MENTAL CAPACITY REPORT: HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

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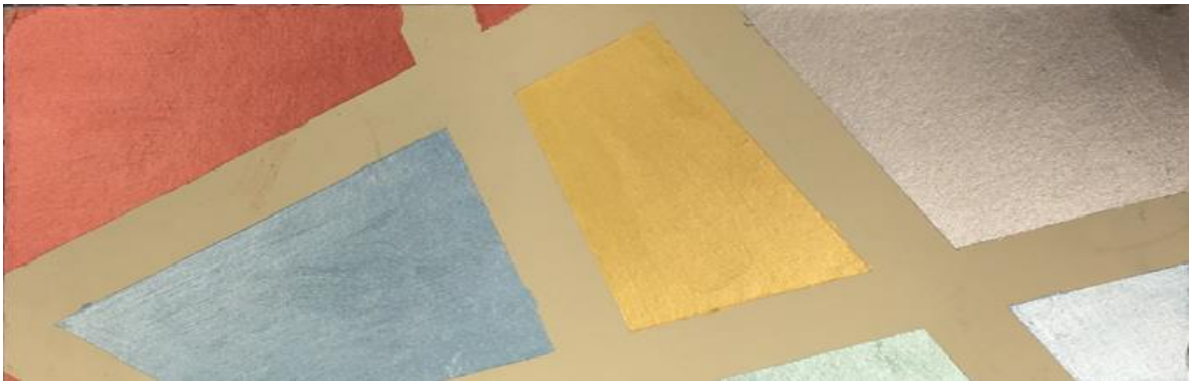

Welcome to the November 2022 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: When it is in a person's best interests to end restraint which is necessary to keep them alive; and removing silos from capacity in substance and procedure.

(2) In the Practice and Procedure Report: A plethora of developments around transparency, reporting restrictions and closed hearings.

(3) In the Wider Context Report: *Morahan* in the Court of Appeal; Updated RCN guidance on sex and sexuality in care homes; and the relationship between clinical guidelines and negligence.

(4) In the Scotland Report: An imperative to reform mental health law; and the Hague Convention on the International Protection of Adults.

You can find our past issues, our case summaries, and more on our dedicated sub-site here, where you can also find updated versions of both our capacity and best interests guides.

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The picture at the top, "*Colourful*," is by Geoffrey Files, a young autistic man. We are very grateful to him and his family for permission to use his artwork.

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Best interests – medical treatment

Summary

In *Cambridge University Hospitals NHS Foundation Trust and Cambridgeshire and Peterborough NHS Foundation Trust v RD, Mrs RD and Mr RD* [2022] EWCOP 47, Lieven J was concerned with a 26-year-old woman, RD, with diagnoses of Emotionally Unstable Personality Disorder, Post-Traumatic Stress Disorder and, at some points, psychosis. The case is particularly tragic because between the last hearing in the case and writing the judgment RD self-harmed and died. It raises the importance of protecting someone's autonomy to refuse life-saving treatment and the complex interplay between mental and physical health.

RD had spent significant periods of time in psychiatric units since the age of 15; and had been frequently detained under the Mental Health Act 1983 ("MHA 1983"). She was driven to hurt herself because of alleged adverse earlier experiences and she was highly resistant to treatment, particularly psychotropic medication. She had had many serious incidents of self-harm, which resulted in long periods of hospitalisation including periods in intensive care. In February 2022, she required tracheal reconstruction as a result of a significant injury she caused to her neck. When on leave from a psychiatric ward in June 2022, she cut her own throat and sustained a further significant neck injury with total transection of her trachea.

Following a brief discharge into a supported living placement, she returned to Addenbrooke's with another serious neck injury in July 2022 that meant she was likely to need a permanent tracheostomy with a possible laryngectomy. She was heavily sedated and ventilated in intensive care, after emergency surgery.

The clinical team discussed the treatment options with RD's parents (who were her health and welfare attorneys); and it was agreed that it was in her best interests to be subject to the least restrictive restraint should she take action which would pose a risk to her life; and a restraint plan was agreed. The clinicians had been particularly concerned that she would try to pull the tracheostomy out.

The applicant trusts sought best interest decisions approving a care plan in respect of treatment for her trachea injury. The plan included two alternative treatment plans.

The first question for the court was whether RD had capacity to make decisions in respect of treatment from her trachea injury, which was not easy to answer. There was evidence that her capacity was fluctuating – most of time she appeared to have capacity; but when she became distressed, she lost it. Lieven J accepted

that the Court of Protection had jurisdiction on the basis that when she became distressed, she could no longer make the relevant decision.

The second question was, in the usual way, whether the treatment plan was in her best interests. The first plan was to apply in circumstances where RD indicated a desire to have medical support in order to prevent harm; and the second applied when RD indicated a desire for no treatment or intervention, which involved removal of the tracheostomy tube and palliative care. That desire could be expressed by RD removing the tracheostomy tube.

The Judge gave significant weight to the evidence from RD's parents, which included an explanation of RD's cycles of response whereby she would state that she wanted to live but then shortly thereafter significantly self-harm. It was therefore view that the time had come to let her make the choice.

Their evidence (along with that of one of the clinicians) was that RD's sense of autonomy was the most important thing for her; and that she is in charge of her own life and decisions. The continued use of restraint and replacing her tube if she removes it undermines her autonomy and further damages mental health.

In terms of RD's wishes and feelings, the Judge observed that they were *'complicated, fluctuating and highly ambivalent…RD will say that she wishes to live and then acts to destroy herself.'* [46] It was clear that this was a repeating pattern.

The court also took into account the evidence that RD could not be kept sedated for a prolonged period of time, given that she needed 3-6 months of consistent engagement in therapy before it was possible to remove the tube. The risks of ongoing sedation and ventilation included infection and physical deconditioning, which in turn would make it more difficult to move her off ventilation. Lieven J noted therefore that, without sedation, RD would instead require physical restraint otherwise she would remove the tube and die.

The Judge ultimately approved the treatment plans, including the alternative involving no restraint and palliative care, and decided that they were in RD's best interests. She acknowledged the complex intersection between RD's mental and physical health; and focused on RD's autonomy.

Comment

Whilst the court ultimately determined that (i) at times, RD lacked capacity to make the relevant decisions and (ii) when capacitous, RD expressed the wish to live, it undertook a careful survey of the authorities establishing that an adult with capacity can refuse treatment to save their lives, including those addressing the obligations inherent in Article 2.

Lieven J emphasised the importance of judicial scrutiny of any proposed treatment plan which gives effect to personal autonomy over the preservation of life; and therefore engages or is likely to engage Article 2. She observed that, *'it will be a very rare case where an adult who at times does not have capacity and who has expressed a will to live is allowed to die*' [47] given RD's expressed wishes on occasions and the sanctity of life. Ultimately, and notwithstanding those important factors, she decided to approve the treatment plans, given the evidence that '*what RD wants above all else is a sense of autonomy*.' [51]

Finally, it is also worth considering briefly how Lieven J addressed the issue of fluctuating capacity. She carefully laid out the relevant legal framework and case law, but as is often the case, she ultimately did not determine the issue, finding that when RD was distressed she lacked

capacity to make the relevant decision in her best interests. We do not have access to the final orders so it might be that the orders identify a specific threshold at which RD loses capacity, but these are not easy to set in concrete terms (see e.g. *Re DY* [2021] EWCOP 28).

Capacity: avoiding silos, and what should a supervisory body do when a DOLS assessor disagrees with a court-appointed expert?

Lancashire & South Cumbria NHS Foundation Trust & Lancashire County Council v AH [2022] EWCOP 45 (12 October 2022)(HHJ Burrows):

Capacity – medical treatment
Capacity – care

Summary

This case considered whether, AH, who had diabetes and a diagnosis of a mild learning disability, had capacity to make decisions about residence, care, sharing information concerning her physical and mental health and care, and to conduct these proceedings.

AH was 46 years old and lived independently in the community. In late 2021, she was admitted to hospital suffering from acute confusion and high blood glucose. It had historically been difficult to ensure she managed her Type 1 diabetes care: AH has made it difficult for District Nurses to provide her insulin; [18] and AH's rigid thinking had led to difficulties with multiagency information sharing. [19] Issues of capacity were considered to be complex [20] and it was queried whether in addition to her established diagnoses, she may also have a personality disorder and autism.

The initial application by the statutory bodies was for AH to be admitted to a care home placement for assessment. A single expert report was obtained from Dr Camden-Smith, which concluded that AH had an:

> *38…inability to understand that the care package she wishes to be supplied to her in her flat is simply not possible. [AH] is further incapable of using and/or weighing the information that she does understand due to her extreme egocentricity and rigidity and refusal to take reality or other views into account. She clings determinedly to her wishes even when these are quite simply impossible.* ***This is due to a combination of her learning disability and personality traits (potentially autism as well) and has been a consistent factor throughout the years that she has been known to local solicitors and her care team****. Learning disability and autism are lifelong immutable conditions, whilst personality disorder can be amenable to therapy, but this has not been effective in [AH's] case. For these reasons it is my opinion that [AH] will not gain capacity in this area."*

Dr Camden-Smith also took the view that AH does not understand *'that she had emotional, psychological and mental health needs'* [39] and that AH lacks capacity to *'make decision about information sharing, restrictions that amount to a deprivation of liberty and to litigate in these proceedings'*. [41]

HHJ Burrows found that the approach taken by Dr Camden-Smith is a '*clear example of the expert moving away from treating capacity decisions in "silos", but rather considering how making decisions about different subjects interact with each other*'. [49] Her report '*considered the correct relevant information in her assessment, including crucially the reasonably foreseeable consequences of making the decision one way or another- as has most recently been made clear in A Local Authority v JB.'* [50] The court accepted the evidence and made declarations accordingly.

HHJ Burrows identified the disconnect between the findings on capacity by the DOLS assessors and the expert evidence before the court. During

the pendency of the case, AH had not been made subject to a standard authorisation (despite being a detained care home resident) due to conflicts between the DOLS assessors. The court had made a finding of lack of capacity for the purposes of s.48 and made orders accordingly. The proceedings could not be reconfigured under s.21A MCA and AH was not entitled to non-means tested Legal Aid [56]. HHJ Burrows expressed the view that *'where a court appointed expert reports on a case in which capacity is in dispute, and that expert concludes that capacity to make decisions as to residence and care are absent, that should be sufficient for the mental capacity requirement of Schedule A1 to be met without more.'*[57] This position, however, was recognised to be unenforceable [58].

HHJ Burrows explored what the supervisory body can do when an assessor concludes that P has capacity.

> *[60]…The assessors are, of course, independent of the supervisory body. That is necessary in order to make the process compliant with Article 5 of the ECHR. It would be unfortunate as well as very costly, if the supervisory body had to judicially review one of their assessors because that assessor reached a view that conflicted with a decision of the Court (see analogously, albeit within the context of the Mental Health Act where a Responsible Clinician challenged his own Hospital Managers in respect of the discharge of a patient: South Staffordshire and Shropshire Healthcare NHS Foundation Trust & Whitworth v The Hospital Managers of St Georges Hospital [2016] EWHC 1196 (Admin).)*
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> *[61] It would be sensible, it seems to me, if the Local Authority as supervisory body agrees that P lacks capacity, that the author of the report ought to carry out the assessment for the purposes of the DOLS, if that is possible. Alternatively, I would expect any mental health or mental capacity assessor to have access to the report and any judgment such as this that has dealt with the issue of capacity.*

HHJ Burrows gave permission for the contents of Dr Camden-Smith's report and any judgment to be disclosed to any mental health or capacity assessor in respect of AH. Although not mentioned in the judgment, an option open to the supervisory body would have been to use that report as an equivalent assessment for the purposes of a standard authorisation.

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Arianna has a specialist practice in mental capacity, community care, mental health law and inquests. Arianna acts in a range of Court of Protection matters including welfare, property and affairs, serious medical treatment and in matters relating to the inherent jurisdiction of the High Court. Arianna works extensively in the field of community care. To view a full CV, click here.

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Adrian is a recognised national and international expert in adult incapacity law. He has been continuously involved in law reform processes. His books include the current standard Scottish texts on the subject. His awards include an MBE for services to the mentally handicapped in Scotland; honorary membership of the Law Society of Scotland; national awards for legal journalism, legal charitable work and legal scholarship; and the lifetime achievement award at the 2014 Scottish Legal Awards.

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Conferences and Seminars

Neil Allen will be running the following series of training courses:

30 November 2022	BIA/DoLS Update Training
13 January 2023	Court of Protection training
26 January 2023	MCA/MHA Interface for AMHPs
2 February 2023 (AM or PM)	Necessity and Proportionality training
16 March 2023	AMHP Legal Update
23 March 2023	Court of Protection training

To book for an organisation or individual, further details are available here or you can email Neil. Local authorities or other organisations can book places by emailing neil@lpslaw.co.uk. Individuals can book online To book for an organisation or individual, further details are available here or you can email Neil. Full details of available online courses are available at www.lpslaw.co.uk/courses/.

'Mediation of Medical Treatment Disputes: A Therapeutic Justice Model': 29 November 2022, 9:30-12:30
The research seeks to investigate whether and, if so, the extent to which, mediation can and should be viewed as a form of therapeutic justice in medical treatment disputes.
The event will start with perspectives from leading practitioners in the field who will draw on their own experience of medical treatment disputes concerning adults and children to consider how mediation can be used in these ethically challenging cases. This will be followed by presentations from the core research team to outline the aims of the research, the empirical methods and the ways that you can get involved with the project.

The launch event will be held online by zoom on the morning of 29 November 2022. Further information about the event is available and you can register to attend here.

Is Mental Capacity Law Law? 23 November 2022, 13:00-14:30
Prof John Coggon is presenting his paper on "Is Mental Capacity Law Law?" in Oxford; those interested can listen remotely and details are available here. From the event page:
There is an in-built principled tension within the statute, which at once aims to promote a value-neutral, skeletal framework for decision-makers, whilst also importing value commitments; both through values-commitments inherent to the Act and—crucially—by the creation of vacuums that must be filled by values that are neither introduced by law nor from the person for and about whom a decision is being made. This invites critical questions about assumptions that underpin the normative validity of the statute: both in its claims to assuring legal authority, and to the essence of judicial decision-making under the Act.

Advertising conferences and training events

If you would like your conference or training event to be included in this section in a subsequent issue, please contact one of the editors. Save for those conferences or training events that are run by non-profit bodies, we would invite a donation of £200 to be made to the dementia charity My Life Films in return for postings for English and Welsh events. For Scottish events, we are inviting donations to Alzheimer Scotland Action on Dementia.

Our next edition will be out in December. Please email us with any judgments or other news items which you think should be included. If you do not wish to receive this Report in the future please contact: marketing@39essex.com.

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