this 'coupled with the more limited experience of staff in withdrawing life sustaining treatment had impacted on its approach to CANH withdrawal cases'.

I acted for the applicant CCG in a similar case of *A CCG -v- P and TD [2019] EWCOP 18*

In that case, there was no dispute with the family, but a court application was necessitated because a number of staff at the care home where P was living found that withdrawal of CANH went against their 'pro-life' ethos and they could not agree with the proposed withdrawal. The professionalism and dedication of all involved was not called into question. In this case, the judge noted that a 'pro-life' point of view is a valid one. However, when caring for patients in this situation it is critical to establish that continuation of treatment is in their best interests. This is an objective test where the patient's previously expressed wishes and feelings carry significant weight.

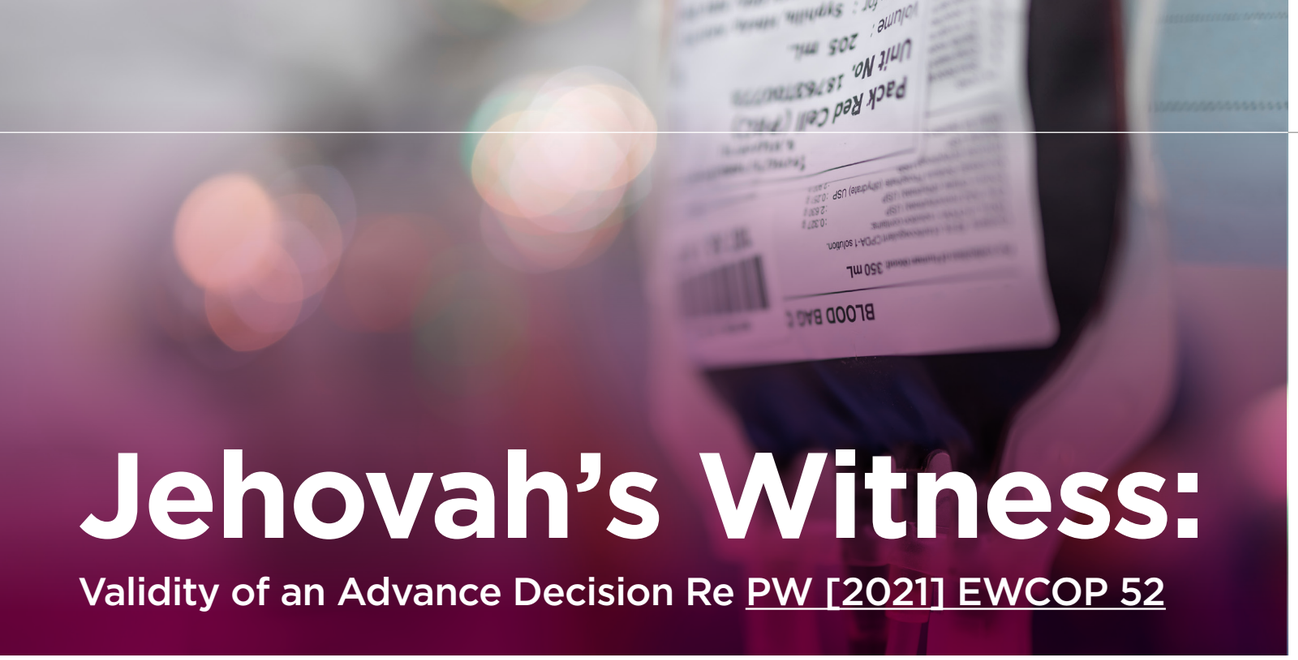
The patients in both cases had expressed very strong views while they had capacity that they would not want continued treatment in such circumstances.

Questions of withdrawal of treatment, particularly nutrition and hydration, can be very difficult for any clinician whose focus is on treatment, recovery and care for patients. Nonetheless, it is equally important to establish a proper legal basis for invasive medical treatment such as CANH and where the patient is incapable of consent, lead to careful consideration of that patient's best interests.

To avoid criticism in cases like this, commissioners and providers of healthcare should:

- Ensure that staff have adequate Mental Capacity Act training;
- Ensure policies have been reviewed and updated following the Court of Protection decision in *Re Y* and the subsequent guidance of the Royal College of Physicians and BMA *Clinically – Assisted Nutrition and Hydration (CANH) and adults who lack the capacity to consent* (2018);
- Consider mediation (see separate article on mediation); and
- In those cases where there is doubt or dispute about a patient's best interests in relation to CANH, involve the Court of Protection at the earliest opportunity.

Joanna Crichton
Legal Director



Jehovah's Witness:

Validity of an Advance Decision Re PW [2021] EWCOP 52

Background

PW is an 80-year-old Jehovah's Witness and has been for most of her adult life. At the time of the hearing, PW was in a perilous condition in hospital. She had severe anaemia following internal bleeding due to an ulcerated gastric tumour. The medical evidence before the court was that, in her current state, PW was at risk of sudden bleeding at any time, which if untreated would almost certainly end her life. With a blood transfusion, the immediate risk of death would have been significantly reduced which would enable PW to undergo investigations and treatment for her tumour. It was presented that PW would likely survive the treatment and may subsequently live for another five to ten years.

PW has Alzheimer's dementia and following an assessment by a consultant geriatrician was assessed as lacking capacity to make decisions about her treatment. However, enquiries made by a doctor revealed that PW had an advance decision from 2001, which appeared to be held on a register of such decisions made by Jehovah's Witnesses.

The court recognises that adults have the right to say in advance whether they want to refuse treatment should they lose capacity in the future, even if this leads to death. This can be done via an advance decision and S.25 of the Mental Capacity Act 2005 (MCA) sets out the requirements for an advance decision for it to be valid and applicable.

The Court of Protection had to determine three questions:

1. Did PW have capacity to refuse/consent to blood transfusion?
2. If not, was her 2001 advance decision to refuse blood valid?
3. If not, was it in her best interests to have the blood transfusion?

On the evidence of the consultant geriatrician, Mr Justice Poole was satisfied that PW lacked capacity in accordance with the test set out in *Masterman-Lister -v- Jewell* [2002] EWCA Civ 189. Therefore, the next step was to look at the validity of the advance decision. The Court considered the evidence before it, including the following key points:

- Earlier in the year, a DNAR was accidentally put on PW's records whilst in hospital. PW brought this to the staff's attention to ensure it was removed. PW did not however raise the issue of being given blood.
- On 17 September 2021, PW told the consultant surgeon that she did not want a blood transfusion even after the risks associated with not having the transfusion were explained to her. However, on the same day, PW had a conversation with her consultant geriatrician (the consultant) who asked her if she would have a blood transfusion to which she responded, 'I'd have to think about it'. The consultant subsequently asked if PW would have a blood transfusion if it meant it would save her life and that if she did not have it, she may die as a result. PW responded, 'in that case, I would have it if it was clean blood'. When asked what PW meant by clean blood, she responded, 'blood free from disease'.
- The consultant returned half an hour later and PW stated that she would not have a blood transfusion. The consultant informed PW that she would die without a blood transfusion to which PW repeated 'in that case, I'll die'.

There was thus, a significant amount of inconsistency regarding PW's position on blood transfusion.

In terms of the advance decision from 2001, PW had not withdrawn it, but had also not renewed or updated it since. The MCA Code of Practice states that anyone who has made an advance decision is advised to regularly review and update it as necessary. Whilst that does not mean that if an advance decision is not reviewed or updated it is automatically invalid or not applicable, a written decision that is regularly reviewed is more likely to be valid and applicable to current circumstances.

In 2020, PW appointed her four children to make decisions about her health and welfare under a Lasting Power of Attorney (LPA) and did not mention the advance decision. Indeed, PW's children were entirely unaware that PW had an advance decision. Under the LPA, PW gave her children authority to make decisions about her health and welfare when she lacked capacity but did not give them authority to give/refuse life-sustaining treatment. She told them she wanted to be resuscitated but did not clarify that she would not want a blood transfusion as part of that resuscitation. PW's children were of the view that PW would want to live and would choose to have the blood transfusion.

Submissions and judgment

The trust submitted that PW's actions were clearly inconsistent with the advance decision remaining as her fixed decision (as per s.25(2)(c) MCA). The official solicitor however submitted that the advance decision ought to be respected and the evidence before the court did not reach the threshold in s.25 MCA for her actions being 'clearly' inconsistent with the advance decision remaining her fixed decision.

Mr Justice Poole found that PW had done things clearly inconsistently with the advance decision remaining as her fixed decision. He said that although the LPA did not give the donees authority in regards to life-sustaining treatment, it "surely' conferred authority on them to give/refuse consent to the administration of allogenic blood and blood products by non-life-sustaining treatment. On the one hand, Mr Justice Poole contended that the advance decision related to such treatment whether life-sustaining or otherwise but, on the other the treatment which was being considered was life-sustaining treatment and authority for such decisions in respect of that treatment was not conferred on the donees under the LPA. He concluded that it might have been argued, but was not, that s.25(2)(b) MCA was satisfied, and he concluded that the advance decision was not valid.

Having established that PW lacked capacity and that the advance decision was not valid, Mr Justice Poole went on to consider PW's best interests. He was satisfied that it was in PW's best interests and lawful in accordance with PW's human rights under articles 2,3,8 and 9 of the European Convention on Human Rights for PW to receive a blood transfusion.

Lesson Learning

It is always worth checking if a patient has an advance decision in place. In this case for example, a junior doctor noticed that PW was a Jehovah's Witness and contacted a database/register which held her advance decision.

Family members should also be consulted to see if they are aware of any advance decisions. The NHS advises that if you are making an advance decision, you should ensure that your family, carers and health professionals know about the advance decision and where to find it, so it is readily available in an emergency situation. That said, this would not have helped in this case as the children were not aware that PW had made an advance decision.

The record of conversations had with PW were crucial. The case is a salient reminder of the importance of accurately documenting exactly what patients say when answering questions in relation to wishes and feelings.

Finally, if in doubt seek legal support as soon as possible particularly if there is uncertainty as to whether an advance decision is valid.

Julie Grifo
Paralegal

Court of Protection cases from October to December 2021

Here is a round-up of the key Court of Protection cases from this quarter which we believe our readers will be most interested in. Please follow the link within the case summary to access the full judgment. Contact our team to discuss any particular case in more detail.

Using the MCA to bring a relative back to the UK *Re AB v XS [2021] EWCOP 57*

In April 2021, AB issued proceedings to bring her 96 year-old cousin, XS, back to the UK from Lebanon. XS is in the advanced stages of dementia, holds a dual (UK and Lebanese) citizenship and travelled to Lebanon in 2014 to visit family but not with the intention of residing there. The three main issues before the court (Mrs Justice Lieven) were:

1. **Whether XS is habitually resident in the UK and therefore the Court of Protection retains jurisdiction.** AB argued that XS remains habitually resident in the UK as she only intended to move to Lebanon temporarily. On behalf of XS it was argued that she had spent a lengthy period of time in Lebanon, was settled and integrated and became habitually resident when she moved there. The court found XS to be habitually resident in Lebanon; it was noted that her medical and therapeutic needs were being met in Lebanon and it had (has) undoubtedly become her home. As a result, the court considered that it had no power under the Mental Capacity Act 2005 (MCA) to make a return order to the UK.
2. **Whether the High Court can make an order for XS to return to the UK under its inherent jurisdiction.** The court's view was that it would be plainly inappropriate to exercise the inherent jurisdiction in this way because it would cut across the statutory scheme for no good reason. In any event, the court considered that it would not be in XS's best interests to return to the UK.
3. **Whether it is in XS's best interests to be brought back to the UK.** The court found that XS would not benefit from returning to the UK as she would not be aware that she had moved, and she would not recognise the Applicant nor any other people she knew previously. It was also noted that a move would be disruptive for her in relation to her care, and she would find the flight physically and possibly emotionally exhausting. The court considered that XS was well cared for and apparently content in Lebanon.

Moving a woman with dementia into a care home due to concerns over her son's behaviour *Re A [2021] EWCOP 60*

A, a 76 year-old woman, has late-onset vascular dementia complicated with agitation, anxiety disorder and psychosis. Prior to the hearings, she had been living at home with her son, B. His behaviour changed mid-August and he cancelled all care and support for A and stopped her from visiting the day centre. He became hostile towards visits from social workers and prevented professionals from entering A's home. An initial application was made by the local authority (LA) without notice to B due to the danger that B would react to notice of the application by placing A at risk of harm (that risk supported by B's behaviour). The court made the following decisions:

1. That B was to allow a health and welfare check to be conducted at A's home for up to one hour on reasonable notice without B present in the same room, and that B was prohibited from obstructing or interfering with that meeting. A penal notice was attached to the injunctive orders made.
2. The without notice application was adjourned. The LA was given permission not to inform B of the application and no other party was also to inform B of the application (to transfer A to a residential care home) until further order of the court.

When the above decisions were communicated to B, and the associated order served on him, he refused to allow a health and welfare check. He subsequently attended a hearing and told the court that A was well. B said he wanted a second opinion on A's mental capacity, as he did not accept that A lacked capacity to make decisions about her residence and care. B said he was opposed to any visitors (including presumably someone instructed to assess capacity) entering the house because of the risk of Covid-19, although the court considered the real reason was distrust of those involved in A's case. B expressed the view that it was nobody else's business how he and A lived. When asked what protective measures were taken in terms of Covid-19, B became agitated and did not answer the question. When asked again, B left the hearing.

The court was concerned about leaving A in the sole care of B with his history of violence and drug use, his easily triggered agitation, his hostility to social workers and other visitors to the house, his determination to isolate A and his obstruction of attempts to assess her health and wellbeing. The court considered that the removal of A from her home to a care home for a short period was necessary and in her best interests and made declarations to that effect.

Appeal of landmark Covid-19 end-of-life case *Cambridge University Hospitals NHS Foundation Trust -v- AH [2021] EWCOP 64 (13 December 2021)*

AH was a 56 year-old woman who had been a patient at Addenbrookes Hospital, Cambridge, since December 2020. She was admitted on an emergency basis suffering from severe symptoms of Covid-19 and had been on mechanical ventilatory support and treatment since January 2021. Her communication was limited to movement of her eyes and head.

In January 2021, AH developed a systemic inflammatory response syndrome (SIRS), a recognised complication of Covid-19, with hyperpyrexia and multi-organ failure. AH required renal dialysis, ventilation and sedation. In June 2021, guided by the views of AH's clinical team, the trust made an application seeking declarations that it was no longer in her best interests to receive ventilatory support and treatment. Following a three-day hearing, judgment was handed down by Hayden J in September 2021 granting the application, although ventilation was to remain in place until such point as all her four children and family members could be with her. AH's family appealed the decision. On 25 November 2021, the appeal was allowed and the Court of Appeal ordered the matter be remitted for re-hearing. The issues in the remitted hearing centred on the medical prognosis and what the family described as changes in how AH had reacted and communicated with them in recent months.

At the remitted hearing, Theis J concluded that the burdens (unlikely prospect of change, a continued deterioration which may last many months of treatment, the risk of an infection and dying away from her family) outweighed the very considerable benefits and the declarations sought by the trust were granted.

Section 21A application to scrutinise restrictions *MM -v- A City Council [2021] EWCOP 62 (07 December 2021)*

MM is a young man with a dissocial personality disorder and mild learning disabilities. He also misuses illicit substances which can lead to challenging behaviours and the breakdown of his residence and care plan.

MM moved to a 24-hour supported accommodation placement in March 2020, so that a level of structure and security could be introduced in his life. MM was subject to a number of restrictions there, including a 22:00 curfew, the requirement to spend the night at the placement and a rule against bringing alcohol or drugs onto the premises or using them. MM objected to these restrictions by threatening staff and absconding.

MM's RPPR (DF) brought proceedings under section 21A of the Mental Capacity Act 2002 (MCA) which were concluded by agreement on 18 October 2021.

It was thought to be in MM's best interests for him to remain at the placement subject to the curfew and the 24-hour support there. While MM's capacity in relation to making decisions relating to contact with other people, and also the use of the internet and other social media could not be assessed, the parties' position was that any restrictions on his freedom would be counterproductive. The order remained silent on these issues in the knowledge that the present restrictions underpinned by the standard authorisation are what is necessary and proportionate to secure MM's safety, in so far as it can be secured. The court was satisfied that the resolution strikes the right balance between keeping MM safe on the one hand and allowing him to do what he wants to do - including making some mistakes - on the other.

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Disapplying anonymity provisions in a transparency order - *PH & Anor -v- Brighton And Hove City Council [2021] EWCOP 63 (23 November 2021)*

This case concerned an application made by the BBC and Sky UK Limited (the Media Applicants) to disapply anonymity provisions in a transparency order made in August 2019. This application was supported by TH's parents (the Substantive Applicants).

The court noted that public hearings subject to a transparency order are intended by the Court of Protection to reconcile the personal nature of information which is likely to be disclosed in Court of Protection proceedings, and the public's need to understand and have confidence in the court's decision-making process. The anonymity provided by a reporting restriction order, however, may be relaxed. The test for relaxation is, as described by the Media Applicants, the familiar balancing test between Articles 8 and 10 of the European Convention on Human Rights. Article 8 protects the right to privacy and family life and Article 10 protects the right to freedom of expression.

The Media Applicants argued that the substance of these proceedings was already in the public domain, such that there could not be many more Article 8 rights engaged in reporting the additional information of TH's situation. He is in the public eye precisely because of the matters that formed the subject of these proceedings and the transparency order restrictions effectively prevented any reporting, because of the risk of jigsaw identification. As a result, the Media Applicants said that they could not sensibly conduct reasonable reporting of this matter. The interference with their Article 10 rights was therefore disproportionate, and moreover not actually what the transparency order had intended to achieve. The Substantive Applicants believed that TH would want every effort to be made to shine a light on his situation. They did not accept that there had been any adverse effect on their son by any of the information that had been to date in the public domain. They said it was positively advantageous to him to have well-reported, clear information in the public domain. They emphasised that TH's interests must be front and centre, not the statutory bodies' interests. It was asserted on their behalf that it is difficult to see any relevance at all in the fact that the hospital had no powers in respect of community-based options, and that public scrutiny is an element of living in a democratic society.

The provider providing care to TH (the organisation) argued that the impact of granting the Media Application on its staff would be significant. There were concerns around the effect on the service as a whole: that other patients may be put at risk; that previous publicity led to a breakdown in the relationship with the Substantive Applicants; TH reflects his parents' anxiety and would pick up on the tensions surrounding publicity; and that the staff, or at least some of them, may be less willing to work with TH (some apparently having already asked to be released from having to provide care to him).The organisation had noted patients had seen filming in a car park, and were distressed and worried that their identity and whereabouts may be discovered. The organisation emphasised that the public interest element of TH's story could be properly communicated without him being identified , and the court should give considerable weight to the normal position of a person within Court of Protection proceedings having the protection of anonymity.

The court concluded that it was appropriate to grant the Media Application. However, the order made did not come into effect until 18:00 the following day to give those providing care to TH time to consider the practical steps necessary to protect him from unnecessary exposure, for example, television reporting.

Revisiting capacity and matter of residence - *ZK (No. 2) [2021] EWCOP 61 (12 November 2021)]*

ZK is a man with Landau-Kleffner Syndrome, a rare neurological syndrome. In 2017, there were concerns about ZK getting married which led to a Forced Marriage Protection Order and proceedings before the Court of Protection. During the proceedings it was noted that while ZK suffered communication difficulties, there was the possibility for him to progress his language development. In September 2020, ZK had consistently expressed a wish to leave his family home, where he lived with his mother, without her knowing. A best interests meeting took place as ZK was determined to lack capacity to make the decision. The decision was made to move him out of the family home and into a placement.

In January 2021, the Court of Protection determined that it was in ZK's best interests to remain at his current placement and then move to another placement where he would receive a consistent package of care that would enable him to benefit from immersion in British Sign Language, rather than return to his mother's home.

At a hearing in October 2021, ZK had not moved to the new placement and the judge was asked on behalf of ZK's mother and some of his family to consider re-opening the issue of residence. The court decided that in the context of this litigation and the cost it must have had on all those concerned, it was not appropriate, necessary, or proportionate to prolong matters further, and proceedings should instead come to an end.

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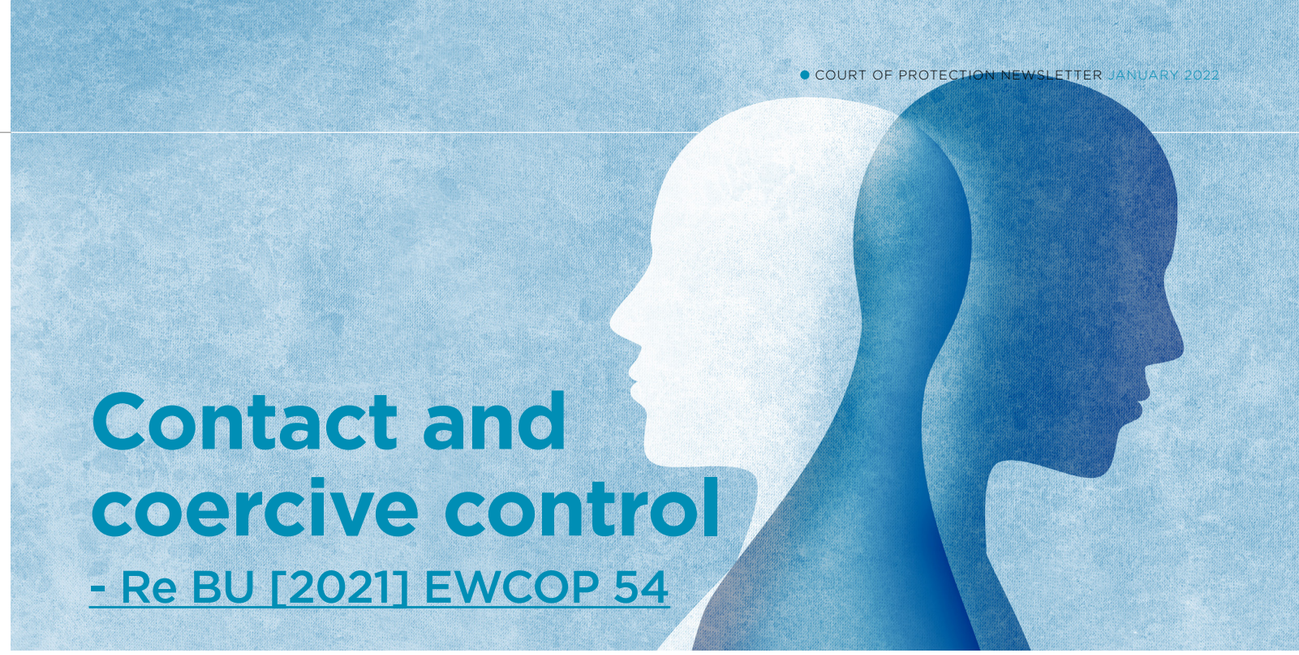

Contact and coercive control

- Re BU [2021] EWCOP 54

We are often instructed to advise our healthcare clients on the potential legal and safeguarding implications of certain relationships which seemingly their patients have voluntarily entered into and wish to maintain.

The inherently challenging question that can often arise in these cases is when the dynamic of that relationship is of such a nature that it impacts on that person's ability to make autonomous decisions and if that is the case, what legal jurisdiction might apply to regulate that relationship.

The court grappled with this issue and the balancing act of promoting personal autonomy and best interests decision-making in the case of *Re BU* [2021] EWCOP heard by Mrs Justice Roberts in September 2021.

These proceedings concerned BU, a 70 year-old woman with a diagnosis of vascular dementia, who was in a relationship with a man, NC, who, as described by Roberts J had "become, for BU, a central and crucially important part of her life and, as she sees it, pivotal to her emotional wellbeing and happiness".

BU's family were extremely concerned about the extent to which BU was vulnerable to harm (in particular with regard to her financial affairs) as a consequence of her relationship with NC and they issued proceedings in the Court of Protection for an order preventing BU from having contact with NC.

The medical evidence was clear that BU suffered from a 'cognitive impairment at multiple levels which interferes with her ability to manage her life independently' albeit the consultant psychiatrist was not persuaded that a diagnosis of vascular dementia was appropriate in this case.

Roberts J agreed with the expert evidence that BU, who had already been assessed as lacking capacity in relation to her property and affairs, also lacked capacity as regards her contact with NC and she accepted that 'because of the corrosive and coercive nature of the control which NC exercised over her BU had been deprived of autonomous decision-making in this context'.

Roberts J was clear that NC had "engaged in a deliberate and calculated attempt to subvert any independent decision-making on BU's part". This resulted in what was described as a 'psychological enmeshment' between BU and NC.

Roberts J therefore had no hesitation in making the order (it was not intended to be a *'forever order'*) to prevent contact between BU and NC but sensitively recognised the impact this would have on BU and so she made a declaration that it was in her best interests to undergo therapy to help her adjust to life without him and to help her make informed and capacitous decisions about any future contact with NC.

While it was assessed that she had capacity to marry (a high threshold applies) it was held that BU could not give valid consent as she was under NC's undue influence and she also did not have capacity to manage her financial affairs, so a forced marriage protection order was also made for 12 months.

The judgment is an interesting read because, while of course fact-specific, it shines a spotlight on the impact of coercive control and abuse and its intersection with safeguarding duties, the Mental Capacity Act 2005 and civil law. It is also serves as a reminder that controlling or coercive behaviour should be dealt with robustly as part of adult and/or child safeguarding and public protection procedures.

Amy Clarke
Senior Associate

P's right to have sex with a sex worker: the Court of Appeal's decision

Background

In this case the Court of Appeal considered whether a care plan to facilitate C's contact with a sex worker could be implemented without an offence under the Sexual Offences Act 2003 (SOA) being committed by care staff assisting C to have such contact. C has capacity to consent to sexual relations and decide whether to have contact with a sex worker, but does not have capacity to make these arrangements himself.

Leah Selkirk represented the CCG, a respondent in the proceedings.

Hayden J, vice president of the Court of Protection, as the first instance judge, had previously concluded that the assistance C would require from carers would not fall within the 'causing or inciting' interpretation under the SOA when applying their obvious meaning. He determined that it would not be unlawful for C's carers to support him to have access to a sex worker and this decision provided a gateway opportunity for a care plan to be prepared and assessed as part of a determination as to whether, being supported to access a sex worker, would be in C's best interests.

The secretary of state for justice ('the SoS') applied for permission to appeal the first instance decision on the basis that Hayden J fell into error in his interpretation of the words 'causing or inciting' in Section 39 of the SOA, by failing to give the words their natural meaning. Had the words been given their natural meaning, the SoS submitted that Hayden J would have concluded that even where C had capacity to consent to sexual relations and have contact with a sex worker, by assisting him to do so, a carer would be committing an offence under Section 39.

The Court of Appeal heard the appeal in July 2021 and the judgment was handed down in October 2021.

Decision

The Court of Appeal granted the appeal agreeing with the SoS that the arrangements envisaged for securing the services of a sex worker for C would place C's care workers at risk of committing an offence contrary to Section 39 of the SOA and consequently C's care plan could not proceed based on such arrangements, as it is imperative that any package of care is lawful so as not to place any carers liable to criminal prosecution.

What does this mean for statutory bodies?

Statutory bodies will want to ensure that any package of care that they commission or are looking to commission is lawful and does not put P or P's carers/support workers at risk of committing an offence under the SOA or otherwise. We know from C's case that any package of care would need to fall outside the scope of engaging Section 39 – ie not to cause or incite a person with a mental disorder to engage in sexual activity. In C's case, the plans to support him included providing him with assistance to navigate the website of a charity specialising in the provision of sexual services and in making the necessary payment.

The Court of Appeal (the Court) considered this to fall within the definition of Section 39. The Court not only said that the course of action proposed in C's case would place the care workers at jeopardy of prosecution under Section 39 of the SOA but would also expose C (and potentially his carers) to the risk of prosecution under Section 53A – another offence to be alive to.

The Court did consider a couple of other examples by way of contrast to C's situation: the first involved care workers who arrange contact between a mentally disordered person and spouse or partner, and the second, a young person who wishes to meet people of their own age and make friends aware that sexual activity may take place.

In these situations, the Court said that carers would more naturally be creating the circumstances for that activity rather than causing it in a legal sense. Furthermore, that it might be appropriate in those situations for the Court of Protection to endorse a care plan under which care workers facilitate or support such contact and to make a declaration under Section 15 of the Mental Capacity Act 2005 that the care plan is both lawful and in P's best interests.

But in making these observations the Court emphasised three important points:

1. The merits of making such a declaration will turn on a thorough analysis of the specific facts of the individual case;
2. In making such a declaration, the court may have to consider carefully whether the steps proposed under the care plan have the potential to amount to a criminal offence under Section 39 of the SOA; and
3. Any declaration would not be binding on the prosecuting authorities, but would no doubt be taken into consideration in the event of any subsequent criminal investigation.

It is important to note that, even if you obtain such a declaration, there is still an underlying risk that a criminal investigation could ensue.

If statutory bodies are considering commissioning such a package of care, we recommend that they obtain legal advice alongside the care provider and/or care staff concerned as the implementation of a plan would directly affect them and potentially put them at risk of committing a criminal offence.

The Court of Appeal judgment will affect many more people than simply those who want to pay for sex, and unfortunately there is no road map in terms of how to navigate this on the ground. It will involve statutory bodies, providers, carers and deputies all having to risk assess the prospect of committing offences in a wide range of situations.

Please feel free to contact Leah Selkirk if you require any assistance with similar cases you may be involved in.

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