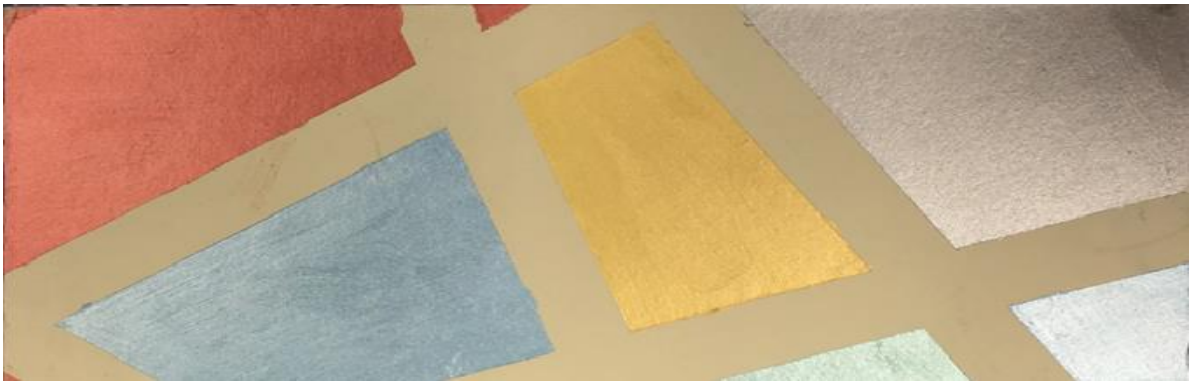
MENTAL CAPACITY REPORT:
HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

May 2018 | Issue 85



Welcome to the May 2018 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: CANH withdrawal on the papers and DOLs statistics;

(2) In the Property and Affairs Report: variation of trusts and the Court of Protection, and Charles J's last hurrah;

(3) In the Practice and Procedure Report: a new President for the Court of Protection and a regionalization update;

(4) In the Wider Context Report: the interim report of the independent MHA review, capacity and housing, covert medication and capacity in the MHT context, and a guest article on autonomy and mental capacity;

(5) In the Scotland Report: an appreciation of the Public Guardian and an update on the AWI consultation;

You can find all our past issues, our case summaries, and more on our dedicated sub-site here.

Editors
Alex Ruck Keene
Victoria Butler-Cole
Neil Allen
Annabel Lee
Nicola Kohn
Katie Scott
Simon Edwards (P&A)

Scottish Contributors
Adrian Ward
Jill Stavert

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

CANH withdrawal and the Court of Protection: further developments

NHS Windsor and Maidenhead Clinical Commissioning Group v SP (by her litigation friend, the Official Solicitor) [2018] EWCOP 11 (Williams J)

Medical treatment – treatment withdrawal

Summary[1]

SP was 50 years old when she suffered a cardiac arrest in October 2014. She was admitted to hospital, treated with clinically assisted nutrition and hydration (CANH) and never regained consciousness. In March 2015, she was transferred to the care of a nursing home and, in April 2015, she was diagnosed as being in a permanent vegetative state (PVS).

Two best interests meeting were held in March 2015 and October 2016 which concluded that it was in SP's best interests to withdraw CANH and provide palliative care only. Although it was very difficult for some of them, all of SP's family agreed that SP would not have wished to live in this condition and that it was in her best interests to with CANH.

In October 2016, the CCG approached the OS to invite him to consider a streamlined application to the court. The OS agreed to act for SP in January 2017 and investigate her case. The OS instructed an expert, Dr Hanrahan, and consulted SP's family. Dr Hanrahan reported on 17 July 2017 and 20 November 2017. Dr Hanrahan confirmed much that the earlier doctors had concluded, namely that SP was in a PVS and that further CANH was not in SP's best interests.

On 15-16 February 2018, the OS confirmed that he and the family were content for the application to the COP to be made on the papers. The proceedings were issued on 19 March 2018. The Court was invited to determine the application without a hearing but with the provision of a public judgment.

After setting out the legal framework and case law, Williams J held (at paragraph 35) that the following factors were most relevant in deciding that it was not in SP's best interests to continue receiving CANH:

> *i) The medical evidence is clear that SP is in a permanent vegetative state with no prospect of improvement. She will never regain capacity and cannot participate in decision making.*

[1] Tor being involved in the case, she did not contribute to this note.

ii) The medical benefits of CANH are limited to simply keeping her body alive. The person that was SP in so far as a person is their personality no longer exists and can never return. CANH cannot help SP to regain consciousness or to resume any part of the life she led. She derives no benefit from living save insofar as being alive in itself (albeit with no awareness of being alive) is a benefit.
iii) Palliative care will reduce to a minimum any experience that SP might have of discomfort or pain as a result of CANH being withdrawn.

iv) The evidence of her family and the nursing staff from their observations of SP is that there has been no improvement in her condition over the years and that her symptoms are consistent with her having no awareness of her surroundings. This is the experience of her closest family including her children; if she was likely to be aware of anyone it would be her children.

v) No one is motivated by a desire to bring about SP's death but rather that it is not in her best interests to live like this.

vi) SP had expressed the view to her son whilst watching a programme about a person in a PVS that she would rather die than stay in a bed for years in that condition. SP had expressed the view that if someone close to her was ill like her father had been she would turn off the life support and not leave them in that state. I accept that she had expressed a wish not to live in the sort of situation she is now in.

vii) SP's actions in life in particular in relation to her approach to her father's terminal illness support the contention that she would prefer the withdrawal of life-sustaining but futile treatment and a move to palliative care only. I accept that her beliefs and values are such that they would influence her to want to have CANH withdrawn,

viii) Her family and friends (those interested in her welfare) are unanimously of the view that having regard to her personality and how she was before the cardiac arrest that she would not want to live as she is now and that it is in her best interests for CANH to be withdrawn and palliative care implemented. The doctors and nursing staff involved in her care are of the view that this course is in her best interests.

ix) The contrast between the full life SP led before the cardiac arrest and her existence now could not be more divergent. For a woman who loved life and lived it to the fullest she would find her current situation intolerable. Not only for her own sake but I believe also to relieve the suffering that her family endure from seeing her in this condition she would want to adopt a course which would end her and their suffering. She would not want to be a burden and would want her family to be able to move on with their lives and remember her as she was. In this case that means ending CANH and entering a palliative care programme.

x) She would want before leaving this life to be satisfied that her minor children were properly provided for and that nothing further could be done in her name to provide for them and their future. I accept that the family believe what has been done would meet with her approval. I also am satisfied she would endorse

those arrangements and accept that there was no more she could do.

xi) The withdrawal of CANH has been planned and will be implemented by the nursing team with input from a hospice nurse. Her family understand what it involves and the timescales. They would have preferred for it to occur in February.

Comment

This case is significant as being the first in which the withdrawal of CANH has been authorised by the court 'on the papers' without a hearing. Whilst the collaborative approach between all parties (the Trust, the family and the OS) is to be commended, the length of time between the best interests meeting on 7 October 2016, at which it was decided that it was in SP's best interests to withdraw CANH, and the eventual decision of the court on 20 April 2018 is striking. Most of that time appears to have been devoted to investigating the circumstances of SP's case and obtaining an expert report by the OS which confirmed the conclusions of two other clinicians. After the investigations had taken place, the application was issued in March 2018 and dealt with by the court within one month. If, following *Re Y* [2017] EWHC 2866 (QB) and the outstanding appeal to the Supreme Court, it is correct that there is no requirement to come to court where P's family and the clinicians are in agreement that it is in P's best interests for CANH to be withdrawn, then this appears to be a case in which treatment could have been withdrawn from SP following the best interests meeting in October 2016 (some 18 months earlier). The move towards a streamlined approach by making an application on the papers where all parties are in agreement is both sensible and pragmatic, but it may be that such applications are not necessary at all in the future. The judgment of the Supreme Court in *Re Y* is awaited with interest.

Court of Protection statistics

The most recent Court of Protection statistics have now been published, covering the period October to December 2017, and accompanied by the first time by a .csv file containing the number of Deprivation of Liberty applications by Local Authority, although, as the file does not break down what sort of applications they were, it is of limited assistance only.

There were 3,995 applications relating to deprivation of liberty made in 2017, up 27% on 2016. There were 1,030 Deprivation of Liberty applications in October to December 2017, up 9% on the same period of 2016. Of these, 557 were *Re X* applications, 318 s.21A applications and 155 were applications for orders under s.16 MCA 2005. For comparison, the figures for the third quarter of 2017 were 630 for *Re X* orders, 306 s.21 applications and 141 applications for s.16 orders. Deprivation of liberty orders made also rose over the same period by 81%.

Children, consent, and confinement

Whilst we wait for the Supreme Court to determine the Official Solicitor's application for permission to appeal the decision of the Court of Appeal in *Re D* [2017] EWCA Civ 1695, cases continue to come thick and fast in relation to the deprivation of liberty of those under 18. In *Buckinghamshire CC v RT (by his Guardian KT)* [2018] EWCOP 12, Williams J made orders under the MCA authorising the deprivation of liberty of a young man of 17 ½. RT presented with high anxiety and when anxious, extremely impulsive

and acting in extremes. He had absconded twice from the placement where was living, he had tied ligatures round his neck and tried to run in front of a moving bus; he also remained fixated on women, especially younger women.

Williams J was clear that the confinement to which he was subject (2:1 support at the placement, and 1:1 at night, with a further 2 members of staff to assist if required):

> [38] *is far in excess of that which might be applied to even the most unruly 17-year-old in a domestic setting. It clearly amounts to continuous supervision and control. Given RT does not have capacity there is a lack of a valid consent. The deprivation of liberty is attributable to the state.*

Williams J considered that it was:

> [35] *clear that RT may injure himself if not subject to the most stringent levels of supervision. He has demonstrated impulsive behaviour of the most extreme kind which has put his life at risk. It is also clear that RT can behave towards others in a highly aggressive and threatening way which puts him at risk of retaliation by third parties who do not know him. It also puts him at risk of being subject to criminal proceedings. There are particular risks relating to his communications with others through his mobile phone. There will need to some limitations on this. I am well aware that this is a bone of contention for almost every parent of a teenager and in that sense authorising restrictions of this sort are no more than many parents might impose but for RT the limits may need to go further.*
>
> [37]. *I take account of the views of the local authority and of his mother who both believe the deprivation of liberty is in his best interests.*

Williams J therefore authorised the deprivation of his liberty as being in RT's best interests.

An oddity of the case is that Williams J does not seem to have his attention directed to the decision of the Court of Appeal in *D*, as he did not seek to examine whether RT's adoptive mother was capable (in law) of giving consent to the arrangements to as to prevent them being a deprivation of RT's liberty up to the point of his 18th birthday.

On one view, the arrangements for RT were materially identical to those the Court of Appeal appear to have considered in *D* to have been "*within ordinary acceptable parental restrictions upon the movements of a child.*"[2] Why, then, could not his adoptive mother consent on his behalf until his 18th birthday? Whilst foster parents appear to be outside the scope of those who can give consent on the approach of the Court of Appeal in *D*, does the same restriction apply to a situation where the person has been adopted (by a mother described as "clearly devoted" to him at para 28 of the judgment)?[3]

The other view is that this is a decision which applies conventional *Storck* principles as explained by Lord Kerr in *Cheshire West* – i.e. one asks whether the arrangements go beyond those societally acceptable for a child of that of

[2] See *D* at 85(iii).

[3] Lord Neuberger in *Cheshire West* would appear to have thought there was a distinction – see paragraph 72.

"*age and relative maturity who are free from disability*" (paragraph 79); if they are, then either one needs the consent of the person themselves or one has a deprivation of liberty.

We will hopefully see in due course the knots in this area revisited – and untied – by the Supreme Court.

In the meantime, consent was under the microscope in the two linked cases of *A Local Authority v SW & Ors* [2018] EWHC 576 (Fam) and *Local Authority v SW & Ors* [2018] EWHC 816 (Fam), Mostyn J was asked to make orders under the inherent jurisdiction authorising the deprivation of liberty of a young person in a placement akin to a s.25 Children Act 1989 secure accommodation order. In the first case, the question arose whether the second limb of the Strasbourg test for deprivation of liberty had to be satisfied for the court to make an order, namely that there was a lack of valid consent on the part of the child. The court concluded that this subjective element did apply, as in other cases engaging Article 5, such that the order could only be made if the child was not validly consenting, even though when the court makes a secure accommodation order, the consent of the child may be present.

Mostyn J also considered the case of *A Local Authority v D* [2016] EWHC 3473 (Fam), in which a 15 year old was found to be validly consenting to his confinement. Mostyn J expressed the view that what this authority shows, is that valid consent must be both (i) authentic – the child must say it and mean it – and (ii) enduring rather than evanescent.

On the facts of the case, there was no such consent, and the order was made in January 2018. By the time of the second judgment in March 2018, two things had happened – the placement had broken down due to the young person's conduct, and the permission to appeal the first judgment had been granted by the Court of Appeal. (Readers may recall that permission had previously been granted in respect of the Re *D* decision, relied on by Mostyn J, but that appeal did not proceed for reasons not relevant to these issues). Mostyn J made a new order in respect of the young person's new placement, and noted that would no doubt also be appealed, so it seems that in the near future, the Court of Appeal will finally grapple with the question of what counts as valid consent in the Article 5(1)(d) context.

Editors and Contributors

Alex Ruck Keene: alex.ruckkeene@39essex.com

Alex is recommended as a 'star junior' in Chambers & Partners for his Court of Protection work. He has been in cases involving the MCA 2005 at all levels up to and including the Supreme Court. He also writes extensively, has numerous academic affiliations, including as Wellcome Research Fellow at King's College London, and created the website www.mentalcapacitylawandpolicy.org.uk. To view full CV click here.

Victoria Butler-Cole: vb@39essex.com

Victoria regularly appears in the Court of Protection, instructed by the Official Solicitor, family members, and statutory bodies, in welfare, financial and medical cases. Together with Alex, she co-edits the Court of Protection Law Reports for Jordans. She is a contributing editor to Clayton and Tomlinson 'The Law of Human Rights', a contributor to 'Assessment of Mental Capacity' (Law Society/BMA 2009), and a contributor to Heywood and Massey Court of Protection Practice (Sweet and Maxwell). To view full CV click here.

Neil Allen: neil.allen@39essex.com

Neil has particular interests in human rights, mental health and incapacity law and mainly practises in the Court of Protection. Also a lecturer at Manchester University, he teaches students in these fields, trains health, social care and legal professionals, and regularly publishes in academic books and journals. Neil is the Deputy Director of the University's Legal Advice Centre and a Trustee for a mental health charity. To view full CV click here.

Annabel Lee: annabel.lee@39essex.com

Annabel has experience in a wide range of issues before the Court of Protection, including medical treatment, deprivation of liberty, residence, care contact, welfare, property and financial affairs, and has particular expertise in complex cross-border jurisdiction matters. She is a contributing editor to 'Court of Protection Practice' and an editor of the Court of Protection Law Reports. She sits on the London Committee of the Court of Protection Practitioners Association. To view full CV click here.

Nicola Kohn: nicola.kohn@39essex.com

Nicola appears regularly in the Court of Protection in health and welfare matters. She is frequently instructed by the Official Solicitor as well as by local authorities, CCGs and care homes. She is a contributor to the 4th edition of the *Assessment of Mental Capacity: A Practical Guide for Doctors and Lawyers* (BMA/Law Society 2015). To view full CV click here.

Editors and Contributors

Katie Scott: katie.scott@39essex.com

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, and is chair of the London Group of the Court of Protection Practitioners Association. To view full CV click here.

Simon Edwards: simon.edwards@39essex.com

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.

Adrian Ward: adw@tcyoung.co.uk

Adrian is a recognised national and international expert in adult incapacity law. While still practising he acted in or instructed many leading cases in the field. 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; national awards for legal journalism, legal charitable work and legal scholarship; and the lifetime achievement award at the 2014 Scottish Legal Awards.

Jill Stavert: j.stavert@napier.ac.uk

Jill Stavert is Professor of Law, Director of the Centre for Mental Health and Capacity Law and Director of Research, The Business School, Edinburgh Napier University. Jill is also a member of the Law Society for Scotland's Mental Health and Disability Sub-Committee, Alzheimer Scotland's Human Rights and Public Policy Committee, the South East Scotland Research Ethics Committee 1, and the Scottish Human Rights Commission Research Advisory Group. She has undertaken work for the Mental Welfare Commission for Scotland (including its 2015 updated guidance on Deprivation of Liberty). To view full CV click here.

Conferences

Conferences at which editors/contributors are speaking

Medical treatment and the Courts

Tor is speaking, with Vikram Sachdeva QC and Sir William Charles, at two conferences organised by Browne Jacobson in London on 9 May and Manchester on 24 May.

Other conferences of interest

UK Mental Disability Law Conference

The Second UK Mental Disability Law Conference takes place on 26 and 27 June 2018, hosted jointly by the School of Law at the University of Nottingham and the Institute of Mental Health, with the endorsement of the Human Rights Law Centre at the University of Nottingham. For more details and to submit papers 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 report will be out in early June. 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.

Michael Kaplan
Senior Clerk
michael.kaplan@39essex.com

Sheraton Doyle
Senior Practice Manager
sheraton.doyle@39essex.com

Peter Campbell
Senior Practice Manager
peter.campbell@39essex.com

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clerks@39essex.com • DX: London/Chancery Lane 298 • 39essex.com

LONDON
81 Chancery Lane,
London WC2A 1DD
Tel: +44 (0)20 7832 1111
Fax: +44 (0)20 7353 3978

MANCHESTER
82 King Street,
Manchester M2 4WQ
Tel: +44 (0)16 1870 0333
Fax: +44 (0)20 7353 3978

SINGAPORE
Maxwell Chambers,
#02-16 32, Maxwell Road
Singapore 069115
Tel: +(65) 6634 1336

KUALA LUMPUR
#02-9, Bangunan Sulaiman,
Jalan Sultan Hishamuddin
50000 Kuala Lumpur,
Malaysia: +(60)32 271 1085