ThirtyNine
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Court of Protection update

Thirty Nine Essex Street Court of Protection Newsletter: July 2012

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Editors

Introduction

Welcome to the July 2012 issue, which features two important judgments relating to healthcare, including the first reported determination of the validity of an advance decision.

We are very pleased to announce that our COP Cases Online database is now live, and can be reached on:

www.39essex.com/court_of_protection.

or even more simply at

www.copcasesonline.com

We very much welcome feedback as to how to improve this database, either to our individual email addresses or to marketing@39essex.com.

With this issue, and as a summer bonus, we include a note by Simon Edwards upon options for a local authority for the management of a patient's finances, the second in the series of practical notes responding to some of the most common issues upon which our advice is sought. The first, upon housing and the MCA, can be obtained upon request to marketing@39essex.com.

As ever transcripts are to be found on www.mentalhealthlaw.co.uk if not otherwise available.

The X Primary Care Trust v XB and YB [2012] EWHC 1390 (Fam)

Medical treatment – treatment withdrawal

Summary

This is the first reported case upon the validity of advance decisions.

Theis J was asked to consider an application by XPCT for declarations under s.26(4) MCA 2005 as to the validity of an advance decision made by XB on 2 November 2011 that he wished, amongst other things, to have his ventilation removed in certain defined circumstances.

XB suffered from Motor Neurone Disease. In 2003 he had a tracheotomy and was fitted with an invasive ventilation device. He subsequently returned home where his care was delivered through his GP, agency care workers and YB, his wife. Although he was unable to talk, XB could communicate through a variety of means, including through use of a communication board. Latterly, he communicated by moving his eyes to the right to indicate that he agreed with the question being asked. XB's nutrition was provided via a PEG. The question of what life sustaining treatment XB wished to receive had been discussed with him since 2010 and although at various points in 2010 and 2011 he had indicated a wish to have that treatment withdrawn, he had not expressed that wish in what was considered to be a sufficiently

consistent form.

On 2 November 2011, he made an advance decision to refuse treatment. The document, which was based on a pro forma advance decision which had been downloaded from the internet, stated that he would wish to have life sustaining treatment withdrawn in the event that his disease progressed to a stage where he was unable to communicate his needs or have control over decisions as to his care and management. The advance decision included a date for review of 2 May 2012 and the date 2 May 2012 had also been entered in the box marked "valid until."

The document was agreed to by XB, with his wife YB, his GP (XW) who had been treating him since 1993 and a mental capacity coordinator (AW).

In 2012, concerns were raised by one of XB's carers as to the circumstances under which the advance decision had been made. In particular, the carer asserted that she had not seen XB expressly consent to the decision by movements of his eyes. It took over a month to convene a meeting to discuss the issues raised by the carer. The meeting eventually took place on 23 April 2012.

In light both of the concern raised by the carer and also the fact that the advance decision appeared potentially to be limited in time, the PCT brought proceedings for declarations under s.26(4) MCA 2005. By the time those proceedings were brought, there was a very great deal of urgency to the matter, the first hearing being on Friday 27 April, and the final hearing before Theis J being on Monday 30 April and Tuesday 1st May so as to cater for the possibility that the advance decision was, in fact, time limited.

In her judgment, Theis J noted that there were three principal issues for determination:

a. XB's current capacity to communicate his decision as to the continuation of life saving treatment;

b. Whether the advance decision of 2 November 2011 was entered in to by XB and if so whether it was valid and applicable; and

c. Whether the advance decision of 2 November 2011 was intended to be time limited to 2 May 2012.

In respect of the first issue, there was no dispute as between the experts (a neurologist and a speech and language therapist, both of whom had visited over the weekend prior to the hearing to conduct an assessment) or the parties that XB lacked the capacity to communicate. It was also accepted by Theis J on the basis of the evidence before her that this lack of capacity was permanent. This meant, therefore, that (1) the condition that XB had indicated that was to be satisfied for his advance decision to take effect was met; but also (2) XB could no longer make a new advance decision in the event that the November 2011 decision was invalid.

In relation to the second issue (which arose as a consequence of the concerns raised by the carer), detailed statements were submitted to the Court. XW made a statement and gave oral evidence as to the circumstances in which the document came to be drafted and the steps that had been taken to ensure that it correlated to XB's wishes. In particular, XW gave evidence that each section had been read out to XB who had communicated consent by movements of his eyes. Theis J noted that this evidence revealed three key points:

a. first, the carer in question had, in fact, not been present on 2 November 2011;

b. second, the events in question were unlikely to have occurred after the 2 November 2011;

c. third, the carer accepted that when she had been present she would not have been in a position to see XB's eye movements as she was on the left hand side of the bed.

On that basis, Theis J accepted XW's evidence, as supported by the evidence of YB and that of AW. Accordingly, the judge concluded that XB had had capacity to make the decision on 2 November 2011 and that it was validly made.

In relation to the third issue, the evidence from AW was that the time limitation referred to in the document had not been discussed with XB or consented to by him. Theis J accepted this evidence and granted a declaration that the advance direction of 2 November 2011 was not time limited.

Theis J made a number of further comments relevant to advance decisions more generally:

a. in the event that an issue is raised as to the circumstances in which an advance decision has been made, this should be investigated as a matter of urgency by the PCT;

b. there is no set form for an advance decision which will necessarily vary in each case. She expressly referred, though, to the guidance in the Mental Capacity Code at paragraphs 9.10 to 9.23 as to what should be included;

c. there are a number of *pro forma* advance decisions on the internet. She noted that organisations responsible for producing such pro forma documents might wish to look again at the merits of including a 'valid until' date.

Comment

This case stands as a cautionary tale in a number of respects. Through the concatenation of circumstances outlined above, the parties and Theis J were confronted with a situation in which XB's family and treating team could not act upon XB's wishes as he had sought to enshrine them in an advance decision, XB could no longer remedy that position because he no longer had the capacity to communicate a fresh decision, and XB would have been aware of the position (there being no suggestion that XB had ceased to be conscious by the time of the final hearing). Alternatively, that advance decision could have been valid but limited in time until only a matter of hours after the parties had finished in Court on 1st May 2012, such that XB's family would have had to act almost immediately upon it; a prospect that does not bear easy contemplation.

Luckily (if that is the correct word in this tragic situation), the evidence before Theis J allowed her properly to conclude both that the carer's concerns did not invalidate the decision and that XB had not inadvertently time limited his decision.

However, and as Theis J noted, the case stands as a clear warning both that concerns as to the validity of advance decisions need to be aired and – if necessary – resolved before the Court in very good time, and also (and perhaps more importantly) *pro forma* advance decisions must be scrutinised very carefully so as to ensure that they do not inadvertently serve to frustrate the wishes of those using them.

The case also stands, perhaps more positively, as an example of the Court of Protection acting at its best, from a standing start of a hearing on a Friday (attended, fortunately, by the Official Solicitor, notified the day before) to a two-day hearing on the Monday and Tuesday, with the benefit of expert reports, witness statements, and representation by experienced solicitors and Counsel. It therefore shows what can happen when, as Theis J noted, 'heaven and earth' really does need to be moved.

A Local Authority v E and others [2012] EWHC 1639 (COP)

Mental capacity – Medical treatment – Advance decisions – Right to life – Deprivation of liberty – Interface with the Mental Health Act 1983

Summary

E was a 32-year-old intelligent and articulate woman who had studied to be a doctor. Suffering from severe anorexia nervosa, emotionally unstable borderline personality disorder, alcohol and prescribed opiate dependency, she had not eaten any solid food for over a year and had not taken any calories for the last two months. She had previously been detained under the Mental Health Act 1983 ('MHA') on around 10 occasions in the past 6 years, and had twice attempted to make an advance decision to end her life. The care team and her parents unanimously decided that all treatment options had been exhausted and that

it was in E's best interests to die in comfort under a palliative care regime:

> '*It upsets us greatly to advocate for our daughter's right to die. We love her dearly but feel that our role should now be to fight for her best interests, which, at this time, we strongly feel should be the right to choose her own pathway, free from restraint and fear of enforced re-feed. We feel that she has suffered enough. She stands no hope of achieving the things that she would value in her life and shows no signs of revising these aspirations. We would plead for E to have some control over what would be the last phase of her life, something she has been denied for many years. For us it is the quality of her life and not the quantity. We want her to be able to die with dignity in safe, warm surroundings with those that love her."* (paragraph 80)

Five weeks along E's end of life pathway, the matter was suddenly brought before the Court of Protection. A week before the hearing, upon discovering that legal proceedings were underway, E tried to hang herself from an emergency cord in a bathroom. With a body mass index ('BMI') of just 11.3, her death was imminent. The hearing began on a Friday. A request for an interim Order to force feed her over the weekend to ensure that she did not die was refused as insufficient information about the longer-term proposals was available. Still alive on the Monday, whether E was to be forced to live or allowed to die was in the hands of Mr Justice Peter Jackson. His Lordship had to determine three questions:

a. Did E currently have the mental capacity to make decisions about her treatment?

b. If not, did she have mental capacity when she made an advance decision in October 2011, and was that decision valid and applicable?

c. If she currently lacked capacity and had not made a valid advance decision, was it in her best interests to receive life-sustaining treatment in the form of forcible feeding with all necessary associated measures?

A. Currently Lacked Capacity

Peter Jackson J found that E did not seek death but saw her life as pointless and wanted to be allowed to refuse food in the knowledge that death would result. Although she could understand, retain relevant information and communicate her decision to refuse to eat, her obsessive fear of gaining weight made her incapable of meaningfully weighing the advantages and disadvantages of eating: '*the compulsion to prevent calories entering her system has become the card that trumps all others. The need not to gain weight overpowers all other thoughts*' (para 49). Her incapacity also derived from the strongly sedating 'drug haze' that was being prescribed as part of her end of life care pathway, together with her severely weakened condition.

B. Formerly Lacked Capacity

E's first purported advance decision in July 2011 was made at a time when at least one doctor believed that she had capacity. Signed by E and countersigned by her mother it stated: "*I do not want to be resuscitated or given any medical intervention to prolong my life*". Days later E was detained for treatment under s.3 of the 1983 Act and PEG fed. Given the confusion amongst the medical, social work and legal professionals as to her capacity, together with her parents' expressed doubts as to her true intentions at that time, the Judge decided that she lacked capacity to make a valid advance end of life decision.

Over the coming months, to maximise her chances of being found to have capacity, E reluctantly complied with the PEG feeding and her BMI peaked at 15 by October 2011. This time with legal advice, she signed another advance decision witnessed by her mother and an independent mental health advocate. It stated that, if close to death, she did not want tube feeding or life support but would accept pain relief and palliative care. It also read: "*If I exhibit behaviour seemingly contrary to this advanced directive this should not be viewed as a change*

of decision." That day, E was again detained for treatment under s.3 of the MHA.

The Judge held that this October advance decision satisfied all of the legal formalities required by s.25 of the Mental Capacity Act 2005 ('MCA'). His Lordship also noted that the general medical view at the time was that she had capacity to make it. However, no 'formal' capacity assessment had been undertaken and the 1983 Act had been invoked that same day:

> '*Against such an alerting background, a full, reasoned and contemporaneous assessment evidencing mental capacity to make such a momentous decision would in my view be necessary.'* (paragraph 65)

Peter Jackson J held that it was at best doubtful whether a thorough investigation at the time would have reached the conclusion that E had capacity. Moreover, she may also have lacked capacity in relation to the associated treatments, such as mechanical ventilation, which might be necessary. As a result, both currently and at the time of her advance decision in October 2011, E was held to lack capacity to accept or refuse treatment in relation to any interventions that were necessary in conjunction with forcible feeding.

C. Best interests

The Court had two extreme options from which to choose. At one extreme, the professionals could continue to provide care and pain relief until E died of starvation. At the other extreme was an immediate transfer to the country's leading eating disorder facility where E would be stabilised, fed via nasogastric tube or a PEG tube inserted through her stomach wall. Any resistance would be overcome by physical restraint or chemical sedation. It was envisaged that such a process of re-feeding was likely to take a year or longer, after which E would be offered therapy.

His Lordship sensitively addressed the best interests considerations, noting the risks of re-feeding syndrome and immediate mortality resulting from the insertion of the PEG line; only a 20% chance of recovery; and E's past and present wishes and feelings, beliefs and values. Her loving parents had grave misgivings about, but not fierce resistance to, the intervention, stating that they could only support it if appropriate treatment for both her anorexia and alcoholism was available. E's consultant gastroenterologist told the Court: '*Re-feeding E takes a prolonged period of time with significant mental distress to her. She has told me it feels like reliving the abuse she suffered as a child approximately four times every hour*." (para 107). The Court-appointed expert reiterated this:

> "*Treatment regimes enforcing weight gain appear, to the outsider, somewhat barbaric. The categorical refusal to ingest calories can only be met with forcible feeding either under physical or chemical restraint. This is harrowing for any patient, but particularly for one who was subjected to extensive childhood sexual abuse.*" (paragraph 87)

The expert felt that E's statements were ambivalent; "*E does not want to eat. I don't think she wants to die*." And his instinct was that she was detainable for treatment under the Mental Health Act 1983. Her consultant psychiatrist confirmed that he would abide by the Court's decision and would participate in placing E under section to ensure the treatment was carried out.

Carefully weighing the respective advantages and disadvantages of the two options, the Court noted that, '*At its simplest, the balance to be struck places the value of E's life in one scale and the value of her personal independence in the other*…' (para 118). Moreover, '*All human life is of value and our law contains the strong presumption that all steps will be taken to preserve it, unless the circumstances are exceptional*.' (para 119). But this principle was not absolute and his Lordship did not accept the proposition '*that one can only be certain about E's best interests if every possible solution has been tried and shown to fail*.' To do so would risk discriminating against incapacitated persons by depriving them of options available to the capacitous (para 134). However, on balance, the Court decided that it was in E's best interests to

be fed, by force if necessary, and that the resulting interferences with her Article 8 and 3 rights were proportionate and necessary to protect her right to life under Article 2 (para 141).

Comment

The ethical and legal issues arising from this tragic case will no doubt be widely debated for some time to come. And it is difficult to do justice to that debate in this brief comment. With respect to his Lordship, the judgment does not contain any significant legal developments, although the requirement for '*a full, reasoned and contemporaneous assessment evidencing mental capacity to make such a momentous decision'* – in addition to the legal formalities required by MCA s.25 – is noteworthy.

Although E's right to life was discussed, no express reference was made to *Rabone v Pennine Care NHS Foundation Trust* [2012] UKSC 2. The positive operational duty to save life, which would most likely have been triggered on the facts, would require the professionals involved and the Court to do all that could reasonably be expected to minimise the real and immediate risk to E's life. In deciding what would be reasonable, however, consideration would have to be given to the ease or difficulty of saving her life, the resources available, and, '*There is a difficult balance to be struck between the right of the individual patient to freedom and self-determination and her right to be prevented from taking her own life*' (Rabone at para 117). A careful balance clearly was struck which differed from that of the care team and E's parents.

It is also interesting to compare the saving of E's life with the death of Kerrie Wooltorton. For those unfamiliar with her case, Kerrie was 26-years-old, diagnosed with borderline personality disorder and would typically attempt suicide by ingesting antifreeze before accepting life-sustaining treatment. Three days after preparing an advance decision, which incidentally would have fallen foul of MCA s.25, she swallowed antifreeze for the final time, called an ambulance and, on the hospital ward, accepted pain relief but refused renal dialysis. Assessed as having capacity, her decision was respected and she died.

Both E and Kerrie had made fatal decisions which their health professionals considered to be capacitous. Both had a history of being compulsorily detained and treated under the 1983 Act. But E's case was referred to Court and her life was compulsorily saved; whilst in Kerrie's case no legal proceedings were initiated and death resulted.

Finally, we should note a matter of some importance that is not referred to in the judgment. We are grateful to Richard Jones for pointing this apparent omission out and Paul Bowen QC for providing the following details (and can confirm that we are permitted to refer to them). On the face of the judgment, there is no reference to the fact that the steps required would almost inevitably lead to a deprivation of E's liberty, but we can confirm this was considered, and steps taken to authorise it.

It was understood by those before the Court that, once the initial steps had been taken to re-feed and stabilise E, the professionals involved would apply to detain her under the Mental Health Act 1983. Until such provision for detention could be put in place, the Court made the following Order:

> "*Any reasonable and proportionate measures used in relation to the provision of artificial nutrition and hydration which have the effect of depriving E of her liberty shall be authorised by the Court pursuant to MCA 2005 s 16 and s 48.*"

If E was not compulsorily detained under the MHA within a limited period of time, the matter was to be brought back to the Court of Protection for a further hearing. At the time of writing, it is not known whether or not E is under section.

Ineligibility anoraks will immediately recognise the potential problem: if E is not detained under the MHA, she risks falling into the amended Bournewood gap. By virtue of MCA s.16A, the Court of Protection cannot authorise a person to be deprived of their liberty if they are, or they become, ineligible. At the risk of overly

simplifying MCA Schedule 1A, E would be ineligible for DOLS and a s.16 Order if she was an objecting mental health patient who "could" be detained under ss.2 or 3 of the MHA (for a more detailed analysis see Allen, '*The Bournewood Gap (as amended?)*' (2010) 18 Medical Law Review 78). Assuming, as one must, that treatment cannot be provided under the MCA, it would appear that an application "could" be made to detain E under MHA s.2 or, depending on the views of her nearest relative, under s.3. In deciding then whether she "could" be detained in hospital in pursuance of such an application, we must assume that two medical recommendations under the MHA have been given. So, in short, it appears likely that E will be within the scope of the MHA.

The next issue is whether she is an objecting mental health patient. Naso-gastric feeding has been held to amount to 'medical treatment for mental disorder' in respect of those with anorexia *(Re KB (Adult)(Mental Patient: Medical Treatment)* (1994) 19 BMLR 144), personality disorder (*B v Croydon Health Authority* [1995] 1 FLR 470, *R v Collins and another, ex parte Brady* (2001) 58 BMLR 173), and depression (*Re VS (Adult: Mental Disorder)* (1995) 3 Medical Law Review 292). The same could surely be said of PEG feeding. Applying the 'but for' test (*GJ v Foundation Trust* [2009] EWHC 2972 (Fam)), it seems clear that the only effective reason for E's hospital detention will be to provide medical treatment for her mental disorder to which she evidently objects.

It follows that if, as appears likely, E is detained under the MHA, no jurisdictional issue arises and the Court's interim DOL Order will cease at that point to have effect. But if, for example, an approved mental health professional were to decide that an MHA application ought not to be made, E will fall between the two regimes of detention, as she will be ineligible under the MCA. We would suggest that this would be an area where (even if there is, in general, parity between the MHA and MCA), the MHA should take primacy, and in areas of doubt, assessors must '*take all practical steps to ensure that that primacy is recognised and given effect to*' (*GJ* at para 65).

SC v BS and A Local Authority (unreported, 7 October 2011)

COP jurisdiction and powers – experts

Summary

These proceedings concerned BS, the 17 year old daughter of SC who was due to turn 18 shortly after the date of the hearing. BS had been accommodated pursuant to section 20 of the Children Act for a number of years and was admitted to a psychiatric unit for a period between October 2009 and March 2010 during which time she was diagnosed with Aspergers and post-traumatic stress disorder. Following that she had spent several periods in a psychiatric hospital following suicide attempts. A diagnosis of autism had also been advanced.

The primary issue before the Court of Protection was the adequacy of the expert evidence as to whether or not BS lacked capacity in certain relevant regards including to litigate, to make decisions as to her residence, whether to accept care and support, contact with others and to take prescribed medication.

On 5 May 2011 an interim declaration that BS lacked capacity had been made by Mostyn J. On 26 May 2011, permission was given to the parties by Roderic Wood J to jointly instruct a psychiatrist to report on her capacity and an independent social worker to report on BS's best interests. However, as BS was at that time subject to orders under section 3 of the Mental Health Act, the instruction of the experts was suspended. By August 2011, consideration was being given to discharging BS from the young people's psychiatric unit where she was accommodated but a dispute arose as between SC and the local authority as to her proposed placement. At a further hearing in September 2011, the local authority indicated that they did not consider that BS lacked capacity and effectively contended that SC exaggerated BS's symptoms. The suspended directions for expert reports were renewed. The Official Solicitor reserved their position as to BS's capacity pending the expert report.

By the time of the hearing before Baker J, the

psychiatrist, a Professor T, had prepared an interim report and his preliminary conclusion was that BS did not lack capacity. The expert attended court to give evidence and acknowledged that he had not had the opportunity to examine the extensive social worker and medical records relating to BS prior to writing that report, had only spoken to BS in reaching his conclusion and had advised BS of his provisional view that she had capacity. The expert also acknowledged that he had not given evidence in the Court of Protection previously and had no experience of applying the Act in practice although he had considered capacity in the context of criminal proceedings.

The local authority accepted that the issue of capacity remained hotly disputed, notwithstanding the preliminary conclusion reached by the expert, given the evidence base on which he relied. It was agreed that the question of capacity could not be definitively resolved until the final report was produced. However, both SC and the Official Solicitor (for different reasons) no longer considered the psychiatrist to be an appropriate expert. In particular, both SC and the Official Solicitor expressed concern that the expert had communicated his preliminary view to BS. Other concerns raised were principally addressed at the expert's lack of experience in applying the MCA 2005 in practice, particularly in the context of proceedings where the determination of this issue was of such significance. The local authority resisted the instruction of a new expert and noted that the alternative experts proposed would not be able to report immediately and their instruction would lead to a further delay of 6 to 7 weeks in circumstances where BS was subject to a deprivation of her liberty and was expressing a strong desire to change accommodation. The original expert wrote to the Court identifying that he could attend MCA training the week after the hearing and prior to preparing his final report.

Baker J concluded that it was appropriate to instruct a different expert. In reaching this conclusion he noted the competing interests of resolving the issues swiftly such as to ensure the minimum restrictions on BS, and the need to ensure the appropriate degree of expertise in a case where the issue of capacity was both complex and fundamental. In particular, Baker J expressed concern that the expert had communicated his provisional views to BS and held that no expert should give a patient a "provisional" view of their capacity without reading the patient's history. Equally, whilst acknowledging the original expert's expertise in autism, Baker J considered that he lacked sufficient experience in applying the test under the Act and it could not be satisfactory to seek the expert opinion from someone who perceives the need to undergo training before he can give that opinion.

Comment

As Baker J acknowledged, it is unusual for the appointment of an expert to generate such a degree of controversy in COP proceedings. Whilst relatively extreme on the facts, this case serves to highlight that when appointing an expert to report on capacity, care should be taken to ensure that the expert has sufficient experience of considering capacity in the specific context of the MCA 2005 rather than in a more general sense, even where, as in the present case, the expert has experience of giving evidence for the purpose of other types of legal proceedings. The editors note, however, that whilst the Court and the parties emphasised the fundamental nature of the issue as to BS's capacity, in reality, capacity is a fundamental issue in all proceedings before the COP given that it forms the basis of the Court's jurisdiction. It follows that this judgment is of potentially far wider relevance.

R (on the application of KM) (by his mother and litigation friend JM) (FC) v Cambridgeshire County Council [2012] UKSC 23

Practice and procedure – other

Summary

We make brief reference to this community care case, in particular because of the approach taken by the Supreme Court to the adequacy of the reasons given by the defendant local authority.

In these proceedings before the Supreme Court, the applicant sought judicial review of a determination by Cambridgeshire County Council to pay him £85,000 by way of a direct payment in discharge of their duties under the Chronically Sick and Disabled Persons Act 1970. The Court of Appeal had granted permission for the judicial review proceedings but had dismissed the substantive application.

In their application to the Supreme Court, the Applicant had sought to challenge whether the Court of Appeal had erred in finding that the local authority had been "*entitled and obliged to moderate the assessed needs to take account of the relative severity of all those with community care needs in their area*..." In particular, the Applicant challenged the earlier decision of the House of Lords in *R v Gloucestershire County Council ex p Barry* [1997] AC 584.

The Supreme Court concluded that the legitimacy of resource based decisions did not arise as an issue in these proceedings where, in fact, the local authority had not sought to rely on any resourcing argument when computing the level of direct payments to the Claimant. Accordingly, the Court declined to review the decision in *R v Gloucestershire County Council ex p Barry* [1997] AC 584. Nevertheless, both Lord Wilson and Lady Hale took the opportunity to reiterate that when analysing its duties under s.2(1) of the Chronically Sick and Disabled Persons Act 1970, a local authority is not entitled to take in to account any limitation on its resources at the first stage, namely when assessing the needs of the disabled person.

The Court also considered the twin grounds on which the applicant had made the initial application for judicial review, namely adequacy of reasons and irrationality and upheld the decision of the Court of Appeal that neither was made out on the facts.

In relation to the duty to provide reasons, Lord Wilson endorsed the decision of the Court of Appeal in *R (Savva) v Kensington and Chelsea Royal London Borough Council* [2010] EWCA Civ 1209, [2011] PTSR 761 and concluded that whilst there were deficiencies in the reasoning given by the local authority of the facts in the present case, this was not sufficient to warrant quashing the determination. Nor could the decision be said to be irrational as the local authority had been entitled to rely on its Resource Allocation Support tool and an Upper Banding Calculator.

Comment

This case had been anticipated to be one of very greater significance, as a revisiting of *Barry*. However, for reasons not material here, the Supreme Court (having lined up a hearing for that purpose, and allowed intervenors on the issue) decided not to revisit it, and therefore the decision was much more limited in its scope. For present purposes, though, the case is of some importance to those in the CoP field as a reminder of the latitude that may be granted to statutory authorities in analysing the adequacy of the reasons they have given. It will also be of some – tangential – importance in any case in which a local authority has not put an option on the table in CoP proceedings and an individual wishes to challenge that decision by way of judicial review proceedings, as an indicator of the likely approach that the Administrative Court will take where the decision has been taken on the basis of resources.

HSE Ireland v SF (A Minor) [2012] EWHC 1640 (Fam)

Article 5 – deprivation of liberty

Summary

We make mention of this case (in which Alex appeared) because, although it is a case involving a child falling outside the scope of the MCA 2005, it is a companion piece to the *Re M* decision ([2011] EWHC 3590 (COP)) discussed in our February newsletter, relating to the placement of a young adult from the Republic of Ireland in an English psychiatric institution. It also raises some of the same complex issues as to the safeguarding of the rights of the vulnerable when they are placed across borders.

In *SF* Mr Justice Baker considered an ex parte application made by the Health Service

Executive of Ireland ("the HSE") for an urgent order under Article 20 of Council Regulation (EC) 2201/2003 ("Brussels II Revised") concerning jurisdiction and the recognition and enforcement of judgments in matrimonial matters and matters of parental responsibility in respect of SF.

SF, aged 17, was diagnosed with an emotionally unstable personality disorder, severe depression with suicidal ideation and post-traumatic stress disorder. When SF was 3 years old, she was received into the voluntary care of the authority responsible for child protection in the part of Ireland where she lived. A full care order was granted on 10 January 2006. In 2008, after a break down in a foster placement, she was placed in a high support unit. However, SF's behaviour deteriorated further and the staff at that unit reached the conclusion that they could not keep her safe. On 5 January 2012, the HSE applied for and was granted an order permitting SF to be detained at a special care unit. Those responsible for her care reached the conclusion that there was no suitable unit in the Republic of Ireland and approached an English unit. Initially, SF was opposed to any move to the English Unit but by March 2012 was consenting to a move to the English Unit for a three month period of assessment and treatment, and indeed, became anxious to leave the Irish unit as soon as possible. There was some delay whilst the authorities sought to obtain consent in accordance with Regulation 56 of the Brussels II revised regulation to transfer SF to the English Unit. In this period, SF's behaviours became the source of considerable concern and two medical experts reported on the urgent need to move her.

The relevant consent was obtained in April 2012 and the HSE applied to the English Courts for the recognition and enforcement of the Irish Order permitting SF to be detained. In the interim they made an application for urgent relief under the provisions of Article 20 Brussels II Revised in the form of an (English) order:

a. that SF do reside at the English Unit for purposes of such care and treatment as may in the opinion of the Director of the English Unit be necessary;

b. that there be leave to the staff of the English Unit to detain at or return SF to the English Unit and to use reasonable force (if necessary) in so detaining her or returning her; and

c. that there be leave generally to Director of the English Unit and those under his direction (to include all or any of the multi-disciplinary team including clinical, care or similar professional and/or ancillary health care staff) to furnish such treatment and care to SF as in their opinion may be necessary.

A central issue before Mr Justice Baker was whether the use of Article 20 for these purposes was permissible.

The Judge considered the case law concerning the interpretation of the Brussels II revised regulation, including the recent preliminary ruling of the CJEU in HSE for *Ireland v SC* (C-92/12 PPU) in which the Irish Court had referred questions to the CJEU in relation to the lawfulness of using Article 20 in what were very similar factual circumstances.

Mr Justice Baker concluded that the CJEU judgment, whilst emphasising the need for expedition on all parts, implicitly approved the use of Article 20 in circumstances such as those arising in the present case, namely where emergency protective measures were required pending registration and enforcement of the Irish Order. The other pre-conditions for reliance on Article 20, as set out in *Re A (Area of Freedom, Security and Justice* (C-523/07) [2009] 2 FLR 1 and *Deticek v Sgueglia* (C-403/09) [2010] 1 FLR 1381, namely that relief is urgent, is in respect of persons in the Member State concerned and is provision, were also met on the facts. Equally, the further requirement that the Member State have the relevant powers (provided for in Article 20 itself), was met as it had long been recognised that the powers under the inherent jurisdiction extent to making orders for the detention of children for therapeutic purposes: *Re C (Detention: Medical Treatment)* [1997] 2 FLR 180.

Accordingly Mr Justice Baker granted the interim order sought. The Judge further noted that all cases should be considered on their facts and emphasised the need for judicial cooperation as between different Member States.

Comment

The compulsory placement of foreign patients in English psychiatric institutions (other than under the provisions of the MHA 1983) is something that we would anticipate that very few of our readers would have thought took place; we would also anticipate that even fewer would have given a thought to how such could be lawfully achieved. However, this case, along with *Re M*, shows the English courts grappling with the issues involved in a creative and pragmatic fashion. At some point, whether with a child under the provisions of Brussels II, or an adult under the provisions of Schedule 3 to the MCA 2005 (an amendment to Schedule 3 due to come into force shortly making it clear that a 16-17 year old could only come under one regime), the Courts will have to test whether the mechanisms adopted to date properly protect their ECHR rights. The views of the editors (or, at least, of Alex, who has spent months thinking about little else) is that the mechanisms do, but we are aware that very strong views to the contrary are held, and a contested hearing will ultimately be the only way in which to resolve the question.

The Local Government Ombudsman and DOLS

The indefatigable Lucy Series (author of *The Small Places* blog, which is indispensable reading for all those concerned with health and welfare matters under the MCA: http://thesmallplaces.blogspot.co.uk/) has recently taken up with the LGO the question of whether the body can consider complaints arising out of deprivations of liberty. We understand that both Lucy and the LGO are happy for us to relay the material parts of the LGO's response.

In terms of jurisdiction, the LGO's approach is that it cannot generally pursue a complaint where a remedy exists by way of an alternative remedy. Someone arguing that they are being unlawfully deprived of their liberty would have a right to approach the Court of Protection and the availability of that "legal remedy" would take the matter outside the jurisdiction of the Ombudsman. The Ombudsman cannot direct that a Deprivation of Liberty authorisation is flawed and should be terminated; only the Court can do this. If the Court makes such a determination, but awards no compensation (either because it cannot, will not or just forgot to address the issue) it would not be right for someone to ask the Ombudsman to address the alleged shortcomings in the Court of Protection procedures.

That said, the LGO considers that the deprivation of liberty issues do fall within the jurisdiction of the LGO and while the Ombudsmen is not able to bring a deprivation of liberty to an end they are able to consider complaints about how deprivation of liberty has been handled and there is no reason why recommendations should not include payments of compensation although any such recommendations are unlikely to be at the kind of levels courts would operate to.

We understand that the LGO's London office is soon to issue a public report upon a DOL issue, which will be on the LGO website. We also reproduce details of two complaint addressed so far so as to give a flavour of how the LGO has approached matters to date.

Case 1 – 10 013 715:

A case where a DoL application was not made promptly and the care home's/council's approach to restrictions placed on the complainant and her mother was flawed.

Dorothy was admitted to a care home in February 2005. Her daughter Melinda kept in touch with her regularly. In May 2008, Melinda raised concerns about Dorothy's care and a safeguarding investigation resulted. The allegations Melinda made centred around poor manual handling, poor care and bullying by staff. The safeguarding investigation took into

account all of the issues around Dorothy's care which included concerns the care home had about Melinda's disruptive behaviour when visiting – she would often shout and get angry.

In June 2008, Melinda's visits to her mother were restricted. This was because the home felt Melinda's behaviour distressed staff and residents and was detrimental to her mother's wellbeing. A variety of conditions were imposed at different times (Deprivation of Liberty Safeguards did not come into effect until April 2009).

In April 2009, Melinda raised more complaints with the council about her mother's care. Another safeguarding investigation ensued which was inconclusive. It was clear the relationship between the staff and Melinda had broken down. In June 2009, Melinda's solicitors wrote to the council and asked on what basis, in light of the new DOLS legislation and associated Code of Practice, the Council believed it had the authority to prevent Dorothy from moving to a new care home. No response was received. In July 2009, a safeguarding meeting was held in the home and, following that meeting, Melinda said she was prevented from leaving the home by the home manager who was threatening and harassing her. No safeguarding investigation was launched as Melinda was not a vulnerable adult.

In August 2009, the council's safeguarding advocate raised the possibility that a deprivation of liberty might be occurring in respect of Dorothy. He advised that the council should carry out a mental capacity assessment. A further meeting was held in September 2009 where it was again suggested that a DoL authorisation was required. In October 2009, the home sought a standard DoL authorisation and granted themselves an urgent authorisation. A standard authorisation was granted in November 2009.

The LGO decided that the original restrictions should have been managed by a suitable risk assessment demonstrating the need for controls and the reasons why. This risk assessment should have been periodically reviewed to ensure the actions were both required and justified as time passed. The home was also criticised for not issuing a formal warning to Melinda before curtailing her visits.

In June 2009, Melinda's solicitors wrote to the supervisory body (the local authority) raising the issue of DoLS but they should have written to the managing authority – the care home – who was responsible for seeking the authorisation. It was a further four months before the local authority advised the manager to seek an authorisation and a further five months before the appropriate request was made.

We concluded the approach taken between June 2008 and October 2009 was flawed. We found fault with both the care home and the council. The council has ultimate responsibility for the care provided to Dorothy as it was funding the placement. It was decided that it should have done more to ensure its own staff and the staff in its contracted services were better trained in such matters. We went on to criticise how the DoL assessments were conducted in this case. This criticism included the best interests assessor determining who would be the most appropriate person to act as the 'relevant persons representative'. However, DoL guidance states that the best interests assessor should first establish whether the relevant person (ie Dorothy) has the capacity to select a representative and, if so, ask her to do so. If the relevant person selects an eligible person, the best interests assessor must recommend that person to the supervisory body for appointment.

It was concluded that certain actions would follow to ensure a robust assessment and proper periodic monitoring of the arrangements in place.

***Case 2 – 10 010 739**:*

A case where the DoL decision taken was not the 'least restrictive' option.

Mrs Jones complained to the LGO about the fact that her sister, Mrs Davies, was not allowed to return home after an admission to hospital. Additionally the council prevented her from moving her sister to another care home of her choosing.

Mrs Davies has a degenerative and congenital condition called Huntingdon's Disease. She was living with and being cared for by her sister until October 2006 when she was admitted to hospital. The admission was triggered by the district nurse finding her on the floor. She was covered in bruises from other falls and had an infection. Mrs Davies told staff on the hospital ward she did not want to return to the care of her sister Mrs Jones. She told others, however, that she did want to return. A multidisciplinary discharge meeting was held. Mrs Davies' other sister Mrs Weston was asked to attend the meeting as she has power of attorney. It was decided that the flat Mrs Jones lived in was unsuitable and that she was unable to give the level of care required. The option of Mrs Davies returning to the flat with a care package was explored but thought to not be viable. Mrs Davies was admitted to a nursing home.

In early 2007 Mrs Jones was also diagnosed as having Huntingdon's Disease. She was suffering from common complications such as poor grip, reduced mobility, slurred speech and memory difficulties. Doctors also had concerns about impulsivity and lack of judgement. Mrs Jones never accepted that she could not care for her sister Mrs Davies. She was unhappy with the care Mrs Davies received in the nursing home at times. Mrs Jones continued to deteriorate and had problems swallowing. She was reluctant to accept help from social services. The records show that Mrs Davies and Mrs Jones missed each other's company a lot. In 2009 the care home placed restrictions on Mrs Jones visiting following some difficulties between her and the carers. After this she was told she could not visit unaccompanied. Some meetings were held at which Mrs Jones stated that she wanted to live in a care home with her sister.

Mrs Jones moved from her small flat to sheltered accommodation and Mrs Davies was able to visit her there. At this time Mrs Davies began asking to go back and live with Mrs Jones. This resulted in an application for a Deprivation of Liberty authorisation. It was granted as Mrs Davies lacked capacity and Mrs Jones was not up to the challenge of providing the level of care required. In addition, Mrs Davies' needs could not have been met in sheltered and supported living accommodation. Both sisters were upset about the authorisation. An IMCA and People's Voice advocacy group was involved.

Eventually Mrs Jones made a formal complaint to the council about the detention. In its response the council said Mrs Davies needed expert care and Mrs Jones would not be able to provide that. The council also said Mrs Davies was settled now and her consultant's view was that her needs were best met at the care home. The authorisation expired after six months and another was made and granted. In the second authorisation it is noted that both sisters voiced a preference for being together. It was however deemed in Mrs Davies's best interests to remain where she was. The council said it would support the sisters spending as much time together as possible. Mrs Jones condition continued to deteriorate and records indicate that she may need residential care very soon.

The LGO decided that we would have expected the council to assess whether the sisters could live together in a home that could cater for the needs of both. In not exploring that option the arrangements may not be the least restrictive. The council agreed to a multi-stakeholder meeting to begin the process of dealing with the

sisters' assessments and begin planning to accommodate them together for as long as they wish.

Our next update should be out at the start of August 2012, unless any major decisions are handed down before then which merit urgent dissemination. Please email us with any judgments and/or other items which you would like to be included: credit is always given.

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