MENTAL CAPACITY REPORT: THE WIDER CONTEXT

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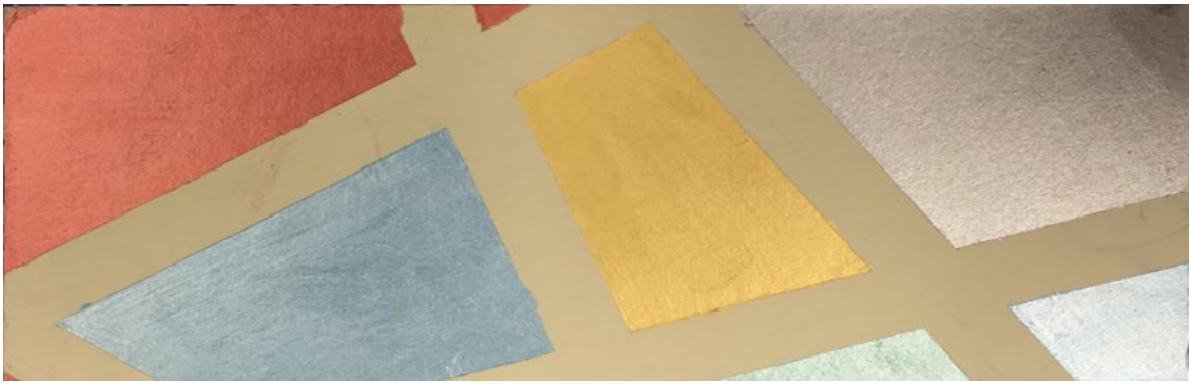

Welcome to the February 2022 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: religion and the burdens of treatment; vaccine case law update; and making the decisions the person would have made;

(2) In the Property and Affairs Report: the scope of the powers under an LPA, and updated safeguarding guidance from the OPG;

(3) In the Practice and Procedure Report: vulnerable parties and witnesses, and covert recordings;

(4) In the Wider Context Report: blood transfusions for teenage Jehovah's Witnesses, s.117 ordinary residence and a new capacity guidance website;

(5) In the Scotland Report: DNACPRs and the relationship between medical decision-making and guardians' decision, cross-border deprivations of liberty of children and guardians' remuneration.

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 man with autism. We are very grateful to him and his family for permission to use his artwork.

Contents

As part of the Mental Health & Justice project, a new website has been launched with guidelines for clinicians and social workers in England & Wales (but also of interest to others, such as lawyers) who are assessing capacity. A short walkthrough of the website is here.

Using the inherent jurisdiction to make medical treatment decisions for young people with capacity

E & F (Minors: Blood Transfusion) [2021] EWCA Civ 1888 (Sir Andrew McFarlane P, Davies LJ, Peter Jackson LJ)[1]

Summary

In *E & F (Minors: Blood Transfusions),* the Court of Appeal considered appeals brought by two young people, both Jehovah's Witnesses who conscientiously reject blood transfusions. They appealed orders in which it was declared that, although they were able to decide whether to consent to or refuse a blood transfusion, it would nevertheless be lawful for their doctors to administer blood in the course of an operation if that become necessary to prevent serious injury or death. Given that no crisis arose in either case, the declarations made at first instance never formally came into effect.

The key question for the court was how the State, acting through the court, should exercise its power to overrule the capacitous decision of a young person aged 16 or 17.

In the case of E, 16, she was diagnosed with acute appendicitis and needed urgent surgery, which would involve diagnostic laparoscopy (a low-risk examination procedure), followed by a laparoscopic appendectomy (removal of the appendix by keyhole surgery), but if that was not possible, by an appendectomy by open procedure. There was a risk, albeit very small, of severe surgical bleeding intraoperatively and there was therefore the possibility that a blood transfusion would be needed without which there was a *'very theoretical possibility"* of E bleeding to death. E provided her written consent to the surgery but wrote that she did not consent to blood transfusions.

The hospital trust filed an urgent application in the High Court, which was heard the same day by Theis J. The treating consultant anaesthetist (Dr A) provided a written statement. E and her father attended the hearing. Cafcass Legal also attended through a solicitor and Cafcass officer. After hearing evidence, Theis J gave a brief judgment in which she recognised E's wishes,

[1] Tor and Arianna having been involved in the case, they have not contributed to this note.

expressed not only by herself but with the assistance of her parents and Guardian, as well as her age and level of understanding. She weighed against that the medical evidence that the procedure needed to be undertaken otherwise there was a risk of rupture with consequent risks of infection and sepsis, ultimately making an order authorising the use of blood products in certain circumstances.

In the second case, F, 17, had lost control of his motorcycle on a bend. He was admitted to hospital and diagnosed with a grade 3 laceration involving a quarter to a third of his spleen. With this kind of injury, there can be primary or secondary bleeding. Primary bleeding happens at or shortly after the time of the injury; whilst secondary bleeding may occur later, as a result of a clot loosening that can then lead to catastrophic bleeding.

An application was filed at court for an order declaring that it was lawful and in his best interests for the doctors to provide blood and blood products in the event of an emergency arising from his injury. The trust initially sought an order for 100 days, but reduced it to 21. Judd J heard from two medical witnesses, as well as F and his parents. She determined that she needed to give very great weight to F's views, given his age (17 and a half), understanding and competence, but that they still form part of the best interest analysis. She decided to make the declaration sought by the Trust.

The central argument made in the appeals was that there is a strong presumption in favour of a young person's capacitous decision and that decision should only be rebutted where, on the balance of probabilities, the decision would cause serious harm or death. It was wrong for the courts to intervene in these cases, because the risks were remote and the young persons' decisions were *"reasonable and safe ones"* (paragraph 38(4)).

In his judgment for the Court, Sir Andrew McFarlane (President) observed that the inherent jurisdiction is available in all cases concerning persons under the age of 18 and *"that has always been so and any change must be a matter for Parliament."* (paragraph 44) The court wrote at paragraph 45:

> *When the court is being asked to exercise its inherent jurisdiction, there are in our view three stages. The first is to establish the facts. The second is to decide whether it is necessary to intervene. If it is, the final and decisive stage is the welfare assessment.*

In relation to the first stage, the court's central concern is to identify the risk in question. *"'[R]isk' can be used to mean the risk of an event occurring (its probability) or the risk from the event occurring (its consequences)"* (paragraph 46). That distinction must be kept *'in mind when making and interpreting statements about risk.'* (paragraph 46)

The next question is whether immediate action is necessary or whether the decision can be postponed. It ultimately depends on the facts and how realistic it is to expect a fair and timely decision if a crisis arises.

Finally, there is the welfare assessment. The authorities require that the assessment is undertaken from the individual's point of view and the court seeks to identify his or her best interests in the widest sense. That analysis does not, however, take place in a vacuum. The Court observed that (para 50):

> *The law reflects human nature in attaching the greatest value to the preservation of life, but the quality of life as experienced by the individual must also be taken into account. The views of the parents of a baby or young child are always matters of great importance. Likewise, our common experience leads us to pay increasing regard to the views of children and young*

> *people as they grow older and more mature.*

When undertaking such assessments in medical treatment cases for competent young people, it involves the *"balancing of two transcendent factors: the preservation of life and personal autonomy"* (para 53). The leading decision is *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64. There is no presumption in favour of the mature adolescent's decision, contrary to the appellants' submission; rather, welfare is the overriding principle. The court must act upon an objective assessment of the young person's best interests, even if this conflicts with their sincere and considered views (para 73).

The court accordingly dismissed the appeals.

Comment

The judgment provides extremely helpful guidance as to how the court should approach these applications, and therefore how practitioners should draft them, in terms of (i) the three stages and (ii) the central task of weighing the two transcendent factors identified above. An undifferentiated list of factors does not help, particularly if that list is extracted from a case concerning a small baby with a brain injury rather than concerning a capacitous child approaching adulthood (para 71). A court should therefore focus on *Re W* and this decision (para 71).

Another important point is that, whilst recognising the pressure under which urgent orders are drafted, the court emphasised the importance of ensuring they accurately reflect the court's decision.

Finally, the Court noted that the first court order in F's case contained a recital to the effect that "*if a declaration was not made the clinicians would be able to treat him "using their emergency powers in the event of an emergency overnight*"". (paragraph 23) Whilst not expressing a concluded view, the Court made the following *obiter* comments (para 24):

> *Doctors undoubtedly have a power, and may have a duty, to act in an emergency to save life or prevent serious harm where a patient lacks capacity or cannot express a view, for example because of unconsciousness. However, we very much doubt that such a power exists in respect of treatment that has been foreseen and refused by a capacitous patient. It is doubtful whether such circumstances can properly be described as an emergency.*

Practitioners therefore need to be extremely cautious in to relying upon clinician's "emergency powers" in the absence of a court order.

S.117 MHA Ordinary Residence: the *Worcestershire* saga continues

R (On the Application Of) Worcestershire County Council v Secretary of State for Health and Social Care [2021] EWCA Civ 1957 (Court of Appeal (Coulson LJ, Carr LJ and William Davis LJ))

Summary

The Court of Appeal considered the appeal of Worcestershire County Council to the judgment of Linden J in [2021] EWHC 682 (Admin) (and summarised in our May 2021 Wider Context newsletter). JG was originally from Worcestershire and was detained under s.3 of the Mental Health Act 1983 with treatment resistant schizoaffective disorder. She was discharged and placed in residential care in Swindon, closer to her daughter. At that point, there was no dispute that Worcestershire was responsible for her MHA s.117 after-care services as she had been ordinarily resident there immediately before being first detained.

Almost a year later, she was re-detained under MHA s.2 and then s.3. Around two months into

this hospital confinement, Worcestershire issued notice to terminate the residential care placement. Around three months later she became a voluntary patient for another 15 months before finally being discharged from hospital.

The issue was whether Worcestershire or Swindon was subsequently responsible for her after-care. At first instance, Linden J held it was Swindon because that was where she had become ordinarily residing immediately before being re-detained.

But the Court of Appeal overturned that decision, holding that Worcestershire remained responsible. The main reason was because the after-care duty continues "*until such time as the clinical commissioning group or Local Health Board and the local social services authority are satisfied that the person concerned is no longer in need of such services*". No such decision had been made. In particular, the termination notice did not reflect such a decision. Moreover, the duty did not automatically end by operation of law when JG was re-detained. Such an approach would run counter to the continuity of care. As Coulson LJ observed:

> *55. There are other practical difficulties with the judge's solution. Indeed, the whole notion of an automatic change in the identity of the authority with the duty to provide after-care services, triggered by law rather than by a decision made by those actually involved in the care of the service user, seems to me to be unrealistic. It would be woefully uncertain. How would that change come about? How would it be effected? How would it be communicated? Who is responsible for identifying that it had happened? There were no answers to these questions.*
>
> *56. In addition, from a purely common sense perspective, the judge's conclusion seems to me to be a most unsatisfactory outcome. Someone like JG is particularly vulnerable. When/if she is detained, everyone must be trying to work to a plan which sees her release from detention as soon as possible. All through the period of her detention, there would be extensive planning by the responsible authority which, on the judge's findings in this case, was Worcestershire. It would be curious to find that, at the very moment those plans come to fruition, and JG is released, Worcestershire suddenly became irrelevant, and a new duty was owed by a new local authority. That would not make for continuity of care, and would be very unsatisfactory for the service user. Unless I was compelled to conclude that was the effect of s.117, I would be very reluctant to reach a decision on that basis.*
>
> *57. For the reasons that I have given, I do not need to reach such a decision. S.117 is clear. The duty subsists until it comes to an end by the communication of a decision by Worcestershire pursuant to s.117(2). There has been no such decision. The duty therefore continued throughout both the second period of detention and beyond."*

The Court of Appeal also confirmed that, unlike the Care Act 2014, there are no deeming provisions in the MHA 1983 (see paragraphs 74-75), except where the accommodation itself provided to meet an after-care need under s.117.

Comment

DHSC has confirmed that Worcestershire County Council has lodged an application for leave to appeal in the Supreme Court. In the meantime, the Secretary of State has confirmed

that after-care disputes will continued to be stayed until we have the final word.

This is a significant decision which impacts upon local authority funding arrangements for after-care services. The first instance decision reflected the conventional legal view (and the Secretary of State's guidance) that, where a person receiving after-care services became ordinarily resident in another local authority area, it was that local authority that would take over s.117 responsibility if the person was re-detained under MHA s.3. Such an approach ensured that those responsible for meeting a person's after-care needs remained local to where they were residing immediately before their hospital admission.

The Court of Appeal's decision changes that approach. It means that the first local authority will continue to remain responsible unless and until a joint decision is made by that local authority and the responsible CCG/LHB that the person is no longer in need of any after-care services. Although re-detention does not automatically terminate the s.117 duty, it seems clear from the judgment that, had a joint decision been taken that JG was no longer in need once she had been re-detention under MHA s.3, the outcome would have been different. As a result, the focus is now likely to move to the circumstances in which after-care bodies can lawfully decide that a person no longer has after-care needs when they are now receiving inpatient hospital care.

There are likely to be a significant number of after-care funding arrangements which will be affected by this judgment. The Swindons of this after-care world that had been paying for s.117 will now want to seek recoupment from the Worcestershires. Many civil debt claims are no doubt being prepared by eager local authority lawyers.

Where is the CCG dispute, you might wonder? Well, by virtue of s.14Z7 of the NHS Act 2006, NHS England has set out rules on payment responsibility which are binding on CCGs. As detailed in section 18 of the 2020 Who Pays? Guidance, such rules very much mirror the Court of Appeal's approach, namely that the "originating CCG" that was first responsible for s.117 retains responsibility until such time as the person is discharged from s.117 after-care. This is the case regardless of where they are treated or placed, and regardless of where they live or which GP practice they are registered with. Further guidance and helpful scenarios are provided therein for those wishing to find out more. In the meanwhile, the cardinal principle is that patients must not be disadvantaged by funding disputes.

Book review: *The Assisted Decision-Making (Capacity) Act 2015: Personal and Professional Reflections*

This month we highlight a recent (free) book on the Irish Assisted Decision-Making (Capacity) Act 2015 ('the 2015 Act') produced by the Irish National Office for Human Rights and Equality Policy with the School of Law at the University of Cork and the Decision Support Service. The book contains a series of essays entitled *The Assisted Decision-Making (Capacity) Act 2015: Personal and Professional Reflections*.

The 2015 Act was enacted in the Republic of Ireland to replace 19th century legislation relating to mental capacity. It intends to provide a framework for the lawful deprivation of liberty for the purposes of providing care and treatment for those who require assistance in exercising their decision-making capacity.
The book covers the main reforms introduced under the 2015 Act, which are summarised in the foreword to the book as including the following:

- *a statutory definition of capacity based on a functional, time-specific and issue-specific assessment;*

- *a regulated three-tier framework for decision-making;*
- *detailed guiding principles, including a statutory presumption of capacity and the replacement of a 'best interests' standard with the requirement to give effect to a person's will and preferences;*
- *enhanced tools for advance planning by way of enduring powers of attorney and advance healthcare directives;*
- *the establishment of the Decision Support Service within the Mental Health Commission, with numerous functions to promote and regulate the new framework.*

One of the much-discussed themes of the book is the adoption of lessons from other jurisdictions within the 2015 Act, following a 150-year period without reform of the system. This is best reflected in the Act's emphasis on enabling persons, so far as is possible, to exercise their decision-making *autonomy* rather than focusing on *capacity*. The book contains much discussion of this 'paradigm shift' from the recognition of all persons as rights-holders, who are entitled to be at the centre of decisions that affect them; with much reference made to the role of the United Nations Convention on the Rights of Persons with Disabilities (CRPD). The book also identifies limitations with the act: its complexity, dense wording, and that it is incomplete – a 2021 amending bill is still in progress.

A video of the launch event, including Ms Aine Flynn, Director of the Decision Support Service, Professor Mary Donnelly, School of Law, UCC, Ms Caoimhe Gleeson, Programme Manager, National Office for Human Rights and Equality Policy is available 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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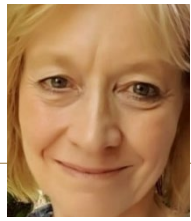
Adrian is a recognised national and international expert in adult incapacity law. He has been continuously involved in law reform processes. His books include the current standard Scottish texts on the subject. His awards include an MBE for services to the mentally handicapped in Scotland; honorary membership 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 are regularly presenting at webinars arranged both by Chambers and by others.

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 March. 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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