Best Interest decision-making in the Court of Protection

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Decision making in the Court of Protection on behalf of persons who lacks capacity is a familiar role for the court. The High Court has exercised its *parens patriae* jurisdiction in order to take decisions on behalf of vulnerable individuals for over 700 years. This jurisdiction was originally part of the Royal Prerogative, deriving from power and duty, based upon the Monarch's conscience, to intervene in order to protect the best interests of his subjects in circumstances where those individuals could not make decisions for themselves.

The origins of the *parens patriae* jurisdiction were described by Lord Brandon in *F v West Berkshire HA*[2] as follows:

> *"This is an ancient prerogative jurisdiction of the Crown going back as far perhaps as the thirteenth century. Under it the Crown as parens patriae had both the power and the duty to protect the persons and property of those unable to do so for themselves, a category which included both minors (formerly described as infants) and persons of unsound mind (formerly described as lunatics or idiots)"*

In practice decision making was undertaken by the King's Judges, taking decisions in the name of the King whilst exercising the Royal Prerogative. This is

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[2] [1991] UKHL 1 [1990] 2 AC 1.

the route by which applications under the inherent jurisdiction for children or vulnerable adults came to be determined by Judges of the Family Division.

When cases came before the High Court under the inherent jurisdiction decisions were taken in the best interests of the protected party, referred to as "P". Since the 19th century P has had the benefit of being represented by the Official Solicitor and the Court developed a practice of requiring counsel to put forward a schedule setting out the advantages and disadvantages of the proposed course of action. This was described by Dame Elizabeth Butler-Sloss in *Re L (medical treatment: benefit) sub nom Winston-Jones (a child) (medical treatment: parent's consent)*[3] at §13 as follows:

> *'The task therefore is for me to weigh up that which is sometimes called the "benefits and dis-benefits" but which I would prefer to call the advantages of giving or not giving potential treatments, and to balance them in order to decide the best interests of L with regard to his future treatment"*

Prior to the coming into effect of the Mental Capacity Act 2005 ("the "MCA") the Judges appear to have been keen to avoid procedural rules or defined practices which governed the process under which they took best interests decisions. In *Re J (a minor) (wardship: medical treatment)*[4] Lord Donaldson said at 35:

> *'I would deprecate any attempt by this court to lay down … an all-embracing test since the circumstances of these tragic cases are so infinitely various. I do not know of any demand by the judges who have to deal with these cases at first instance for this court to assist them by laying down any test beyond that which is already the law: that the interests of the ward are the first and paramount consideration, subject to the gloss on that test which I suggest, that in determining where those interests lie the*

[3] [2004] EWHC 2713 (Fam) [2005] 1 FLR 491
[4] (1990) 6 BMLR 25.

court adopts the standpoint of the reasonable and responsible parent who has his or her child's best interest at heart.'

One of the contrasts between the position at common law and under the MCA is that, as explored below, the MCA requires all authorised substituted decision makers, including Judges of the Court of Protection, to adopt the structured decision making process set out in section 4.

These cases often concerned the giving or withdrawing of medical treatment for a critically ill child where the giving of treatment had potential disadvantages and the prospects of benefit for the child were sometimes remote. One attempt to put a gloss on the concept of best interests was an attempt was made to persuade the Courts that the principle of sanctity of life meant that treatment ought to be provided to P unless it was intolerable for P to accept the treatment. The "intolerability test" emerged in its strongest form in the first instance judgement of Mr Justice Munby in *R (ota Burke v General Medical Council*[5]. The attempt to insert a gloss on to the best interests test was firmly rejected by the Court of Appeal in that case[6], and was reinforced by the Court of Appeal the following year in *Re Wyatt (a child) (medical treatment: continuation of order)*[7]:

".. we agree with Hedley J that whilst "intolerable to the child" should not be seen either as a gloss on or a supplementary guide to best interests, it is, as he said, a valuable guide in the search for best interests in his kind of case."

The legal requirement that a substituted decision maker for a person who lacks capacity, P, is required to take decisions on behalf of P in his best interests is one of the core principles of the MCA and is set out at section 1(5).

[5] [2005] 2 WLR 431.
[6] See : *R (ota Burke) v General Medical Council & Ors* [2005] EWCA Civ 1003.
[7] [2005] EWCA Civ 1181, 86 BMLR 173.

The statute requires an objective assessment by the decision maker of what is in the best interests of P. Part of that decision-making involves, as set out below, an assessment of what decision P would be likely to have make for himself, if he had capacity. The decision that P would have made for himself is one factor to be taken into account in the overall decision-making process but a best interests decision is not to be equated with a guess at what decision P would have made if he had had capacity.

Under the Act there is, as Lewison J noted in *In re P (Statutory Will)*[8] a "structured decision-making process". The Judge in that case said:

> *"Having gone through these steps, the decision-maker must then form a value judgment of his own giving effect to the paramount statutory instruction that any decision must be made in P's best interests. In my judgment this process is quite different to that which applied under the former Mental Health Acts."*

Thus cases on statutory wills under the Mental Health Acts should therefore be "consigned to history": see Munby J in *In re M (Statutory Will)*[9]. In that case Lord Justice Munby described the approach to decision making by making the following points:

> *"(1) The first is that the statute lays down no hierarchy as between the various factors which have to be borne in mind, beyond the overarching principle that what is determinative is the judicial evaluation of what is in P's "best interests".*
>
> *(2) The second is that the weight to be attached to the various factors will, inevitably, differ depending upon the individual circumstances of the particular case. A feature or factor which in one case may carry great,*

[8] [2010] Ch 33.
[9] [2011] 1 W.L.R. 344.

possibly even preponderant, weight may in another, superficially similar, case carry much less, or even very little, weight.

(3) The third, following on from the others, is that there may, in the particular case, be one or more features or factors which, as Thorpe LJ has frequently put it, are of "magnetic importance" in influencing or even determining the outcome: see, for example, Crossley v Crossley[10], para 15 (contrasting "the peripheral factors in the case" with the "factor of magnetic importance") and White v White[11] where he said, at p 314:

> *"Although there is no ranking of the criteria to be found in the statute, there is as it were a magnetism that draws the individual case to attach to one, two, or several factors as having decisive influence on its determination."*

Section 4 defines the procedure to be followed in any assessment of best interests under the Act. Section 4(1) provides that a decision as to what is in a person's best interests must not be made "*merely on the basis of*" the person's age or appearance or a condition of his, or aspect of his behaviour, which might lead others to make unjustified assumptions about what might be in his best interests.

The important words in this subsection are "*merely*" and "*unjustified assumptions*". Any substituted decision-making must take into account <u>all</u> relevant factors. Thus the age and, potentially, the appearance of P may or may not be relevant depending on the circumstances. Equally P's presenting condition, whatever that may be, and his behaviour may or may not have relevance to the decision-making process. However any assumptions made on the basis of P's age or presenting condition must be justified assumptions and not unjustified assumptions.

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[10] [2008] 1 FLR 1467.
[11] [1999] Fam 304 (affirmed, [2001] 1 AC 596)

Section 4(2) states:

> *"The person making the determination must consider all relevant circumstances and, in particular take the following steps"*

There are 2 points to draw from this wording. First, the "steps" listed in section 4 are mandatory. A decision maker must follow the structured decision making process set out in section 4. Secondly, what is and is not a "relevant circumstance" is a matter for the decision maker, provided the decision maker acts reasonably, and not something that is to be judged objectively. Section 4(11) explains that relevant circumstances are "those of which the person making the determination is aware and which it would be reasonable to regard as relevant". Having said that there are however no limits set out in the Act as to the types of factors which a reasonable decision maker could determine are relevant and thus ought to be taken into account.

Section 4(3) provides that the decision maker must consider whether it is likely that P will "at some time" have capacity in relation to the matter in question and, if it does appear likely, when that time is likely to be. This wording emphasises the principle that decision should not be taken for P unless it is necessary for someone else to take the decision. If the decision can properly be delayed until P regains capacity, consistent with a focus on P's best interests, then the decision maker should decline to take the decision, or should only take such an interim decision as is needed to preserve P's best interests, until P regains capacity.

Section 4(4) provides that, so far as reasonably practicable, the decision maker must permit and encourage P to participate in the decision-making process. He must take all appropriate steps to improve P's ability to participate as fully as possible in any act done for him or any decision affecting him. This subsection is particularly relevant where, even though P lacks capacity, P nonetheless has

some understanding of the decision which is to be taken on his behalf. The wording encourages the decision maker to work with P to the greatest extent reasonably practicable to involve P in any decisions made on his behalf. Thus, for example, a young woman with learning difficulties may not have capacity to decide where she should live. The local authority, who are likely to be the substituted decision-making in this case, have a duty to involve the young woman as much as possible by discussing different accommodation options with her, taking her to see the various placements for herself and discussing the advantages and disadvantages for her of each placement, and encouraging her to express views. This will mean that the decision maker understands her reaction to the various options and can feed those views into the decision-making process.

This seems to me to have both a legal and practical aspect. The legal aspect is that a person who lacks capacity nonetheless retains article 8 rights. The state is clearly acting in breach of the autonomous rights of an individual by imposing a decision maker on P. However that breach of article 8(1) can be justified under the provisions of article 8(2) by P's lack of capacity. Nonetheless the intrusion into the autonomy of an individual must be the least level appropriate which is consistent with that individual's best interests. The duty to involve P to the greatest extent that is reasonably practicable in the decision-making process is almost certainly required in order to meet the tests for justification under article 8(2) and thus justify the removal of the autonomous rights of an individual under article 8(1).

The practical benefit of involving P in decision making is that decisions taken on a cooperative basis with P are far more likely to be acceptable to P and therefore to work to P's advantage in the long run.

Section 4(5) is relevant to medical treatment decisions. It provides that a person who makes decisions on behalf of P relating to life-sustaining treatment must not be "motivated by a desire to bring about his death". Life-sustaining treatment is

defined in section 4(10) is being treatment which, in the view of the person providing healthcare for P is necessary to sustain life. So a substituted decision maker cannot book tickets to Dignitas for P even if this was the clearly expressed wish of P before he lost capacity.

This section emerged as a result of the Parliamentary process in order to reassure those who felt that the power of substitute decision-making could be used to bring about the death of people who lacked capacity. However it does not mean that appropriate palliative care should not be provided to P even if one effect of such a care regime is to hasten an inevitable death. As long as the aim of the care regime is to benefit P, for example by alleviating pain, then this will be lawful.

This balance is shown in the MCA Code of Practice paragraph at 5.31 where it says:

> *"There will be a limited number of cases where treatment is futile, overly burdensome patient or where there is no prospect of recovery. In circumstances such as these, it may be that an assessment of best interests leads to the conclusion that it would be in the best interests of the patient to withdraw or withhold life-sustaining treatment, even if this may result in the person's death. The decision maker must make a decision based on the best interests of the person who lacks capacity. They must not be motivated by a desire to bring about the person's death for whatever reason, even if this is from a sense of compassion. Healthcare and social care staff should also referred to relevant professional guidance when making decisions regarding life-sustaining treatment"*

The reference in the above Guidance to "relevant professional guidance" must include the GMC guidance "Treatment and care towards the end of life: good

practice in decision making"[12], guidance published by the Royal College of Paediatrics and Child Health[13] or guidance in this area published by the British Medical Association[14].

Section 4(6) requires the decision-making to focus on P when making the decision. It sets out factors which "so far as is reasonably ascertainable" the decision maker must "consider". The factors are:

> *"(1) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity),*
>
> *(2) the beliefs and values that would be likely to influence his decision if he had capacity, and*
>
> *(3) the other factors that he would be likely to consider if he were able to do so"*

There can, of course, be a conflict between a person's expressed past wishes and feelings and his present expressed wishes and feelings, and this is particularly problematic if the present expression of wishes and feelings comes from somebody who has considerably less capacity than in the past.

In *In re M (Statutory Will)*[15] Munby LJ offered the following approach to assist decision-makers in understanding how they should consider P's wishes and feelings:

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[12] See http://www.gmc-uk.org/guidance/ethical_guidance/end_of_life_care.asp
[13] See http://www.rcpch.ac.uk/sites/default/files/Witholding.pdf
[14] See http://www.bma.org.uk/ethics/end_life_issues/
[15] [2011] 1 W.L.R. 344.

"(1) First, P's wishes and feelings will always be a significant factor to which the court must pay close regard: see Local Authority X v M[16] *paras 121–124.*

(2) Secondly, the weight to be attached to P's wishes and feelings will always be case-specific and fact-specific. In some cases, in some situations, they may carry much, even, on occasions, preponderant, weight. In other cases, in other situations, and even where the circumstances may have some superficial similarity, they may carry very little weight. One cannot, as it were, attribute any particular a priori weight or importance to P's wishes and feelings; it all depends, it must depend, upon the individual circumstances of the particular case. And even if one is dealing with a particular individual, the weight to be attached to their wishes and feelings must depend upon the particular context; in relation to one topic P's wishes and feelings may carry great weight whilst at the same time carrying much less weight in relation to another topic. Just as the test of incapacity under the 2005 Act is, as under the common law, "issue specific", so in a similar way the weight to be attached to P's wishes and feelings will likewise be issue specific.

(3) Thirdly, in considering the weight and importance to be attached to P's wishes and feelings the court must of course, and as required by section 4(2) of the 2005 Act, have regard to **all** *the relevant circumstances. In this context the relevant circumstances will include, though I emphasise that they are by no means limited to, such matters as:*

> *(a) the degree of P's incapacity, for the nearer to the borderline the more weight must in principle be attached to P's wishes and feelings: Local Authority X v M,*[17] *para 124;*

[16] [2009] 1 FLR 443.
[17] [2009] 1 FLR 443.

(b) the strength and consistency of the views being expressed by P;

(c) the possible impact on P of knowledge that her wishes and feelings are not being given effect to: see again Local Authority X v M , at para 124;

(d) the extent to which P's wishes and feelings are, or are not, rational, sensible, responsible and pragmatically capable of sensible implementation in the particular circumstances; and

(e) crucially, the extent to which P's wishes and feelings, if given effect to, can properly be accommodated within the court's overall assessment of what is in her best interests"

At this point that maybe worth noting the difference between an Advance Decision and a written or oral statement by P made in the past which expresses P's views about what decision ought to be made in the circumstances if P were to lose capacity. An Advance Decision under section 24 is a specific decision taken by P when he has capacity to refuse to consent to a "specified treatment" at a defined point in the future. An advance decision relating to life-sustaining treatment must be in writing and must comply with the procedural requirements in section 25(5) and 25(6).

In contrast an advance statement can be any expression by P of his own views which is a matter that the decision maker is required to consider under section 4(6) along with all the other relevant circumstances, but is not binding.

Section 4(7) places a duty of the decision maker to consult other people close to P where practical and appropriate to do so, on decisions affecting P and what may be in P's best interests. The persons to be consulted are:

- Anyone named by P someone to be consulted on the matter in question or on matters that kind;

- Anyone engaged in caring for P or interested in P's welfare

- Any donee of a lasting power of attorney granted by P

- Any deputy appointed for P by the court.

The consultation is for 2 purposes, namely:

- In order to ascertain information about P's own wishes and feelings and the other matters set out in section 4(6); and

- In order to inform the decision about what decision would be in P's best interests.

The categories of people who need to be consulted are widely drawn. However it is important to note that these people are consultees; they are not decision-makers. The Code of Practice says at paragraph 5.54:

> *"People who are close to the person who lacks capacity, such as close family members, are likely to know the best. They may also be able to help with communication or interpret signs that showed the person's wishes and feelings. Everybody's views are equally important - even if they do not agree with each other. They must be considered alongside the views of the person who lacks capacity and other factors"*

Hospitals have a tendency to ask "who is the next of kin", and then to seek to ascribe to this person a preferential position in the hierarchy of those who can influence decisions about a person who lacks capacity. This approach does not follow the scheme of the MCA. The expression "next of kin" has no legal definition. It tends to be used to describe the class of individuals who are entitled

to an interest in the estate of a person who dies intestate, now defined by the Administration of Estates Act 1925. Accordingly, if you go into hospital and asked "who is your next of kin" the “clever-dick” answer ought to be "*are you expecting me to die imminently*" or "*it is okay, I have made a will*". I do not recommend these as answers to the booking clerk who is likely, at best, to respond with a sarcastic comment. He or she has a form to fill in, and needs to have this information to answer this “pseudo-legal” question. However the serious point is that the tendency to ascribe the title "*next of kin*" to a particular relative has the ability to place that person's views on a pedestal, and relegate the importance of the views of everybody else.

To show how this works in practice to the detriment of P, I would like to refer to a recent case where a difficult medical decision needed to be made for an elderly lady who lacked capacity. The person who knew her best was a heroic next door neighbour who had provided daily care for P for several years. The elderly lady's family lived some distance away and, through no fault of their own, had limited knowledge of their mother's views. In that situation members of the family clearly had an interest in P’s welfare and so were entitled to be consulted under section 7(b). However the next door neighbour was a person who was "engaged in caring" for P and so should be consulted. Despite the fact that she was not a blood relative, her views were required under the Act to be treated with equal worth to those of the family. Managing the expectations of the family in such a situation can be difficult, but the MCA gives no precedence to the views of blood relations.

The weight to be accorded to the views of those who are consulted is, of course, a matter for the decision maker and depends on all the relevant circumstances. Hence the decision maker, having weighed all these considerations, then needs to make a decision. Provided the decision maker acts *bona fide* and does not stray outside of scope of a reasonable decision the decision maker will be acting lawfully. Two final points to make on that point. First these decisions engage ECHR rights and so the “reasonableness” test would not be a simple

Wednesbury test but the enhanced test "anxious scrutiny" test explained by the Court of Appeal in *R v Ministry of Defence ex p Smith*[18]. Secondly, if the person making the decision owes P a legal duty of care, then negligence in the making of the decision make still open the clinician to a legal action.

The final area to examine is the potential conflict between best interest decisions and the statutory duties of public bodies who are required to provide services to an individual. The problem in this area is easy to state. Once the court is seized of a decision-making process there is an understandable deference amongst public bodies who feel that decisions about P should be made by the court and not the public body.

This can arise, for example, where decisions need to be made about the provision of long-term accommodation for young adults with learning difficulties. It can also arise where individuals have lost capacity as a result of an accident and there is a substantial compensation claim in the background. In each of these cases there are powerful forces seeking to secure the best possible package for P, and the Court of Protection is sometimes used by those seeking to promote P's interests to get the best possible package of care from the statutory agencies, or possibly attempting to minimise the costs to a defendant insurer.

However, as a matter of law, this is a completely misconceived approach. It is misconceived because it assumes that a Declaration as to what is in P's best interests carries an obligation on all parties to deliver the package of care so determined. In fact, absent an injunction, there is no such obligation.

The fact that a person lacks capacity does not give an individual any right to an enhanced level of services from the statutory agencies[19]. Through different mechanisms all health and social care provided by the NHS and by Social Service authorities is rationed. Policies define what level of service an individual

[18] See [1996] QB 517 at 554E.

[19] See *In re J (A Minor) (Child in Care: Medical Treatment)* [1993] Fam 15.

with a defined level of needs is entitled to receive, and this level of service provision is almost always significantly below the level that would be assessed by a court undertaking a compensation analysis in the personal injury action (which can be seen as being effectively assessed on a best interest basis).

The High Court clearly decided in *A v. A Health Authority*[20] that an order made under the inherent jurisdiction did not place public bodies under any duty to act in accordance with the views of the court. In that case the Judge said:

> *".. the court must limit the exercise of its jurisdiction so as to avoid coming into conflict with the exercise by the local authority of its statutory powers and duties.."*

This theme has recently been taken up by Charles J in the Court of Protection who decided in *A Local Authority v PB & P*[21] that such issues should be identified early on that:

> *".. in exercising a welfare or best interests jurisdiction (to my mind, whether under the Children Act, under the inherent jurisdiction, or under the Mental Capacity Act), the court is choosing between available options"*

That formulation, of course, begs the question as to what are the "available options". The judge focused on this issue saying:

> *"In that context, it seems to me that the point arises whether or not a litigant, whether it be a member of P's family or P, can obtain relief from the Court of Protection that effectively adds to the available options from which the best interests choice falls to be made (and thus by the application of public law and Human Rights tests and principles in those private law proceedings), or whether they can only effectively obtain such*

[20] [2002] Fam 213.
[21] [2011] EWHC 502 (COP).

relief by seeking judicial review. Also in the exercise of the jurisdiction of the Court of Protection questions arise as to what orders it can make, or is precluded from making, as a public authority by reference to Human Rights points, and as to whether the court should embark on a process of negotiation with another public authority, or a fact-finding exercise, that is relevant to decisions of that authority concerning the best interests of P"

Although, Charles J did not specifically answer this question, in practice the answer must be that the issues can only be decided in proceedings which are jointly constituted in the Court of Protection and in the Administrative Court (as was the case in *A v. A Health Authority*). If a public body, lawfully discharging its statutory obligations, offers a package of care which is less than a package that might be thought to be in the best interests of P and is not prepared to offer a higher level of care[22], it must follow that the best interests package is not relevant to the deliberations of the Court of Protection. There is little point in taking considerable amount of time debating the details of the care package when there is nobody available to provide such a package. Charles J rightly suggested that:

"One of the reasons they need to be alert to the points is to seek to ensure that Court of Protection proceedings are not utilised for an inappropriate purpose. Looked at only from the perspective of the individuals involved, proceedings of this type concern emotional issues and the parties should not suffer distress from proceedings that are inappropriate and/or which cannot achieve the result they want. Money also, of course, comes into play and the court should not spend time (often a number of days) considering what it thinks is in the best interests of P, only to be met by the relevant public authorities saying at the end of the day: "We are not obliged to and are not going to act in accordance with a best interests declaration or order under s. 16 Mental Capacity Act 2005 if it involves the provision of services that we have decided not to provide".

[22] And there is no other source to fund care for P at an enhanced level.

Despite ever reducing welfare budgets, there may be some reluctance amongst practitioners in the Court of Protection to accept that the statutory agencies should not defer to the court but must work out the care package offered to P for themselves, applying their own policies. That process, and not the court process, ought to define the options that the statutory agency is prepared to offer. The Court of Protection should then be able, if necessary, to make the best interests decision between the options that are on offer.

It make take considerable courage by NHS bodies and local authorities to stand up to insistent lawyers for the patient, and even more insistent lawyers for the defendant insurers who are trying to off load care costs onto the state. However the above cases provide a clear jurisdictional basis to support this approach and any other approach means, in effect, a person who lacks capacity whose case is before the Court of Protection will secure an enhanced level of services from the statutory agencies over and above provided to those who have capacity or who do not have capacity but whose cases are not before the court.

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