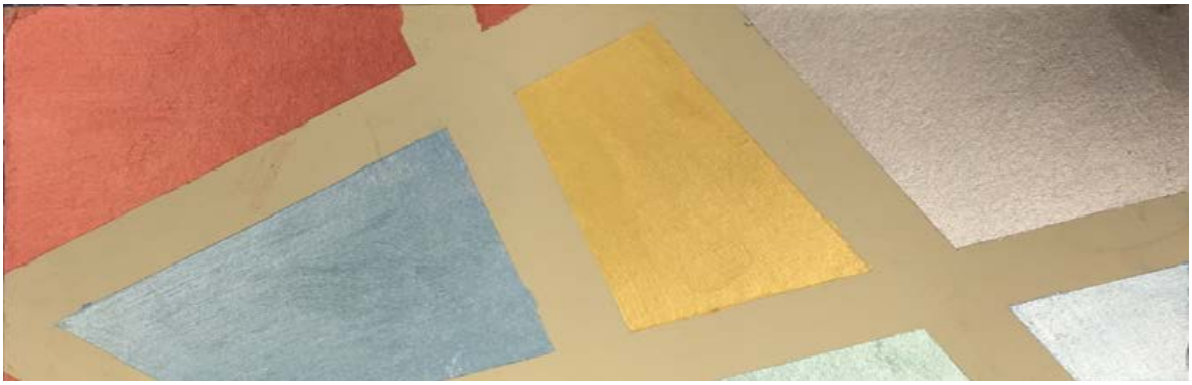

Welcome to the October 2024 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: what to do where there is no reliable evidence of P's wishes and feelings;

(2) In the Property and Affairs Report: gifts, attorneys and deputies;

(3) In the Practice and Procedure Report: the perfect as the enemy of the good, and what to do when the situation changes;

(4) In the Mental Health Matters Report: the human rights consequences of outsourcing in the mental health context;

(5) In the Wider Context Report: the Law Commission consults on disabled children's social care law and the Grand Chamber of the European Court of Human Rights balances Articles 2 and 8 in the medical treatment context ;

(6) In the Scotland Report: AWI legislative reform on the cards?

There is one plug this month, for a free digital trial of the newly relaunched Court of Protection Law Reports (now published by Butterworths. For a walkthrough of one of the reports, see here.

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.

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.

Contents

The perfect as the enemy of the good

Re PG [2024] EWCOP 49 (T3) (Cobb J)

Best interests – medical treatment

Summary

In this case, Cobb J was asked to determine the capacity and best interests of a woman as regards investigation and treatment of potentially serious conditions including different forms of cancer. The woman had a long-standing mental health condition, which was described as treatment-resistant. She may have been the subject of a serious sexual assault and /or rape, which professionals considered might account in part to her firm resistance to even mildly invasive obstetric and /or gynaecological examination. She was detained under the MHA 1983, but was on s.17 leave to a supported living placement which was described as being successful. Cobb J describes how in the context of unusual bleeding and other gynaecological symptoms:

> [t]*he clinically instinctive wish to investigate that pathology was met with a strong body of psychiatric opinion by those who know PG well that any investigation into the cause of the presenting symptoms was likely to cause PG significant and enduring distress, and substantially impact on her fragile mental health.*

However, and:

> *54. Regrettably, and for reasons which have not been entirely adequately explained, there was a significant delay in the issuing of these proceedings from the moment when investigations into possible cancer were first flagged in August 2023; this has been, at least potentially, to PG's detriment.*
>
> *55. It may well be that the delay in the making of the application has arisen from a lack of communication between the two Applicants; this was hinted at by Dr. H. It may be that it flowed from an understandable concern by the Applicants that it would be inappropriate to trouble the court with an inchoate application in the absence of an agreed "fully-worked up" care plan, in respect of the investigations. If so, I would wish to encourage these Applicants and/or any other applicant in such circumstances with such a case, to be less concerned about ensuring that every 'i' is dotted and every 't' crossed before making the application where speed of decision-making may be of the essence: perfect in this instance may well be the enemy of the good. Once it became apparent that NHS Guidance regarding the investigation and/or treatment of PG's condition could not be complied with timeously, and/or where it was clear that PG's treating/receiving clinicians could not agree upon a care plan to facilitate the investigations and/or treatment, the*

> *application could or should have been issued. The Court could then have ensured with the assistance of counsel and solicitors that evidence was filed from the necessary factual and expert witnesses to enable the detail of the care plan to be completed, and a decision to be reached promptly in respect of PG's best interests.*

When the application was brought, there was ample evidence that PG lacked the capacity either to conduct the litigation or to consent to medical treatment, in particular to the investigation and treatment of suspected gynaecological malignancy. The more difficult question was as to her best interests. Cobb J reminded himself of Baroness Hale's comments in Aintree as to the proper approach to best interests, in particular that:

> *37. It is a ""best interests" rather than a "substituted judgment" test, but one which accepts that the preferences of the person concerned are an important component in deciding where his best interests lie..." (Baroness Hale in Aintree (above) at [24]).*

And:

> *39. In this regard, it is appropriate that I should have regard to the quality of life which this patient (PG) would regard as worthwhile; it is clear from the Aintree case that the purpose of the best interests' test is to consider matters from the patient's point of view. As Baroness Hale went on to say in that case, it is not that the wishes of the patient will prevail (assuming that it is possible to determine what those views were and/or are), but insofar as it is possible to ascertain the patient's wishes, her beliefs and values, they should be taken into account in the best interests evaluation (see Aintree at [45]).*

Cobb J then asked himself a series of questions: (1) as to the optimal outcome; (2) what PG would want; (3) could she be assisted to cope with investigations and /or treatment; (4) is it in her best interests to be subject to investigation if she never be compliant with treatment; (5) to what extent, if at all, would the force, or restraint, or the administration of sedation, be in her best interests if this were to achieve investigation and /or treatment; (6) is it in her best interests to do nothing; and (7) what as to the wider picture? On the facts of the case before him, he concluded (and – by the end of the hearing – reflecting the agreed position of the parties) that:

> *59* […]
>
> *iii) It is not in PG's best interests to undergo any of the following investigations of her gynaecological symptoms, examination under general anaesthetic and biopsy, local MRI, CT scan of her whole body;*
>
> *iv) It is not in PG's best interests to undergo the following treatment of her gynaecological symptoms, either by way of surgery, radiotherapy, or chemotherapy;*
>
> *v) It is in PG's best interests to receive such palliative care as her clinicians considered to be in her best interests at the time.*
>
> *60. Based on Mr N's evidence, it appears that PG's demise could be imminent, that is to say, within weeks rather than months. The health and social care professionals looking after her, need to know how to manage all aspects of her demise, both physical and psychological. I shall therefore list this application for further hearing in a few weeks' time to consider the revised care plan which will have as its focus the palliative care arrangements for PG.*

Separately, Cobb J also made a community deprivation of liberty order "*so that PG's section 3 MHA 1983 order can be discharged, so that her bed in hospital can be released, and her placement can be maintained at York House*" (paragraph 61). In light of the delay noted above, Cobb J concluded his judgment by emphasising that:

> *57. The case nonetheless causes me to emphasise for future reference that where cancer is a suspected pathology in respect of a person who lacks or may lack capacity to make treatment decisions, the Hospital Trusts should not hesitate one moment before bringing the matter before the court. I hardly need to underline here that cancer which is diagnosed at an early stage, when it is not too large and has not spread, is more likely to be treated successfully; where investigation and/or treatment is in respect of someone who lacks capacity like PG, court approval should be urgently sought.*

In the instant case, however, Cobb J acknowledged that:

> *even if the case had been heard last year, PG's resistance to investigation and/or treatment, and the long-term outcome for her, would not have been different, or materially so.*

Comment

Procedurally, Cobb J was at pains to emphasise that the perfect can be the enemy of the good when it comes to making applications to court; that, equally, applies to clinicians asking for help from legal. There is nothing wrong, and indeed often much which is very right, with clinicians getting in touch with Trust legal as soon as it appears that there may be an issue which might require resolution. Of course, however, that depends on (1) recognition that there may be an issue; and (2) Trust legal (or external legal advisers) being available and resourced to be able to assist at speed.

Substantively, it is striking, that Cobb J was at pains to point out that the case, in fact, was much more clear-cut than it might have appeared at first blush. It therefore shows how often clarity in the process of decision-making can help strip away unnecessary complexity. Indeed, the careful set of questions Cobb J that set himself which would be equally relevant for any decision-making taking place outside court within the s.5 (and 6) MCA framework. Asking and answering those questions in a suitably rigorous fashion will, in many cases mean that, in fact, judicial endorsement of either treatment or non-treatment is required, given Lady Black's clear statement that "if *the provisions of the MCA 2005 are followed and the relevant guidance* [1] *observed, and if there is agreement upon what is in the best interests of the patient, the patient may be treated in accordance with that agreement without application to the court*" (NHS Trust v Y at paragraph 126).

Medicine is a Science of Uncertainty and an Art of Probability

Re NR (A Child: Ceilings of Treatment after Survival of Withdrawal of Life Sustaining Treatment) [2024] EWHC 2400 (Fam) (Family Division (Poole J)

Other proceedings – family (public law)

Summary[2]

[1] Which would include, in a case such as PG's, the relevant NHS guidance for treatment of the (suspected) gynaecological conditions in question.

[2] Note: Tor having been involved in the case, she has not contributed to this note.

In in this case, Poole J dealt with a quite extraordinary set of facts: an order authorising the withdrawal of life-sustaining ventilation which culminated, via circuitous routes and serendipity, to a child, previously confined to a critical care unit, living at home with his parents.

This case was the third in a series of cases concerning NR, a now four year-old boy, born with a severe brain malformation. In previous hearings in January and April 2024 – *Re NR (A child: Withholding CPR)* [2024] EWHC 61 (Fam); *NR (A child: Withdrawal of Life Sustaining Treatment)* [2024] EWHC 910 (Fam) – Poole J had made orders, first authorising ceilings of care including CPR and escalation of ventilatory support, neither of which were to be carried out in the event of a deterioration in NR's health; and subsequently, an order authorising withdrawal of life-sustaining treatment on the understanding that NR would die shortly thereafter.

Poole J had heard evidence at the April withdrawal of treatment hearing that there was "*no realistic prospect of NR being able to return home for care*" (paragraph 19); that extubation would be "one-way" (paragraph 39); and that there was no prospect of NR moving to fully enteral feeding. In light of this evidence, Poole J had concluded that the burdens of treatment far outweighed the benefits of keeping him alive and granted the Trust's application for invasive ventilation and life-sustaining treatment to be discontinued.

In the event, as Poole J explained in the September 2024 judgment:

> *2. Over four months after extubation, not only is NR still alive but he is now living at home. He is breathing for himself. He is fully enterally fed. He is urinating normally having previously had an indwelling urinary catheter. He has confounded all medical expectations and his case underlines the maxim that "medicine is a science of uncertainty and an art of probability." (Sir William Osler, 1849-1919).*

It was in this context that NR's parents, observant Christians who had never accepted the Trust's evidence as to their son's prospects of long-term survival, brought an application for the previous orders establishing ceilings of care and a withdrawal of life-sustaining treatment to be set aside. As Poole J records, in light of their son's unanticipated survival, NR's parents considered that their views about NR had been vindicated; they believed that the Trust "[did] *not truly value NR's life*" (paragraph 3).

Casting a more positive light on the wholly unexpected outcome, Poole J observed:

> *16/* A decision to withdraw life sustaining treatment *is not a decision to bring about the death of a patient, but a decision that the continuation of the treatment is not in their best interests. NR's survival and progress have shown that the withdrawal of invasive ventilation was indeed in his best interests. At the time, based on the prognoses provided to the Court, I decided that ventilation should cease despite, not because of, the strong expectation that NR would die soon afterwards. I do not wish to minimise the emotional turmoil suffered by Mr and Mrs R and the continuing burdens that NR suffers because of his conditions, but it seems to me to be a wonderful surprise that NR has confounded expectations, that he no longer requires continuing invasive interventions and, in particular, that he has been able to return home to the loving care of his devoted parents.*

Poole J noted with approval Tor Butler-Cole KC's submission on behalf of the Guardian at paragraph 25 that:

> *in a case such as this where NR's circumstances are not fully predictable and where the Trust accepts that new medical evidence at the relevant time may mean that any declaration granted is not in fact followed, the Court should exercise caution before making or continuing any declarations. Baroness Hale endorsed such caution in Aintree University Hospitals NHS Foundation Trust v James [2013] UKSC 67. In Portsmouth Hospitals NHS Trust v Wyatt [2005] 1 WLR 3995, the Court of Appeal said:*
>
> > *"117. We would, however, as a matter of practice counsel caution in making declarations involving seriously damaged or gravely ill children which are open-ended. In the same way that this court said in R (Burke) v General Medical Council (Official Solicitor intervening) [2005] 3 WLR 1132 that it is not the function of the court to be used as a general advice centre (see para 21 of this court's judgment), it is, in our view, not the function of the court to oversee the treatment plan for a gravely ill child. That function is for the doctors in consultation with the child's parents. Judges take decisions on the basis of particular factual substrata. The court's function is to make a particular decision on a particular issue.*
> > *118. As a general proposition, therefore, we have reservations about judges making open-ended declarations which they may have to revisit if circumstances change.""*

Having reviewed the evidence of NR's remarkable survival and heard of the significant change in his circumstances – which included both a family life at home and visits to the park – both the declaration permitting the withholding of CPR and the declarations regarding ceilings of treatment were discharged.

Poole J's conclusion at paragraph 35 is likely to be cited with great frequency by family members opposing withdrawal of treatment going forward:

> *This case does not establish that the Court cannot rely on medical evidence as to the prognosis for a critically ill patient. It does show that medicine is a science of uncertainty. The Court has to deal with medical predictions and probabilities and such evidence is very valuable. A prediction should not be disregarded simply because it may prove to be wrong. However, confident predictions are sometimes confounded and the Court must be vigilant and humble in the face of apparent certainty.*

Comment

We would expect – indeed, hope, given the profound distress experienced by NR's family – that the facts of this case would remain rather extraordinary. [3] It remains, however, a useful reminder of the importance for decision-makers in re-examining and revisiting decisions in the context of a changing evidential background. The old adage, "when the facts change, I change my mind" applies: decisions made in the best interests of a child – or P – are not necessarily set in stone. This case reiterates the importance for decision-makers of keeping an open mind in an area of medicine and law which is always evolving.

Short note: excluding observers

In *Stockport MBC v NN & Anor* [2024] EWCOP 51 (T1), District Judge Matharu served a useful reminder that, whilst open justice is enormously

[3] Some might also think that they serve as a useful reminder of the limits of prognostication relevant to debates about assisted dying.

important, it must take account of P's wishes. As she identified when responding to a request for an observer to attend a remote hearing:

> *10. These decisions require a balance between the need for open justice and the interests of the protected party not being adversely impacted in any way. I am told that merely knowing that the observer had asked for permission to join the hearing caused her to be very anxious and it was submitted that involvement in the hearing was likely to cause her distress. I am told that her behaviours became "heightened".*

Hearing this, "*the public observer, having heard all of this, graciously said that she was willing to leave the hearing as she did not want to cause NN distress*." As District Judge Matharu noted:

> *14. The mere fact of being a protected party does not automatically mean that the hearing is to be private; however, this protected party is at risk of not being able to participate fully in a "private" environment where she has fully participated in earlier remote hearings where there was no observer. Her voice should be heard when she has made it clear she does not want an observer to be involved in her hearing.*

This also provides us with an opportunity to highlight (in advance of a fuller review on Alex's website), the recent publication of *A Practical Guide to Privacy, Transparency, Reporting Restrictions and Closed Hearings in the Court of Protection* (Law Brief Publishing, 2024). This short book by Laura Mannering does precisely what it says on the tin, and will be very useful for those having to navigate these provisions.

Short note: contempt before the court

KL v Manchester City Council & Anor [2024] EWCOP 54 (T1) provides a useful worked example of sentencing for contempt (in the absence of the defendant), following the refusal by the defendant to comply with a Court of Protection order requiring him to vacate a property belonging to P and not come within 200 metres of it.

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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 European Law Institute Annual Conference in Dublin (10 October, details here).

Peter Edwards Law have announced their autumn online courses, including, Becoming a Mental Health Act Administrator – The Basics; Introduction to the Mental Health Act, Code and Tribunals; Introduction – MCA and Deprivation of Liberty; Introduction to using Court of Protection including s. 21A Appeals; Masterclass for Mental Health Act Administrators; Mental Health Act Masterclass; and Court of Protection / MCA Masterclass. For more details and to book, 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 November. 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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