MENTAL CAPACITY REPORT: HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

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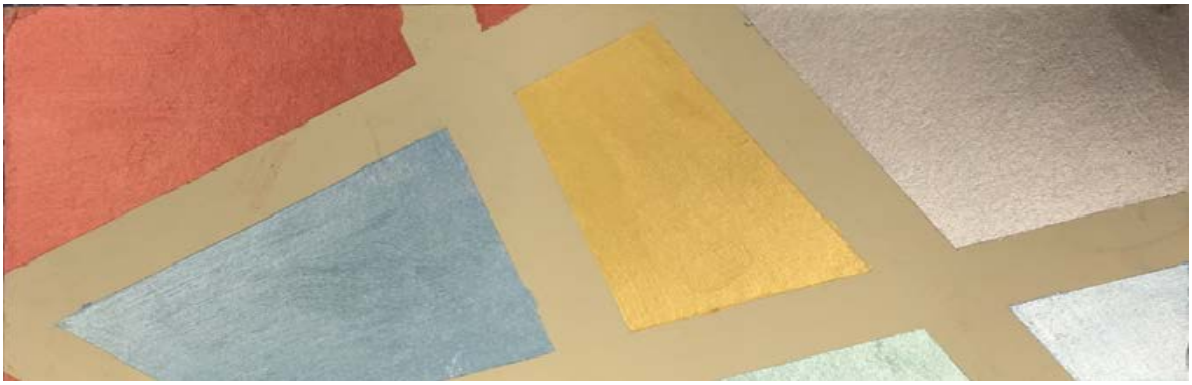

Welcome to the December 2023 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: the least worst option as regards compulsory feeding, putting values properly into the mix and the need for a decision actually to be in contemplation before capacity is considered;

(2) In the Property and Affairs Report: relief from forfeiture in a very sad case;

(3) In the Practice and Procedure Report: counting the costs of delay, guidance on termination cases, and a consultation on increasing Court of Protection feeds;

(4) In the Wider Context Report: forgetting to think and paying the price, the cost of getting it wrong as litigation friend, Wales potentially striking out alone on mental health reform, and a review of Arianna's book on social care charging;

(5) In the Scotland Report: reduction of a Will: incapacity and various vitiating factors, and an update on law reform progress.

You can find our past issues, our case summaries, and more on our dedicated sub-site here, where you can also sign up to the Mental Capacity Report.

We will be taking a break in January, so our next Report will be out in February 2024. For those who are able to take a break in December, we hope that you get the chance to rest and recuperate. For those of you who are keeping the systems going in different ways over that period, we are very grateful.

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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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The least worst option?

East Suffolk and North Essex NHS Foundation Trust v DL and Norfolk and Suffolk NHS Foundation Trust [2023] EWCOP 47 (Henke J)

Best interests – medical treatment

Summary[1]

In the first reported Court of Protection decision by the newly-appointed Ms Justice Henke, she considered the sad case of DL, a woman in her 30s who was detained in a psychiatric intensive care unit under s.3 Mental Health Act 1983. As Henke J noted, "*DL has a mild learning disability, complex PTSD, a dissociative disorder and an Emotionally Unstable Personality Disorder at a borderline level. She has a history of violent behaviours towards herself and others, including those caring for her*" (paragraph 6).

The judgment records at paragraph 7 that *"since about August 2023 DL has been restricting her intake of nutrition and hydration. Her current intake is incompatible with life. It is accepted by all parties before me that without intervention DL will die. All parties agree that DL wishes to live. It is the treatment plan which will sustain her life which is in dispute*." By early October 2023, DL was estimated to have a BMI of 17, and was described as emaciated and dehydrated. At that time, DL was expressing a wish to die. A consultant gastroenterologist attended on her, and considered she would be at risk of deterioration or potential death if refeeding did not start within 48 hours; it was proposed that this occur while she was sedated on a physical intensive care unit. This did not occur, and a series of meetings took place over the coming weeks, which did not result in a treatment plan for her.

This application was made on an out of hours basis on 21 October 2023 by the mental health trust (Norfolk and Suffolk Trust), though the acute Trust (East Suffolk and North Essex Foundation Trust) which would be delivering the refeeding was substituted as the applicant.

By the time of the hearing, DL was continuing to decline food and was drinking approximately 100ml water daily. It was agreed that this was not sufficient to sustain life, and DL was now consistent in her view that she wished to live; due to her continued refusal of food and the period of time she had been without food, this would require a formal refeeding plan. The court was initially invited to choose between two available options:

a) Restraining DL (physically and/or

[1] Note: Alex, Tor and Katie having had direct or indirect involvement in the case, they have not contributed to this note.

> *chemically) to insert and then maintain a NG tube in place to enable regular bolus feeding; or*
>
> *b) Feeding DL via a NG tube under general anaesthetic with an endotracheal tube being used, to prevent asphyxiation.*

DL's brother and sister participated in the proceedings, and set out their support for DL to be refed under sedation. They voiced strong opposition to DL being fed via an NG tube under restraint in light of a series of hospital admissions over the last four years that DL has found traumatic. DL had also told them she wanted to 'sleep and wake up better' (a comment which she also made when meeting with the judge) which they felt was in accordance with refeeding under sedation. DL took broadly the same view as her siblings when speaking to the court, stating that she wanted to go to hospital to get better, and was very clear that she did not want to be touched or have people holding her.

The court heard from DL's responsible clinician under the Mental Health Act, a consultant gastroenterologist and a consultant in Intensive Care Medicine and Anaesthetics in the acute trust. All of these were DL's treating clinicians or those who would have responsibility for her care when the refeeding plan commenced rather than external experts. The evidence from the responsible clinician set out that refeeding DL under restraint with an NG tube would be traumatic given DL's history. The responsible clinician took the view that this proposal was unrealistic, as DL is very likely to remove tubes and cannulas repeatedly.

The clear preference of the gastroenterologist and Intensive Care consultant was to refeed DL under restraint, as they felt that DL did not require ITU-level care, that the risks of a long-term general anaesthetic to deliver re-feeding under sedation were considerable (including trauma caused by post-ITU syndrome). The intensive care consultant in particular felt that other ward-based options should be attempted before sedation under general anaesthetic to avoid a wide range of potential complications which may arise (including a significant risk of circulatory collapse and lung injury). The view of the gastroenterologist and intensive care consultant was that it was in DL's best interests to attempt a stepwise approach, and only refeed under a general anaesthetic if refeeding under restraint were unsuccessful to avoid the high risk of complications which would accompany the plan. However, the acute trust was willing to provide refeeding under sedation if the court found it to be in DL's best interests. The evidence was also clear that DL was at risk of grave harm or death if no intervention were made.

Following the evidence, the two proposed treatment plans were amended:

> *20. Shortly before court commenced on 26 October 2023, the applicant filed two fresh treatment plans. They were to be read in a linear fashion. The first was a refeeding treatment plan via a NG tube. The plan proposed elective admission to a side room on a ward of the Ipswich hospital, physical restraint to enable IV access and then initial chemical restraint /sedation to a level where DL requires minimal physical restraint. The last paragraph of the plan reads: "If DL is unable to be safely managed on the ward she will be escalated to ITU. Escalation will require sedation and a PICC line." The escalation plan to ITU confirmed deep sedation and the insertion of a PICC line to enable parenteral feeding. Both the treatment plan and escalation plan set out the benefits and burdens of each plan. I have factored those balances into my decision making.*

The acute trust continued to prefer a linear approach of attempting refeeding without a general anaesthetic, but accepted that if the court "*found the treatment plan on the ward to be as a matter of fact unmanageable, then the court could proceed to consider the escalation plan to be in DL's best interests*" (paragraph 22). The mental health set out that it was 'moving towards neutrality' on the evidence of the acute trust, but her Responsible Clinician felt that "[f]*rom a psychological perspective, Dr Axford considered that* [the second option] *minimises the risk of further trauma for DL and maximises the welfare outcome for DL going forward*" (paragraph 23). The Official Solicitor considered that NG re-feeding under restraint would not work and was not a realistic option, and thus the second option should be pursued (also emphasising the likely traumatising impact of this option if it were pursued).

Citing *JK v A Local Mental Health Board* [2019] EWHC 679 (Fam), *A Healthcare and B NHS Trust v CC* [2020] EWHC 574 (Fam) and *An NHS Trust v Dr A* [2013] EWCOP 2442, Henke J considered "*that the Court of Protection has jurisdiction in relation to DL and is the appropriate forum for making best interest decisions in relation to the treatment proposed to feed and hydrate her*" (paragraph 27).

Henke J readily concluded that DL lacked capacity to make decisions in relation to her nutrition and hydration.

In relation to best interests, Henke J considered that the key issue was whether the proposal to refeed DL by NG tube under restraint was realistic. Henke J noted that although DL:

> *35.* […] *is weakened by her malnutrition and dehydration, she continues to be held in a segregation unit on PICU as a result of past assaultive behaviours. She has no contact with other patients because it continues to be unsafe for her to do so. In her statement dated 21 October 2023 Dr Axford's evidence, which was not challenged, was that as of that date DL was still assaulting staff members. Her aggressive behaviours mean that it continues to be unsafe to weigh DL. DL continues to need a high staff ratio.*
>
> *36. I also take into account that DL is adamant that she does not want a NG tube and that she has stated she will pull it out. DL has also forcefully stated that she does not want to be placed on a ward and that if she is placed there against her will- she will kill, kill , kill. I find that there is cogent evidence before me upon which I can and do find that there is a very real and high risk that if DL is subjected to such actions against her will, she will cause physical harm to herself and others.*
>
> *37. I also accept the evidence of DL's siblings that DL's last admission to a ward in a general hospital ended disastrously. I have no doubt the intentions at that time were good, but the effect was to cause further harm to DL.*

Henke J also noted that DL "*does not like to be touched and held. Attempting to restrain her against her will is likely to aggravate her and her presentation. Dr Axford's evidence to me was that trauma was at the root of DL's disorders. Physically restraining her is likely to trigger her responses. According to Dr Axford, attempting to treat DL under restraint simply will not work. Physical restraint will only cause DL to deteriorate. Further chemical restraint is unlikely to be of value because the drugs and dosages that can be used by reason of her frailty are unlikely to be sufficient*" (paragraph 39).

Henke J found that, while she could appreciate the views of the acute consultants in favouring

an incremental approach, "[t]*here is an inevitability in this case that the treatment plan would be unmanageable from the start and the escalation plan triggered. I find that even to attempt to implement the treatment plan would present a significant risk of harm to DL. She is likely to be traumatised by the attempt which I find is highly likely to fail*" (paragraph 41).

Henke J thus adopted the second plan (as revised following the evidence) as being in DL's best interests, noting in particular the cycle of hospital admissions that DL had found to be traumatising, and that there was "*a significant risk on the facts of this case that those events will cause additional trauma and cause DL's disorders to be aggravated and her presentation to deteriorate still further. There is a significant risk of DL being caused further psychological or psychiatric harm by any such interventions*" (paragraph 43).

Comment

The choice before the court was a stark one, in which the court had to select between two plans which medical professionals considered posed significant risks of harm to DL. The acute hospital consultants were setting out stark warnings that DL may suffer serious and lasting physical harm as a result of refeeding under sedation, including cardiac collapse and damage to her organs, and she may also suffer mental trauma from post-ITU syndrome – this was in no way the 'easy' choice for her from a medical perspective. In contrast, both her psychiatrist and family thought that she would suffer severe mental harm from the physically 'safer' option of refeeding under restraint. Henke J ultimately took the decision on the basis of the likely infeasibility of refeeding under restraint, electing to avoid what would likely be delays in the start of refeeding which would have been occasioned if the NG-feeding under restraint had been tried without success.

Placing store on values

Manchester University NHS Foundation Trust v Mr Y & Ors [2023] EWCOP 51 (John McKendrick KC, sitting as a Tier 3 Judge)

Best interests – medical treatment

Summary

A 42-year-old man was found unresponsive, brought to A&E with multiple injuries, and had a seizure necessitating intensive care. There had been prior concerns that he was not taking his antipsychotic medication for paranoid schizophrenia and, after he stabilised and returned to the ward, he was detained under s.3 of the Mental Health Act 1983. A symptom of his mental health crisis was an inability to believe what his treating clinicians were telling him.

He required surgery to treat a fractured and dislocated left shoulder, which fell outside the scope of s.63 MHA 1983, and the relevant information for deciding the matter included:

(a) the nature and purpose of the sole treatment option for his shoulder injury;

(b) that there were risks to this treatment option;

(c) the likely outcome or success of the treatment option;

(d) the potential consequences if treatment was not provided.

He was experiencing psychotic delusional beliefs and thinking that resulted in him not believing the surgery was necessary to avoid future pain and the loss of function in his left arm. The evidence clearly demonstrated that he was unable to make the decision because of paranoid schizophrenia.

As to best interests, not having the surgery would

put his independence at risk for he lived alone and travelled alone to London to meet his family. Such independence was a value which he prized, and it was right that significant weight was given to that value. His brother, himself a consultant orthopaedic surgeon, supported the surgery, as did his father. John McKendrick KC went on to observe:

> *45. Lady Hale in Aintree focussed the court on the need to understand that "[t]he purpose of the best interests test is to consider matters from the patient's point of view." As she goes on to say, values can account for what is 'right' for the patient. Both values and present wishes can furnish the court with the patient's point of view. At times they may be in conflict. In an appropriate context, the patient's history may paint a picture of who they are through their lived values, more accurately than their present day wishes. That is not to discount their wishes. Each part of the picture must be considered to focus the court, as accurately as possible, on the point of view of the subject of the proceedings. In the context of a patient with recurrent severe psychiatric ill-health, their ordinary day-to-day existence may permit the court an Each part of the picture must be considered to focus the court, as accurately as possible, on the point of view of the subject of the proceedings. In the context of a patient with recurrent severe psychiatric ill-health, their ordinary day-to-day existence may permit the court an understanding of who they are and what they might want with greater clarity than their recorded wishes at the moment of crisis from a hospital bed. Giving effect to Mr Y's value of independence more effectively respects his dignity and promotes his autonomy than seeking to follow his currently expressed wishes and feelings. This underlines the importance of all parties seeking to provide the court with evidence as to who P is, as Mr Edwards helpfully sought to do.*

In conclusion, John McKendrick KC held that the surgery (including the potential need for sedative medication and restraint to administer general anaesthesia) was in the man's best interests.

Comment

What is particularly interesting about this decision is the role of values in the best interests analysis. The patient's present wishes and feelings opposed surgery, but the independence he valued so much favoured it. Reliably identifying someone's lived values, particularly in an acute situation like here, may not always be easy but consulting with family members (and significant others) often provides an insight into what they might be. For those wanting to think more deeply about values, and how to bring them fully before the court, we recommend this video from the Judging Values Project.

The need for an actual decision to be in prospect

GK & Anor v EE & Anor [2023] EWCOP 49 (MacDonaldJ)

Mental capacity – medical treatment

In this rather unusual application, MacDonald J considered the emotive subject of when parents – or indeed the courts – can intervene in the personal lives of adolescents: in this case, the life of a 17 year old, non-binary individual, EE, in conflict with their[2] parents.

The application was brought by EE's parents seeking injunctive relief in both the Court of

[2] MacDonald J used a variety of pronouns in describing P, EE, in this case. He recorded in his judgment, however, that EE was non-binary and used the pronouns they/them.

Protection and under the inherent jurisdiction of the High Court to prevent EE from having so-called "top" surgery (ie gender-affirming mastectomy) or taking testosterone treatment.

The application was unusual both because EE was almost 18 at the time of the application (and thus at the very limits of the powers of the Court exercising its Inherent Jurisdiction) but also – and most significantly – because there was no evidence that EE was in fact seeking any such surgery or hormone treatment. In fact, as MacDonald J spelled out towards the end of his judgment, *"EE has made clear, and I accept, that whilst they aspire to undergo gender affirming medical treatment, including top surgery, **there is no gender affirming medical treatment currently scheduled and nor will there be for some time**"* (paragraph 60, emphasis added).

The application was brought by EE's parents, unrepresented by the time of the final hearing, who sought orders (a) to prevent EE from having the treatment they alleged was sought, (b) for evidence from an expert psychologist and psychiatrist (unidentified at the time of the hearing) concerning EE's capacity to make decisions on gender-affirming treatment and (c) an order appointing the parents as EE's personal welfare deputies.

Underlying the application was the parents' challenged assertion that EE lacked capacity to make decisions on their treatment. The disconnect in the case presented by the parents concerning their child's past and current presentation and that presented by EE themselves and by the local authority is striking.

The parents, relying on a one-line report from their native (anonymised) country to which EE had been returned during various stages of childhood, maintained that EE suffered from a *"schizotypal personality disorder"* and/or schizophrenia and that their sexual preference (EE is reported to describe themselves as lesbian [67]) was newly announced and their purported wish to undergo treatment *"a form of self-harm"* (paragraph 33).

EE's evidence was that their parents had been aware of their sexuality since they were 11 years old but that they had stopped trying to convinced their parents about *"being a LGBT"* (paragraph 15) since they were 13 or 14. EE's evidence was that their parents were very hostile towards their sexuality and ascribed it to mental illness.

In contrast to the picture painted by the parents, the local authority, which, as of November 2022 was providing care for EE pursuant to s.20 Children Act 1989, described EE as *"a mature, independent teenager who can articulate their feelings and emotions positively"* (paragraph 22). The local authority informed the court that *"at no point have any professionals shared a concern for EE and her mental health"*.

It was in this context that the parents made an application under the inherent jurisdiction in June 2023, and in the Court of Protection by way of COP1 in July 2023, seeking an order *"preventing surgery or medical treatment in respect of gender reassignment / removal of breast in the interim"* (paragraph 57).

In response to these applications, as MacDonald J recorded at paragraph 5 of his judgment:

> *both EE and the local authority invite the court to conclude that, in circumstances where there is no gender affirming medical treatment scheduled, a decision with respect to EE's capacity to make decisions in that regard would be inappropriate where there is currently no "matter" for the purposes of s.2(1) of the Mental Capacity Act 2005 to be decided. In any event, both EE and the local authority submit that the evidence currently available in this case is plainly insufficient to rebut the presumption of*

> *capacity with respect to decisions concerning gender affirming medical treatment from which EE benefits pursuant to s.1(2) of the Mental Capacity Act 2005. In each of these circumstances, EE and the local authority contend it is not necessary for the court to have an expert report in the proceedings in the Court of Protection in order to determine the issue of capacity. Accordingly, both EE and the local authority invite the court to dismiss the proceedings in the Court of Protection. They further invite the court to dismiss the proceedings under the inherent jurisdiction.*

MacDonald J set out the law relating to capacity, following his earlier "masterclass" in capacity, *North Bristol NHS Trust v R* [2023] EWCOP 5, in terms of the assessment of capacity, from which the following (at paragraph 45) is of particular importance:

> *It follows that "in order to determine the question of capacity under Mental Capacity Act 2005 in accordance with the legal framework set out above, **there must first be before the court a correctly identified and formulated "matter" that falls for decision proximate in time to the point at which the court determines the question of capacity**. Absent this being the position, the court is unable to satisfy itself with respect to the remaining cardinal steps of the exercise of its jurisdiction under Part 1 of the 2005 Act as summarised in the previous paragraph. Namely, what is the information relevant to the decision, is the person unable to make a decision on the matter and, if the person unable to make a decision on the matter, is that inability caused by a disturbance in the functioning of their mind or brain* (emphasis added).

In terms of jurisdiction, MacDonald J set out that s.8 Family Law Reform Act 1969 taken with the House of Lords finding in *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 plus the Mental Capacity Act 2005 provided that:

1. (as set out by Sir James Munby in *NHS Trust v X [2021]* EWHC 65 (Fam), "*(1) Until the child reaches the age of 16 the relevant inquiry is as to whether the child is Gillick competent. (2) Once the child reaches the age of 16: (i) the issue of Gillick competence falls away, and (ii) the child is assumed to have legal capacity in accordance with section 8 [Family Law Reform Act 1969], unless (iii) the child is shown to lack mental capacity as defined in sections 2(1) and 3(1) of the Mental Capacity Act 2005*;"
2. Unless there is a rebuttal of the presumption of mental capacity under s.1(2) MCA 2005, whilst between the age of 16-18, P (or EE in this case) could consent to medical treatment (which would include hormone treatment or surgery if such treatment were available) under s.8 of the Family Law Reform Act;
3. Once over 18, EE could consent to treatment save in circumstances where the capacity to consent to treatment is rebutted.

MacDonald J noted that there was "*at present no cogent evidence demonstrating that EE is a young person who suffers from schizophrenia or a schizotypal personality disorder or is a young person who has issues with respect to their capacity generally*" (paragraph 67). His judgment makes clear however, that the court – whether the Court of Protection or the High Court exercising its inherent jurisdiction – had not even got to the point of having to reach conclusions as to EE's capacity to make decisions regarding gender affirming medical treatment in circumstances where there was no evidence that any such treatment was presently proposed or available. In those circumstances he held (at

paragraph 60) that:

> *I am satisfied that it is not possible in this case at present to identify the "matter" for the purposes of s.2(1) of the 2005 Act with any greater particularity than the formulation used in the parents' Annex B form, namely "surgery or medical treatment in respect of gender reassignment/ removal of breast." In my judgment, that formulation of the matter is not a sufficient basis on which to assess capacity having regard to the principles I have set out above. Further, and of equal importance, the absence of any scheduled gender affirming medical treatment necessarily means that the court would not be assessing EE's capacity in that regard sufficiently proximate in time to the decision falls to be made. For the court to make what, in effect, would be anticipatory declarations as to EE's capacity with respect to a broad category of medical treatment would run entirely contrary to the cardinal principles of the 2005 Act.*

Having reached such a conclusion, MacDonald J determined that any expert would be in entirely the same position of being unable to identify the "*matter*" on which he/she was being asked to assess EE's capacity and that any expert evidence would thus be "*unnecessary*" within the meaning of COPR 15.

Further, MacDonald J was:

> *68.* […] *satisfied in the foregoing context that it is not necessary for the purposes of Part 25 of the FPR 2010 to give permission for expert psychological and psychiatric evidence. In circumstances where the court's jurisdiction in respect of EE under the inherent jurisdiction comes to an end during September 2023, I am in any event satisfied that it would be wholly disproportionate to permit the instruction of an expert in the proceedings under the inherent jurisdiction. Having regard to the matters set out above, I further refuse to grant an injunction under the inherent jurisdiction preventing EE from undergoing gender affirming medical treatment.*

The parents' application was, unsurprisingly, dismissed.

Comment

The complex facts of this case (and the sad story they tell of family breakdown) notwithstanding, this is now a relatively well-trodden area of law.

The assessment of capacity draws back to first principles: the burden of proving a lack of capacity lies on those asserting the same; the court when assessing capacity must look at the actual decision which it is being said P is unable to make.

In circumstances where there *was in fact* no surgery or hormone treatment either in contemplation or actually available, the only conclusion that the court could draw was that there was simply no decision on which the court's assessment could "*bite*".

As to the reach of parental power, the courts have reviewed this at some length in recent years, both in *NHS Trust v X* [2021] EWHC 65 (Fam) to which MacDonald J referred, but also the Tavistock litigation, not just the Court of Appeal in *Tavistock v Bell* [2021] EWCA Civ 1363 but also the antecedent judgment of Lieven J in *AB v CD* [2021] EWHC 741 (Fam).

One point of no little interest whilst we wait for the final report of the Cass Review into gender identity services for children and young people is MacDonald J's confirmation that gender affirming medical treatment constitutes 'medical treatment' for purposes of the Family Law Reform Act 1969. Whilst on the face of this

might appear obvious, such is the controversy around these issues that it would not have been entirely surprising had the parents advanced the argument that such interventions did not constitute 'medical treatment' for purposes of the FLRA.

The interface in an hour

Those grappling with the MCA / MHA interface, in particular in the hospital setting, and wanting to think through the implications of recent cases in this area, might want to watch the recording of a recent webinar hosted by Bevan Brittan, featuring Hannah Taylor (Bevan Brittan) and Alex.

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Katie advises and represents clients in all things health related, from personal injury and clinical negligence, to community care, mental health and healthcare regulation. The main focus of her practice however is in the Court of Protection where she has a particular interest in the health and welfare of incapacitated adults. She is also a qualified mediator, mediating legal and community disputes. To view full CV click here.

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Simon has wide experience of private client work raising capacity issues, including *Day v Harris & Ors* [2013] 3 WLR 1560, centred on the question whether Sir Malcolm Arnold had given manuscripts of his compositions to his children when in a desperate state or later when he was a patient of the Court of Protection. He has also acted in many cases where deputies or attorneys have misused P's assets. To view 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

Members of the Court of Protection team regularly present at seminars and webinars arranged both by Chambers and by others.

Alex is also doing a regular series of 'shedinars,' including capacity fundamentals and 'in conversation with' those who can bring light to bear upon capacity in practice. They can be found on his website.

Adrian will be speaking at the World Congress of Adult Support and Care. This event will be held at the Faculty of Law of the University of Buenos Aires from August 27-30, 2024. For more details, see here.

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 February. 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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