Mental Capacity Law Newsletter December 2015: Issue 61

Court of Protection: Health, Welfare and Deprivation of Liberty

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Introduction

Welcome to the December 2015 Newsletters. Highlights this month in a bumper set include:

(1) In the Health, Welfare and Deprivation of Liberty Newsletter: landmark best interests and capacity decisions in the medical treatment sphere, more on the cross-over between the MHA and the MCA, forced marriage, and the CQC's latest DOLS report;
(2) In the Property and Affairs Newsletter: gratuitous care, conflicts of interest and the OPG's new guidance on safeguarding;
(3) In the Practice and Procedure Newsletter: a very important decision on fact-finding (and when it is and is not necessary), and guidance – by analogy – from the Supreme Court on the 'urgency' cross-border jurisdiction of the Court of Protection;
(4) In the Capacity outside the COP Newsletter: DNACPRs notices and capacity, a College of Police Consultation on Mental Health practice, a coroner fully grasping capacity, the inaugural UK Mental Disability Law Conference and a book corner;
(5) In the Scotland Newsletter: important amendments to the Education (Scotland) Bill, an important – and troubling – judicial review decision on ordinary residence in the cross-border context and guidance from the MWC on hidden surveillance.

And remember, you can now find all our past issues, our case summaries, and much more on our dedicated sub-site here. 'One-pagers' of the cases in these Newsletters of most relevance to social work professionals will also shortly appear on the SCIE website.

We are taking a break over the holiday period so (those of you who get them) happy holidays, and we will return in February from our new COP Towers in Chancery Lane.

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Placing the individual at the heart of decision-making even in an MCS

M v Mrs N & Ors [2015] EWCOP 59 (Hayden J)

Best interests – medical treatment

Summary

[Editorial Note: the judge, Hayden J, expressly debated with himself whether it was necessary to review the progress of Mrs N's condition, his instinct being to give priority to her privacy and the protection of her dignity. He ultimately decided that he had to set out some of the key features of the progression of the disorder and Mrs N's responses as part of the broad canvas of evidence which informed his ultimate decision. Whilst he needed to do so – he considered – so as to make clear that his reasoning was both transparent and uncompromised – the editors are not so bound and we therefore do not give those details in this judgment, which received wide publicity at the time. We also mindful of the – characteristically thoughtful – observations of Lucy Series as to the level of detail given in the judgments in both this case and the *C* case also covered in this newsletter].

This case is the first one in which the court has expressly sanctioned the withdrawal of Clinically Assisted Nutrition and Hydration ('CANH') from a person who is in – or was treated by the court as being – in a Minimally Conscious State.[1] It was brought by a woman, M, in respect of her mother, Mrs N, who profoundly impaired both physically and cognitively in consequence of the progressive degenerative impact of Multiple Sclerosis.

Hayden J undertook a careful and comprehensive of the law starting – rightly – with the principles in ss. 1 and 4 MCA 2005. He endorsed the 'admirably succinct' submissions of the Official Solicitor recorded at paragraph 27, namely that:

> "*(a) The court is the decision maker and thus has to make the decision by:*
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> *(i) considering all relevant circumstances; and*
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> *(ii) Taking the steps set out in section 4(3) to (7): see section 4(2);*
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> *(b) There are no limits placed on the nature or type of circumstances which may be relevant to the decision. It all depends on the facts of the case. However, in order to take a decision properly which considers all relevant circumstances, the decision maker must undertake a proper inquiry into both:*
>
> *(i) P's circumstances; and*

[1] Strictly, it should be noted that the court in *United Lincolnshire Hospital NHS Trust v N* [2014] EWCOP 16, in which a woman in an MCS continually sought to pull a PEG tube out, Pauffley J declared that it was lawful and in her best interests for the clinicians (a) not to make any further attempt to secure a means of providing artificial nutrition; (b) to withdraw the provision of intravenous fluids and dextrose; and (c) to provide such palliative care and related treatment (including pain relief) as considered appropriate to ensure she suffers the least distress and retains the greatest dignity until such time as her life comes to an end. The case seems to have been treated subsequently as a 'withholding' rather than a 'withdrawal' case but in particular in light of declaration (b) was a combination of both. It is perhaps more accurate to say that this case represented the first case in which withdrawal was considered in a case where, absent such withdrawal, it would be expected that the individual would continue to live for an appreciable period of time.

(ii) the type of decision that the decision maker is being called upon to make;

(c) Baroness Hale explains in Aintree at §24 that the Act does not propose a totally objective best interests decision making process but a compromise which is under the label of "best interests" but nonetheless is a compromise which contains a "strong element of substituted judgment". This compromise ensures that P as a human being remains at the very centre of decision-making concerning [them]*;*

(d) The compromise is achieved by requiring the decision maker to 'consider' (i.e. take fully into account) both P's past and present wishes and feelings: see section 4(6)(a). Whilst particular attention must be paid to expressions of P's wishes and feelings that were written down by P at a time when P had capacity, the decision maker must inquire into and then consider all other evidence of wishes and feelings before taking the decision: see §5.18 to 5.20 of the Code of Practice. That other evidence can include evidence from relatives about P's wishes and feelings which may assist the decision maker to understand P;

(e) Separately to considering P's wishes and feelings, the decision maker must also consider 'the beliefs and values that would be likely to influence his decision if he had capacity'. This means that the decision maker must inquire into P's beliefs and values. This is not limited to religious beliefs but beliefs and values about what matters were important to P, how they affected P's view of the world and the factors which P thought were important in taking decisions for himself or herself. This part of the statutory process asks the decision maker to inquire into and reach views about the general approach that P had to making decisions for himself or herself and to ask what factors were important to P in P's own capacitous decision making as a prelude for asking what decision P would have made for himself or herself if P still had capacity;

(f) The court also needs to look beyond P's 'beliefs and values' by considering any other factors that would, assuming P retained capacity, be have been likely to have influenced P in making the relevant decision: see section 4(6)(c)."

Hayden J further highlighted the observations of Baroness Hale in *Aintree* at paragraph 39, namely that:

"39. The most that can be said, therefore, is that in considering the best interests of this particular patient at this particular time, decision-makers must look at his welfare in the widest sense, not just medical but social and psychological; they must consider the nature of the medical treatment in question, what it involves and its prospects of success; they must consider what the outcome of that treatment for the patient is likely to be; they must try and put themselves in the place of the individual patient and ask what his attitude to the treatment is or would be likely to be; and they must consult others who are looking after him or interested in his welfare, in particular for their view of what his attitude would be."

and *Re S (Protected Persons)* [2010] 1 WLR 1082, in HHJ Hazel Marshall QC had held:

"55 In my judgment it is the inescapable conclusion from the stress laid on these matters in the 2005 Act that the views and wishes of P in regard to decisions made on his behalf are to carry great weight. What, after all, is the point of taking great trouble to ascertain or deduce P's views, and to encourage P to be involved in the decision-making process, unless the objective is to try

to achieve the outcome which P wants or prefers, even if he does not have the capacity to achieve it for himself?

56. The 2005 Act does not, of course, say that P's wishes are to be paramount, nor does it lay down any express presumption in favour of implementing them if they can be ascertained. Indeed the paramount objective is that of P's 'best interests'. However, by giving such prominence to the above matters, the Act does, in my judgment, recognise that having his views and wishes taken into account and respected is a very significant aspect of P's best interests. Due regard should therefore be paid to this recognition when doing the weighing exercise of determining what is in P's best interests in all the relevant circumstances, including those wishes."

Hayden J noted that he had given these passages very considerable thought, but that:

"*28.* […] *I draw from them only this: where the wishes, views and feelings of P can be ascertained with reasonable confidence, they are always to be afforded great respect. That said, they will rarely, if ever, be determinative of P's 'best interest's'. Respecting individual autonomy does not always require P's wishes to be afforded predominant weight. Sometimes it will be right to do so, sometimes it will not. The factors that fall to be considered in this intensely complex process are infinitely variable e.g. the nature of the contemplated treatment, how intrusive such treatment might be and crucially what the outcome of that treatment maybe for the individual patient. Into that complex matrix the appropriate weight to be given to P's wishes will vary. What must be stressed is the obligation imposed by statute to inquire into these matters and for the decision maker fully to consider them. Finally, I would observe that an assessment of P's wishes, views and attitudes are not to be confined within the narrow parameters of what P may have said. Strong feelings are often expressed non-verbally, sometimes in contradistinction to what is actually said. Evaluating the wider canvass may involve deriving an understanding of P's views from what he may have done in the past in circumstances which may cast light on the strength of his views on the contemplated treatment. Mr Patel, counsel acting on behalf of M, has pointed to recent case law which he submits, and I agree, has emphasised the importance of giving proper weight to P's wishes, feelings, beliefs and values see Wye Valley NHS Trust v B [2015] EWCOP 60; Sheffield Teaching Hospital Foundation Trust v TH and TR [2014] EWCOP 4; United Lincolnshire Hospitals NHS Trust v N [2014] EWCOP 16.*"

Having cited paragraph 5.31 of the Code of Practice (addressing when it is proper for steps not to be taken to prolong life, Hayden J noted that:

"*30. It is clear, therefore, that the framework of the Act and the scheme of the Code of Practice place great emphasis on the importance of personal autonomy and the obligation to be alert to direct or indirect discrimination against those who lack capacity. Decisions taken in the 'best interests' of an incapacitous individual must factor in the recognition that respect for an individual's past and present (where relevant) wishes and identifiable codes and beliefs by which he has lived are a crucial part of promoting best interests. To subvert these to a substitution of an objective evaluation i.e. to superimpose what the Court thinks best, may result in indirect discrimination. The central objective is to avoid a paternalistic approach and to ensure that the incapacitous achieve equality with the capacitous.*" (emphasis added)

From the legislative structure relating to Advance Decisions to Refuse Treatment (contained in ss.24-26 MCA 2005) Hayden J noted that: "[p]*erhaps the most significant impact of these provisions is that they illustrate that the presumption of life, predicated on what is often referred to as the 'sanctity of life' or the 'intrinsic value of life', can be rebutted (pursuant to statute) on the basis of a competent adult's cogently expressed wish. It follows, to my mind, by parity of analysis, that the importance of the wishes and feelings of an incapacitated adult, communicated to the court via family or friends but with similar cogency and authenticity, are to be afforded no less significance than those of the capacitous*" (paragraph 32, emphasis added).

Hayden J analysed in detail both the competing medical evidence as to whether Mrs N was in an MCS or a Vegetative State, noting that there was agreement between the doctors as to the clinical findings and disagreement as to the correct nomenclature to be applied. Which category she was in had important consequences legally, but was (he found) an arid debate clinically given that all ultimately agreed on the medical facts.

Hayden J noted that it was well-established that, if Mrs N was in an MCS, then any evaluation of her best interests must involve a proper identification of the advantages and disadvantages of each proposed course: i.e. the 'balance sheet,' noting – importantly – that "the balancing exercise is qualitative rather than quantitative." He usefully reminded practitioners of the observation of McFarlane LJ in *Re F (A Child) (International Relocation Cases)* [2015] EWCA Civ 882 that, whilst some form of balance sheet may be of assistance to judges in seeking to assess competing welfare issues [in that case relating to a child]:

> *"52.* […] *its use should be no more than an aide memoire of the key factors and how they match up against each other. If a balance sheet is used it should be a route to judgment and not a substitution for the judgment itself. A key step in any welfare evaluation is the attribution of weight, or lack of it, to each of the relevant considerations; one danger that may arise from setting out all the relevant factors in tabular format, is that the attribution of weight may be lost, with all elements of the table having equal value as in a map without contours."*

By contract, and citing *A Hospital v SW* [2007] Med LR 273, Hayden J noted that, if she was in a VS, the balance sheet itself did not apply, the very diagnosis establishing the futility of further intervention.

Hayden J set out in detail and with care the evidence that he had heard as to the views and attitudes of Mrs N, noting that it left him with little doubt that:

> *"60* […] *Mrs. N would have been appalled to contemplate the early pain, increasing dependency and remorseless degeneration that has now characterised her life for so long. I have no difficulty in accepting the family's view that she would not wish to continue as she is. More than that, she would have wished to have discontinued her treatment some considerable time ago.*
>
> *61. For one who has set such store by outward appearance and who has been so attentive to the impression she created on others, her decline, in the way I have outlined, is particularly poignant. Some might well have endured all that Mrs. N has with phlegmatism and fortitude. Mrs. N is simply not such a person. I am satisfied, as the family say, that some considerable time ago now she had simply had enough and that, as they see it, to*

> *force nutrition and hydration upon her is to fail to respect the person she is and the code by which she has lived her life."*

Hayden J noted that the Official Solicitor had, until the conclusion of the family's evidence, taken the view that the strong presumption in favour of the benefit of the continuance of life had not been displaced, but that, following careful consideration, the Official Solicitor had concluded that it would be wrong for him to continue to oppose the application. Whilst he did not criticise the Official Solicitor for so doing, he noted:

> "*64.* […] *the Court was then left in the position of contemplating a serious and important development in the evolution of the case law in the absence of opposing arguments. I was instinctively uncomfortable with that situation. Accordingly, as is by now clear from this judgment, I required each of the experts to give evidence as well as those conducting the SMART assessment. Mr Lock, notwithstanding the change of position, continued to act, in effect, as amicus to the Court, testing the evidence as it evolved.*

Hayden J emphasised the case was not concerned with the right to die, as no such right existed. Rather:

> "*70.* […] *What is in focus here is Mrs. N's right to live her life at the end of her days in the way that she would have wished. I am required to evaluate the 'inviolability of life' as an ethical concept and to weigh that against an individual's right to self determination or personal autonomy. Not only do these principles conflict, they are of a fundamentally different complexion. The former is an ideological imperative found in most civilised societies and in all major religions, the latter requires an intense scrutiny of an individual's circumstances, views and attitudes. The exercise is almost a balance of opposites: the philosophical as against the personal. For this reason, as I have already indicated, I consider that a formulaic 'balance sheet' approach to Mrs. N's best interests is artificial.*
>
> *71. As I have already set out and at some length, I am entirely satisfied that Mrs. N's views find real and authoritative expression through her family in this courtroom. I start with the assumption that an instinct for life beats strongly in all human beings. However, I am entirely satisfied that Mrs. N would have found her circumstances to be profoundly humiliating and that* ***she*** *would have been acutely alert to the distress caused to her family, which* ***she*** *would very much have wanted to avoid. LR told me that Mrs. N would not have wanted to have been a burden; that I also believe to be entirely reliable.*
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> *72. There is an innate dignity in the life of a human being who is being cared for well, and who is free from pain. There will undoubtedly be people who for religious or cultural reasons or merely because it accords with the behavioural code by which they have lived their life prefer to, or think it morally right to, hold fast to life no matter how poor its quality or vestigial its nature. Their choice must be respected. But choice where rational, informed and un-coerced is the essence of autonomy. It follows that those who would not wish to live in this way must have their views respected too.*
>
> [….]
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> *75.* […] *Ultimately, I have concluded that her wishes, so thoughtfully presented by her family, coupled with the intrusive nature of the treatment and its minimal potential to achieve any medical objective, rebut any presumption of continuing to promote life. Quite simply, I have come to the conclusion that it would be*

> *disrespectful to Mrs. N to preserve her further in a manner I think* ***she*** *would regard as grotesque."* (emphasis added).

Comment

It is difficult to know whether to be pleased or be concerned that it is now only in the 10th year of the MCA's life that we are having such a spate of decisions that so squarely seek to place the individual at the heart of the process, whether that be as regards the assessment of capacity (the *C* case also reported in this issue) or in the determination of best interests. Let us take the former course, and celebrate the fact that the courts are now determined to make such efforts to identify and (even if being careful not to say that they are being governed by) to respect the wishes of the individuals concerned where they can be identified.

As with the *Wye Valley* case, this is a model of best interests decision-making. That it may have represented an extension of the court's jurisdiction into new areas is – frankly – neither here nor there because it did soon the basis of so careful an analysis and application of the core principles of the Act.

One final procedural point should be noted. N's case was different to those previously considered by the courts in another way: her prolonged disorder of consciousness was caused not by a sudden onset acquired brain injury, but as a result of a degenerative disease. The RCP Guidelines on Prolonged Disorder of Consciousness is very firmly focused upon those who have sustained a sudden onset profound acquired brain injury. However, none of the experts who gave evidence before Hayden J (all of whom had been involved in drafting the Guidelines) suggested that they were not relevant to the diagnostic issues before the court.

Nor was there anything in Hayden J's judgment to suggest that M's application was anything other than appropriate or necessary – i.e. he did not dissent in any way from the clear statement made by Baker J (endorsed by the President) in *W v M* that applications to withhold or withdraw ANH from a person in VS or MCS must be referred to the court. Treating Trusts and CCGs must therefore consider carefully whether they are required to bring applications for withdrawal of CANH from those in MCS (and indeed PVS) however caused. That having been said, the editors hope that in due course the attention of the courts will be drawn firmly back to the observations of the Court of Appeal in *Burke v GMC* [2005] EWCA Civ 1003 as to the extent to which applications to court are required by law as opposed to being good practice where the legality of the proposed course of action is in doubt (see paragraphs 70-80).

Capacity at the limits

Kings College NHS Foundation Trust v C and V [2015] EWCOP 59 (MacDonald J)

Mental capacity – assessing capacity – medical treatment

Summary

[Editorial note: this case has attracted much media coverage, which has used much of the judge's description of C's unconventional and 'sparkly' life-style. Whilst we consider that the picture painted by MacDonald was one that sought – properly and sensitively – to examine C's entire personality so as to be able to assess whether she had capacity to make the decision in question, we are conscious that there are ongoing proceedings as to whether C's name should be revealed, and one of the points made

on behalf of C's family is as to the impact upon them of the case. We also have some reservations about the extent to which the details of C's lifestyle require wider circulation so as to be able to summarise the principles of law in play. We have therefore taken a deliberate decision not to rehearse them in detail here, but instead to focus upon the law].

The question for MacDonald J was whether a woman, C had the capacity to decide whether or not to consent to the life-saving treatment that her doctors wished to give her following her attempted suicide, namely renal dialysis. Without such treatment the almost inevitable outcome was the death of C. If the treatment were to have been administered the likelihood was that it would save C's life, albeit that there remained an appreciable and increasing possibility that C would be left requiring dialysis for the rest of her life. C refused to consent to dialysis and much of the treatment associated with it. She was supported in that decision by her family, and in particular her two elder daughters G and V, who considered that she had the requisite capacity. Along with the psychiatrists who had examined C on behalf of the treating clinicians (including by way of a second opinion), an independent expert jointly instructed by the Trust and the family considered that she lacked the material capacity (although his evidence was given very little weight by the court in light of serious shortcomings in his report). C, who was 'present' before the court by way of attendance notes of meetings with the representatives of the Official Solicitor, maintained she had the requisite capacity.

MacDonald J began his judgment by reminding us of the clear – and long-established – principle that a capacitous individual is entitled to decide whether or not to accept medical treatment, including treatment. As he noted at paragraph 2 "[t]*his position reflects the value that society places on personal autonomy in matters of medical treatment and the very long established right of the patient to choose to accept or refuse medical treatment from his or her doctor (voluntas aegroti suprema lex). Over his or her own body and mind, the individual is sovereign (John Stuart Mill, On Liberty, 1859),*" such that *"where a patient refuses life saving medical treatment the court is only entitled to intervene in circumstances where the court is satisfied that the patient does not have the mental capacity to decide whether or not to accept or refuse such treatment. Where the court is satisfied, on the balance of probabilities, that the patient lacks capacity in this regard, the court may take the decision as to what course of action is in the patient's best interests.*"

MacDonald J took the opportunity to restate in clear form the principles relating to the assessment of capacity, which merit reproduction as a very useful tour d'horizon of the case-law decided since the MCA 2005 came into force:

> "*25. The following cardinal principles flow from the statute (PH v A Local Authority [2011] EWHC 1704 (COP) at [16]). First, a person must be assumed to have capacity unless it is established that they lack capacity (Mental Capacity Act 2005 s 1(2)). The burden of proof lies on the person asserting a lack of capacity and the standard of proof is the balance of probabilities (Mental Capacity Act 2005 s 2(4) and see KK v STC and Others [2012] EWHC 2136 (COP) at [18]).*
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> *26. Second, determination of capacity under Part I of the Mental Capacity Act 2005 is always 'decision specific' having regard to the clear structure provided by sections 1 to 3 of the Act (see PC v City of York Council [2014] 2 WLR 1 at [35]). Thus capacity is required to be*

assessed in relation to the specific decision at the time the decision needs to be made and not to a person's capacity to make decisions generally.

27. Third, a person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success (Mental Capacity Act 2005 s 1(3)).

28. Fourth, a person is not to be treated as unable to make a decision merely because he or she makes a decision that is unwise. It is important in this regard to recall the words of Peter Jackson J in Heart of England NHS Foundation Trust v JB [2014] EWHC 342 (COP) at [7]:

> *"The temptation to base a judgment of a persons capacity upon whether they seem to have made a good or bad decision, and in particular on whether they have accepted or rejected medical advice, is absolutely to be avoided. That would be to put the cart before the horse or, expressed another way, to allow the tail of welfare to wag the dog of capacity. Any tendency in this direction risks infringing the rights of that group of persons who, though vulnerable, are capable of making their own decisions. Many who suffer from mental illness are well able to make decisions about their medical treatment, and it is important not to make unjustified assumptions to the contrary."*

29. Likewise, the outcome of the decision made is not relevant to the question of whether the person taking the decision has capacity for the purposes of the Mental Capacity Act 2005 (see R v Cooper *[2009] 1 WLR 1786 at [13] and York City Council v C [2014] 2 WLR 1 at [53] and [54]).*

30. Within these contexts, the fact that a decision not to have life saving medical treatment may be considered an unwise decision and may have a fatal outcome is not of itself evidence of a lack of capacity to take that decision, notwithstanding that other members of society may consider such a decision unreasonable, illogical or even immoral, that society in general places cardinal importance on the sanctity of life and that the decision taken will result in the certain death of the person taking it. To introduce into the assessment of capacity an assessment of the probity or efficacy of a decision to refuse life saving treatment would be to introduce elements which risk discriminating against the person making that decision by penalising individuality and demanding conformity at the expense of personal autonomy in the context of a diverse, plural society which tolerates a range of views on the decision in question (see Mental Incapacity (1995) (Law Comm No 231) (HC 189), [1995] EWLC 231, para 3.4).

31. Fifth, pursuant to s 2(1) of the 2005 Act a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain (the so called 'diagnostic test'). It does not matter whether the impairment or disturbance in the functioning of the mind or brain is permanent or temporary (Mental Capacity Act 2005 s 2(2)). It is important to note that the question for the court is not whether the person's ability to take the decision is impaired by the impairment of, or disturbance in the functioning of, the mind or brain but rather whether the person is rendered unable *to make the decision by reason thereof (see Re SB (A Patient: Capacity to Consent to*

Termination) *[2013] EWHC 1417 (COP) at [38]).*

32. Sixth, pursuant to s 3(1) of the 2005 Act a person is "unable to make a decision for himself" if he is unable (a) to understand the information relevant to decision, (b) to retain that information, (c) to use or weigh that information as part of the process of making the decision, or (d) to communicate his decision whether by talking, using sign language or any other means (the so called 'functional test'). An inability to undertake any one of these four aspects of the decision making process set out in s 3(1) of the 2005 Act will be sufficient for a finding of incapacity provided the inability is because of an impairment of, or a disturbance in the functioning of, the mind or brain (see RT and LT v A Local Authority [2010] EWHC 1910 (Fam) at [40]). The information relevant to the decision includes information about the reasonably foreseeable consequences of deciding one way or another (Mental Capacity Act 2005 s 3(4)(a)).

33. The order in which the relevant terms of the Mental Capacity Act 2005 are drafted places the 'diagnostic test' in s 2(1) before the 'functional test' in s 3(1). However, having regard to the wording of s 2(1), namely, "he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain" (emphasis added), the order in which the tests are in fact applied must be carefully considered. In York City Council v C [2014] 2 WLR 1 at [58] and [59] McFarlane LJ (with whom Richards and Lewison LLJ agreed) held as follows:

> *"It would be going too far to hold that in approaching matters in this way Hedley J plainly erred in applying the law. His judgment refers to the key provisions and twice refers to the nexus between the elements of an inability to make decisions set out in s 3(1) and mental impairment or disturbance required by s 2(1). There is, however, a danger in structuring the decision by looking to s 2(1) primarily as requiring a finding of mental impairment and nothing more and in considering s 2(1) first before then going on to look at s 3(1) as requiring a finding of inability to make a decision. The danger is that the strength of the causative nexus between mental impairment and inability to decide is watered down. That sequence - 'mental impairment' and then 'inability to make a decision' - is the reverse of that in s 2(1) – 'unable to make a decision … because of an impairment of, or a disturbance in the functioning of, the mind or brain' [emphasis added]. The danger in using s 2(1) simply to collect the mental health element is that the key words 'because of' in s 2(1) may lose their prominence and be replaced by words such as those deployed by Hedley J: 'referable to' or 'significantly relates to'…Approaching the issue in the case in the sequence set out in s 2(1), the first question is whether PC is 'unable to make a decision for herself in relation to the matter', the matter being re-establishing cohabitation with NC now that he is her husband and now that he is has regained his liberty.".*

34. Within this context, it is important to remember that for a person to be found to

lack capacity there must be a causal connection between being unable to make a decision by reason of one or more of the functional elements set out in s 3(1) of the Act and the 'impairment of, or a disturbance in the functioning of, the mind or brain' required by s 2(1) of the Act.

35. In this case the Trust bases its submissions regarding the 'functional test' squarely on section 3(1)(c) of the 2005 Act, which provides that a person is unable to make a decision for himself if he is 'unable to…use or weigh' the relevant information as part of the process of making the decision (as the disjunctive 'or' comes after the negative, 'unable to' in s 3(1)(c) the subsection requires the person asserting a lack of capacity to demonstrate an inability on the part of the individual to use and *weigh the relevant information).*

36. In PCT v P, AH and The Local Authority [2009] COPLR Con Vol 956 at [35] Hedley J described the ability to use and weigh information as "the capacity actually to engage in the decision making process itself and to be able to see the various parts of the argument and to relate one to another".

37. Within the context of s 3(1)(c) it is not necessary for a person to use and weigh every detail of the respective options available to them in order to demonstrate capacity, merely the salient factors (see CC v KK and STCC [2012] EWHC 2136 (COP) at [69]). Even though a person may be unable to use and weigh some information relevant to the decision in question, they may nonetheless be able to use and weigh other elements sufficiently to be able to make a capacitous decision (see Re SB [2013] EWHC 1417 (COP)).

38. It is important to note that s 3(1)(c) is engaged where a person is unable to use and weigh the relevant information as part of the process of making the decision. What is required is that the person is able to employ the relevant information in the decision making process and determine what weight to give it relative to other information required to make the decision. Where a court is satisfied that a person is able to use and weigh the relevant information, the weight to be attached to that information in the decision making process is a matter for the decision maker. Thus, where a person is able to use and weigh the relevant information but chooses to give that information no weight when reaching the decision in question, the element of the functional test comprised by s 3(1)(c) will not be satisfied. Within this context, a person cannot be considered to be unable to use and weigh information simply on the basis that he or she has applied his or her own values or outlook to that information in making the decision in question and chosen to attach no weight to that information in the decision making process.

39. Finally, whilst the evidence of psychiatrists is likely to be determinative of the issue of whether there is an impairment of the mind for the purposes of s 2(1), the decision as to capacity is a judgment for the court to make (see Re SB [2013] EWHC 1417 (COP)). In PH v A Local Authority [2011] EWHC 1704 (COP) Baker J observed as follows at [16]:

> *"In assessing the question of capacity, the court must consider all the relevant evidence. Clearly, the opinion of an independently-instructed expert will be likely to be of very considerable importance, but in many cases the evidence of other clinicians and professionals who have experience of treating and working with P will be just as important and in some cases more important. In assessing that evidence, the court must be*

> *aware of the difficulties which may arise as a result of the close professional relationship between the clinicians treating, and the key professionals working with, P. In Oldham MBC v GW and PW [2007] EWHC136 (Fam) [2007] 2 FLR 597, a case brought under Part IV of the Children Act 1989, Ryder J referred to a "child protection imperative", meaning "the need to protect a vulnerable child" that for perfectly understandable reasons may lead to a lack of objectivity on the part of a treating clinician or other professional involved in caring for the child. Equally, in cases of vulnerable adults, there is a risk that all professionals involved with treating and helping that person – including, of course, a judge in the Court of Protection – may feel drawn towards an outcome that is more protective of the adult and thus, in certain circumstances, fail to carry out an assessment of capacity that is detached and objective.'"*
> (emphases in original)

The first question for the court, MacDonald J held, was whether:

> *71.* […] *the Trust has established on the balance of probabilities C is unable to make a decision about the matter in hand having regard to the matters set out in s 3(1) (the so called 'functional test'). The Trust accepts that C is able to understand the information relevant to the decision, to retain that information and to communicate her decision. In relation to the remaining element of the functional test I am not satisfied that the Trust has proved to the requisite standard that C is unable to use and weigh the information relevant to the decision in question.*
>
> *72. Notwithstanding the submission of the Trust, I am not satisfied that C lacks belief in her prognosis or a future that includes her recovery to the extent she cannot use that information to make a decision, or that C is unable to weigh her positive prognosis and the possibility of a future recovery in the decision making process. In my judgment, the evidence in this case, when viewed as a whole, is indicative of C acknowledging that her prognosis is positive, that there is a possible future in which she survives and of her weighing that information in her decision making process.*

MacDonald J then reviewed that evidence in detail, noting that it was important to have regard that, in addition to the position that she had taken with regard to her prognosis, C had given a range of reasons for reaching the decision that she had regarding further treatment, and that she had undertaken the decision-making exercise on the basis of "*placing into the balance many factors relevant to her decision*" (paragraph 91).

As it was conceded by the Trust that C met the other criteria comprising the functional test, MacDonald J pronounced himself satisfied that C was not a person unable to make a decision for herself for the purposes of s.3(1) MCA and, accordingly, did not lack capacity to decide whether or not to accept dialysis. He went on:

> *"93.* [h]*aving found that C is not a person unable to make a decision for herself for the purposes of s 3(1) it is not necessary for me to go on to consider the so called 'diagnostic test'. It is right to record that, as I observed at the conclusion of the hearing, had I been satisfied that C was unable to use and weigh information in the manner contended for by*

the Trust, I believe I would have had difficulty in deciding that this inability was, on the balance of probabilities, because of an impairment of, or a disturbance in the functioning of, the mind or brain. Whilst it is accepted by all parties that C has an impairment of, or a disturbance in the functioning of, the mind or brain, the evidence as to the precise nature of that impairment or disturbance was far from conclusive. Further, and more importantly, with regard to the question of causation, and in particular whether what was being seen might be the operation of a personality disorder or simply the thought processes of a strong willed, stubborn individual with unpalatable and highly egocentric views the evidence was likewise somewhat equivocal. However, as I say, I need say no more about this in light of my conclusions as set out above."

MacDonald J noted that his conclusion did not accord with the considered opinion of two very experienced psychiatrists, but was careful to make clear that this was "*in large part a product of this being a finely balanced case in which a number of reasonable interpretations of the information available are possible*" (paragraph 94).

In concluding, MacDonald J noted that

"*97. The decision C has reached to refuse dialysis can be characterised as an unwise one. That C considers that the prospect of growing old, the fear of living with fewer material possessions and the fear that she has lost, and will not regain, 'her sparkle' outweighs a prognosis that signals continued life will alarm and possibly horrify many, although I am satisfied that the ongoing discomfort of treatment, the fear of chronic illness and the fear of lifelong treatment and lifelong disability are factors that also weigh heavily in the balance for C. C's decision is certainly one that does not accord with the expectations of many in society. Indeed, others in society may consider C's decision to be unreasonable, illogical or even immoral within the context of the sanctity accorded to life by society in general. None of this however is evidence of a lack of capacity. The court being satisfied that, in accordance with the provisions of the Mental Capacity Act 2005, C has capacity to decide whether or not to accept treatment C is entitled to make her own decision on that question based on the things that are important to her, in keeping with her own personality and system of values and without conforming to society's expectation of what constitutes the 'normal' decision in this situation (if such a thing exists). As a capacitous individual C is, in respect of her own body and mind, sovereign.*

98. In circumstances where I have decided that C has at this time the capacity to make the decision in question, this court has no jurisdiction to interfere with the decision making process. Accordingly, although rightly brought, I dismiss the application of the Trust for declarations under the Mental Capacity Act 2005.

99. As I said at the conclusion of this hearing, my decision that C has capacity to decide whether or not to accept dialysis does not, and should not prevent her treating doctors from continuing to seek to engage with C in an effort to persuade her of the benefits of receiving life saving treatment in accordance with their duty to C as their patient. My decision does no more than confirm that in law C is entitled to refuse the treatment offered to her for her benefit by her dedicated treating team. Nothing I have said prevents them from continuing to offer that treatment."

It was subsequently reported that C had died some days after the hearing but before the judgment was handed down.

Comment

It is understandable perhaps that this case attracted significant media attention. Standing back from it, however, it is primarily important for two reasons:

1. As a very clear statement of the law relating to the assessment of capacity which was both admirably succinct and (with one exception noted below, admirably accurate);

2. As a deeply sympathetic application of those principles to a real person viewed, above all, as a person. It is therefore absolutely of a piece with the approach adopted by Peter Jackson J in *Wye Valley* (and indeed with that adopted by Hayden J in the *Re N* case discussed in this Newsletter).

In its – frank – recognition at paragraph 94 of the fact that capacity assessment in complex cases such as this represents no more than the attempt to place a reasonable interpretation upon the information available, the case also stands as a reminder of:

1. The difficulty of imposing a necessary 'binary' black and white legal framework upon the realities of human beings; and therefore

2. How careful assessors must be to make sure that they have obtained all the relevant information and seek to approach – insofar as possible – the person that they are assessing on that person's own terms.

The one area in which we would – respectfully – quibble with MacDonald J's summary of the law is his assertion at paragraph 35 that a person seeking to prove that another lacks capacity has to show that they lack the capacity to both use and weigh the relevant information. As discussed in greater detail in the guest note which follows prepared by Wayne Martin and Fabian Freyenhagen of the University of Essex, we would respectfully doubt that this in fact represents a correct statement of the law. We should emphasise that we do not consider that applying the correct approach (i.e. that a person lacks the relevant capacity if they cannot either use or weigh the information) would have made any different on the facts of this particular case.

It should be noted, finally, that MacDonald J appeared to take it as axiomatic that – at least in the case before him – it was necessary to approach the test for capacity on the basis of the functional aspect first (i.e. in line with the approach suggested by the Court of Appeal in *PC*, and contrary to the approach suggested in the Code of Practice). Parker J in *NCC* doubted whether the Court of Appeal had in fact intended to reverse the two, and this case may well therefore re-open the debate. As suggested in our guidance note on the assessment of mental capacity, the way through this debate may well be:

1. To note that it may be a question of the focus upon the particular aspect of the test that is most relevant in the circumstances facing the assessor; and

2. In all cases to ask the vital third question – whether the apparent inability to take the decision is because of the relevant impairment of or disturbance in the mind or brain.

Use *or* Weigh? or Use *and* Weigh? A Note on the Logic of MCA sec. 3(1)

[This guest note is prepared by Wayne Martin and Fabian Freyenhagen of the Essex Autonomy Project]

In *Kings College Hospital NHS Trust Foundation Trust v C and V* [2015] EWCOP 80, MacDonald J made an observation, almost in passing, about the framing of the definition of mental capacity in the *Mental Capacity Act 2005* (MCA). The particular matter at issue concerns the logical relationship between the concepts of *use* and *weigh* as they figure in that definition. It is not our purpose here to assess MacDonald J's ruling in this important and difficult case, which is discussed elsewhere in this issue of *The Mental Capacity Newsletter*. But on the particular point concerning the logic of the capacity test, we respectfully submit that MacDonald J's analysis is incorrect.

Rather than turning directly to MacDonald J's analysis, we begin from the language of the statute itself. As is well-known, the MCA relies on a functional definition of the notion of "decision-making capacity." One quirk of the statute is that its definition of this central concept is negative: the relevant section of the statute defines not the *possession* but the *absence* of the ability to make a decision for oneself. In particular, MCA sec. 3(1) establishes that:

> *For the purposes of section 2, a person is unable to make a decision for himself if he is unable—(a) to understand the information relevant to the decision, (b) to retain that information, (c) to use or weigh that information as part of the process of making the decision, or (d) to communicate his decision (whether by talking, using sign language or any other means).*

The matter at issue for us here concerns the logical form of this definition. Notice in particular that it is presented as a list of four functional abilities, but that the third of these has a disjunctive character: to use *or* weigh information in making a decision. MacDonald J's logical observation concerned the significance of the logical connective: *or*.

What should we make of the "or" in MCA sec. 3(1)(c)? Our own approach in answering this question begins with the observation that there are in fact two occurrences of the word "or" in the relevant clause. One appears between the word "use" and the word "weigh"; the second appears at the end of the clause, serving as the logical connective linking 3(1)(c) to 3(1)(d). In fact, we submit, there is an implicit "or" at work at each step in the functional definition. In effect what it says is that a person lacks the ability to make a decision for themselves if and only if they *either* lack the ability to understand … , *or* lack the ability to retain … , *or* lack the ability to use … , *or* lack the ability to weigh … , *or* lack the ability to communicate.[2]

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[2] These implicit occurrences of "or" can be seen explicitly in the original Law Commission draft of what was then called *The Mental Incapacity Bill*:

> *For the purposes of this Part of this Act a person is at the material time unable to make a decision by reason of mental disability if the disability is such that at the time when the decision needs to be made – (a) he is unable to understand or retain the information relevant to the decision, including information about the reasonably foreseeable consequences of deciding one way or another or of failing to make the decision; or (b) he is unable to make a decision based on that information. (The Law Commission, Mental Incapacity Report LC No. 231, page 223; emphasis added)*

Once again, it is worth keeping in mind that this disjunctive logical form appears in the context of statutory language that defines a *negative* trait (the *inability* to make a decision for oneself) in terms of the *absence* of certain psychological capacities. If we turn that around in order to define the *positive* trait (the *ability* to make a decision for oneself) in terms of the *possession* of certain psychological capacities, then all these occurrences of "or" become so many occurrence of "and." A person *has* the ability to make a decision of themselves in a matter if they *have* the ability to understand … , *and* the ability to retain … , *and* the ability to use … , *and* the ability to weigh … , *and* the ability to communicate. This transposition follows as a matter of logic.[3] Independent evidence in its support can be found in the *Explanatory Notes* that accompanied the MCA, which included just such a positive transposition of the statutory definition. The relevant portion of the positive definition, which takes an explicitly conjunctive character, reads as follows.

> *To make a decision, a person must first comprehend the information relevant to the decision … , secondly retain this information … and thirdly use and weigh it to arrive at a choice. If the person cannot undertake one of these three aspects of the decision-making process then he is unable to make the decision.*[4]

On our reading, therefore, a person must have all *five* abilities (i.e. to be able to understand, retain, use, weigh, communicate) in order to pass the functional test for decision-making capacity.

With all this in mind, then, let us consider MacDonald J's recent ruling in the *C* case. In para. 35, MacDonald J writes:

> *In this case the Trust bases its submissions regarding the 'functional test' squarely on section 3(1)(c) of the 2005 Act, which provides that a person is unable to make a decision for himself if he is 'unable to…use or weigh' the relevant information as part of the process of making the decision (as the disjunctive 'or' comes after the negative, 'unable to' in s 3(1)(c) the subsection requires the person asserting a lack of capacity to demonstrate an inability on the part of the individual to use and weigh the relevant information).*

On the analysis we have offered, this is not correct. The requirement of MCA sec. 3(1)(c) can be satisfied *either* by establishing that a person is unable to use *or* by establishing that a person is unable to weigh. One way of exhibiting the error in MacDonald J's reasoning is to return to double occurrence of the word "or" in section 3(1)(c). As

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It should be noted that the Law Commission report was drafted at a time when the common law definition of incapacity was being refined, coming as it did between the decisions in *Re C* [1994] 1 WLR 290 and *Re MB* [1997] 2 FLR 426. In the latter case, Lady Justice Butler-Sloss wrote that:

> [The] *inability to make a decision will occur when (a) the patient is unable to comprehend and retain the information which is material to the decision, especially as to the likely consequences of having or not having the treatment in question. (b) the patient is unable to use the information and weigh it in the balance as part of the process of arriving at the decision. … . (Re MB* [1997] 2 FLR 426, para. 30.4., emphasis added.)

In this passage from *MB*, the conjunctive form ("use *and* weigh") is used in the context of a definition of the *inability* to make a decision. It is important to note, however, that Lady Justice Butler-Sloss was not offering an interpretation of a statute adopted by Parliament, as there was not yet a statute to interpret.

[3] Logically, the crucial theorem is (~p ↔ (~q v ~r)) ↔ (p ↔ (q & r)). That this formula is indeed a tautology can be proved by constructing a truth table.

[4] Department of Health, 2005: *Explanatory Notes to the Mental Capacity Act*: emphasis altered. See also the MCA's *Code of Practice*, 4.21.

we have seen, one occurrence links "use" and "weigh;" the second links section 3(1)(c) and section 3(1)(d). *Both* occurrences come, as MacDonald J puts it, "*after the negative, 'unable to*.'" If we were to apply MacDonald J's reasoning consistently, we would have to conclude that the person asserting a lack of capacity must demonstrate an inability to communicate as well as an inability to use/weigh. Indeed, a proof of incapacity would have to establish that all five abilities are absent. Since such a conclusion is plainly incorrect, we respectfully suggest that the principle informing MacDonald J's interpretation of the first "or" in section 3(1)(c) cannot be accepted.

Does any of this really matter? Much depends, of course, on how the other words in MCA 3(1)(c) are interpreted. What, in particular, is meant by the terms *use* and *weigh*? If those two terms are effectively synonyms (or irredeemably ill-defined), then it does not much matter whether they are linked conjunctively or disjunctively. But if they are distinct concepts, then our interpretation of the functional test has the effect of setting the bar higher for decision-making capacity. In order to have the ability to make a decision for oneself in a particular matter at the material time, a person must be able *both* to use *and* to weigh the information relevant to the decision. Simply having one of the two abilities does not suffice. Our own view, which we shall not seek to defend here, is that "use" is best understood as a broader category than "weigh." A person can *use* information in a variety of different ways: for example in hypothetical reasoning, in subsuming particular information under a general rule, or simply by paraphrasing information in their own words. *Weighing* treatment information is a more specific deliberative task; it characteristically involves considering the pros and cons of different options in the process of reaching a decision. On our understanding of MCA 3(1)(c), a capacity assessment should consider *both* a person's broad ability to use information, *and* the more specific ability to "weigh up," comparing the advantages and disadvantages of different options.[5]

Medical treatment, the MCA and the MHA

A Hospital NHS Trust v (1) CD (2) A Mental Health Trust [2015] EWCOP 74 (Mostyn J)

Best interests – medical treatment – MHA 1983 – interface with MCA

Summary

The issue in this case was whether it was in the best interests of a 43 year old woman, CD, who suffered from paranoid schizophrenia to have a total abdominal hysterectomy in circumstances where she lacked capacity to make that decision for herself.

CD had an established diagnosis of schizoaffective disorder and was detained under section 3 of the Mental Health Act 1983. Her illness had a remitting and relapsing course and her mental capacity had fluctuated in the past. She had a long history of aggression and violence. The evidence showed that CD's delusional beliefs impaired her ability to weigh up the advantages and disadvantages of medical treatment. Mostyn J had no difficulty in finding that that CD manifestly lacked capacity to make the relevant decision.

[5] We wish to thank Alex Ruck Keene for his assistance in the preparation of this note.

The object of the surgery was to remove two very large ovarian growths or masses. All the medical experts and all the parties, including the Official Solicitor who represented CD, agreed that it was in CD's best interests to have the operation. CD strongly expressed the wish to have the operation. Based on the totality of the medical evidence, and on CD's wishes and feelings, Mostyn J concluded that it was in CD's best interests that the operation must take place.

Ancillary to the operation taking place, it was necessary for Mostyn J to authorise a deprivation of CD's liberty which engaged the difficult interface between the MHA and MCA. The question was whether CD was ineligible to be deprived of her liberty because the surgical removal of the ovarian masses was not in accordance with the MHA regime. There were two ways of reading this which gave rise to directly contradictory results. Mostyn J adopted a purposive (rather than literal) reading of paragraph 3(2) to schedule 1A to the MCA which permitted him to make the orders sitting in the Court of Protection under the MCA rather than in the High Court exercising power under the common law inherent jurisdiction. As an aside, Mostyn J commented that it was "*counterintuitive*" that someone going freely and enthusiastically to hospital to have an operation performed under general anaesthesia was deprived of her liberty. However, as it was not a decision that CD could make, and if she changed her mind she would be operated on nonetheless, Mostyn J was satisfied that the state of affairs fell within the acid test in *Cheshire West* (as to which he had a number of distinctly acerbic comments).

Comment

Following on from the recent and moving judgment in *Wye Hospital NHS Trust v B* [2015] EWCOP 60, Mr Justice Mostyn concentrated on CD's own wishes and feelings. However, he emphasised *"it is vital that wishes and feelings are strictly confined to the best interests analysis and do not act subtly to undermine a capacity assessment. Where, as here, there is no doubt about incapacity when the wishes and feelings of the protected person cannot alter that fact even if they happen to align exactly with a rational, "capacitous", decision."*

In reaching his conclusion on CD's deprivation of liberty, Mostyn J reaffirmed the purposive and pragmatic approach in his earlier decision of *An NHS Trust v A* [2015] EWCOP 761 reported briefly upon in our November newsletter. This puts another nail in the coffin for *Re AB* [2015] EWCOP 31 where a contrary approach was taken.

Readers with a classical education (or ready access to Google Translate) will no doubt appreciate Mostyn J's observations as to the views of hoplites as to the meaning of deprivation of liberty.

Constrained choice can be true choice

MM v WL Clinic and MHS [2015] UKUT 0644 (AAC) UT (AAC) (Charles J)

Article 5 – deprivation of liberty – MHA 1983 – conditional discharge

Summary

The patient was 32 years old with a diagnosis of mild learning disability, autistic spectrum disorder and pathological fire starting. Convicted of arson, the Crown Court imposed a restricted hospital order (MHA ss37/41). He sought a conditional discharge on the basis that his capacitous consent to a care regime in the community would

render lawful what would otherwise be a deprivation of his liberty.

The crux of the appeal was whether the threat of recall to hospital from the community meant that the patient's consent was not free and therefore invalid. Applying his analysis and obiter comments in *Secretary of State for Justice v KC and C Partnership NHS Foundation Trust* [2015] UKUT 0376 (AAC), Charles J held that:

> *"63. The points made in paragraphs 56 to 62 above, show that conditions relating to a placement outside a hospital which when implemented will create on an objective assessment a deprivation of liberty:*
>
> *i) cannot be lawfully imposed on a restricted patient under the MHA,*
>
> *ii) can be part of the terms and conditions of a conditional discharge that is, or which a restricted patient can reasonably conclude is, in his best interests because it is the least restrictive option and one that enables him to demonstrate that (a) it is no longer necessary for him to be in hospital or liable to recall to hospital to receive treatment for a mental disorder for the purposes set out in the MHA and so that (b) he should be given an absolute discharge,*
>
> *iii) can promote the underlying purposes of the MHA and a conditional discharge (see paragraphs 85 to 89 of my decision in the KC case), and*
>
> *iv) can only be made a lawful option or alternative for a capacitous restricted patient if he gives a valid consent to it.*
>
> *64. The factors set out in the last paragraph show that:*
>
> *i) a capacitous restricted patient (like the Court of Protection or a DOLS decision maker in respect of a restricted patient who lacks the relevant capacity) has a real choice founded on the advantages and disadvantages and so the merits of the proposed placement assessed through the eyes of the restricted patient to consent to such conditions, and that*
>
> *ii) any such decision is most unlikely to be driven by a threat that he might be recalled to hospital.*
>
> *This is because he is not being presented with a choice between two alternatives that can be imposed on him and the driver for his consent would be a move from hospital (albeit one that might end with an imposed recall) to a placement outside hospital which he has concluded is in his best interests because, for example, in his view that would be a step towards his absolute discharge into the community."*

Accordingly, the patient's consent to the proposed conditional discharge arrangements meant that he would forego his Article 5 right and could lawfully be discharged.

Comment

The decision in *KC* enabled those lacking capacity to be lawfully discharged from hospital into a community deprivation of liberty. This eminently sensible decision enables those with capacity to similarly do so where they consent to the arrangements. Both decisions appear to settle the law, but where does this leave the Court of Appeal's decision in *Secretary of State for Justice v RB* [2012] 1 MHLR 131? Doubts may linger unless and until that decision is put to bed by the

appeal courts. As Charles J noted at paragraph 8, "*… as a matter of good administration, the Secretary of State should "put up or shut up…*" as regards his position relating to patients in this position (as to which see further, perhaps, the response to *No Voice Unheard* outlined in the Capacity outside the Court of Protection Newsletter).

Capacity, marriage and consent

Luton Borough Council v (1) SB (2) RS (by his litigation friend, the Official Solicitor) [2015] EWHC 3534 (Fam) (High Court Family Division (Hayden J))

Summary

RS was a 25 year old man with an intellectual disability and autism spectrum disorder. He lived with his mother (SB) and six of his seven siblings.

Proceedings were commenced by the local authority seeking a Forced Marriage Protection Order. The application was designed to forestall an anticipated marriage. However, it subsequently transpired that a marriage between RS and W had taken place in Pakistan. The proceedings were reconstituted under the inherent jurisdiction of the High Court.

The issues included:

- Did RS lack capacity to consent to marriage?
- Did RS lack capacity to consent to sexual relations?
- If RS lacked capacity to consent to marriage and/or sexual relations, should the court exercise its discretion under the inherent jurisdiction to make a declaration that the marriage was not recognised at English law?

Applying the tests in *Re M (An Adult) (Capacity to Consent to Sexual Relations)* [2015] Fam 61, and *Re E (An alleged patient): Sheffield City Council v E* [2005] 1 FLR 965, to the facts, Hayden J had little difficulty concluding that RS lacked capacity to marry and consent to sexual relations, and that there was no real prospect of RS gaining the capacity.

Following his findings that RS lacked capacity to consent to marriage and sexual relations, Hayden J was invited to make a declaration of non-recognition of the Pakistani marriage. Hayden J gave careful consideration to various competing interests. In respect of M, he said:

> "*Having heard all the evidence in this case I am convinced that the objective of this marriage was to provide RS with care and security for the remainder of his life. M, in particular, had been shocked and disturbed by her son's isolation and unhappiness in the residential unit. She found it difficult to manage her distress as she told me about this period in her son's life. As the records at the time reveal, even then, M contemplated marriage as a solution for her son's predicament. I think that she considered the options for her son's future and found them, by the standards of her hopes and expectations as a mother, to be bleak.*"

In respect of W, Hayden J said:

> "*In her evidence to me W was respectful to the family, to her husband and to the Court. I formed the impression that she had made a utilitarian calculation of her own interests in this marriage. From a purely western perspective that might appear to be a critical observation. I do not intend it to be regarded*

> *as such. W has different cultural expectations; social priorities which are influenced by her upbringing in Kashmir and by her own understandings of the responsibilities and obligations expected of women in her society. She was articulate in her assertion that she had entered this marriage of her own free will. Despite the highly personal nature of the inevitable and proper questions she confirmed with some robustness, that the marriage had been consummated. She also told me that at the time of her menstruation her new husband had shown sensitivity and forbearance. In short, I have absolutely no sense that she had entered this marriage under duress or in consequence of any abusive pressure. On her part I am entirely satisfied that she gave free consent.*"

However, the decisive factor in granting the declaration sought was RS's inability to consent. Hayden J said:

> "*Ultimately however, I have come to the conclusion that capacity, at least in the circumstances here, is an intrinsic, indivisible facet of both psychological and moral integrity. The absence of RS's capacity to consent either to sexual relations or to marriage ultimately compromises the ability of this couple to forge the mutual and reciprocal commitment which, in my judgement, is an essential component of a marriage, perhaps even universally so.*"

Comment

This judgment demonstrates a careful and sensitive application of the law to the facts. Hayden J echoed the words of Mostyn in *D Borough Council v B* [2011] EWCOP 101 where he said that the restriction of sexual relationship engages a very profound aspect of an individual's civil liberties and personal autonomy, and recognised "*the development of psychological and moral integrity and relationships with other human beings as key aspects of individual human rights*." Although granting the declaration of non-recognition, and expressing the view that in most cases the court will be required to make a declaration of non-recognition, Hayden J made clear that there may be circumstances in the interests of justice, fairness and respect of individual autonomy where discretion could be exercised against any such declaration.

Article 5 and conditions of detention

R (on the application of Idira) v Secretary of State for the Home Department [2015] EWCA Civ 1187 (Court of Appeal (Master of the Rolls, The President of the Queen's Bench Division, and Lord Justice McCombe))

Article 5 – deprivation of liberty

Summary

This case, from the immigration context, concerns a claim for unlawful detention contrary to Article 5(1) ECHR.

The appellant was an Algerian national whose leave to remain in the UK had expired. He was sentenced to a term of imprisonment for theft and sent to a prison. Once the custodial part of his sentence was over, he remained in prison before being moved to an immigration detention centre. The issue was whether the applicant's continued detention in a prison, rather than an immigration removal centre, was unlawful and in breach of his rights under article 5(1).

The Court of Appeal, interpreting the authorities, reached the view that the task of the national court is to decide whether the place and

conditions of detention are suitable and appropriate. In this particular context, the Court of Appeal held that immigration detention in a prison rather than an immigration removal centre was not generally contrary to article 5(1).

Comment

This case is interesting for what it says about the conditions of detention under Article 5(1). The appropriateness of place and conditions are relevant criteria for determining whether detention is arbitrary. This reasoning applies equally to detention in the context of, for example, a care home or hospital setting, under Article 5(1)(e) (lawful detention of persons of unsound mind). Indeed, in reaching its conclusion on the law, the Court of Appeal referred to a number of Article 5(1)(e) cases including *Ashingdale v United Kingdom*(1985) 7 EHRR 528. In that case, the European Court of Human Rights made clear that *"there must be some relationship between the ground of permitted deprivation of liberty relied on and the place and conditions of detention. In principle, the "detention" of a person as a mental health patient will only be "lawful" for the purposes of sub-paragraph (e) of paragraph 1 if effected in a hospital, clinic, or other appropriate institution authorised for that purpose…"* The Article 5 obligation to ensure that the place and conditions of detention are suitable and appropriate chimes with a basic principle in the MCA that, in making arrangements for a deprivation of liberty, regard must be had to whether it can be achieved in a way that is less restrictive of P's rights and freedoms.

Short Note: St George's and the powers of the court

Newton J has authorised the publication of the order he made in *St George's Healthcare NHS Trust v P & Q* [2015] EWCOP 42 (discussed here). The order makes clear what we had suspected must have been the case (but was made inadvertently ambiguous in the judgment), namely that he did not order the Trust to continue providing P with renal replacement therapy; rather he declared that it was lawful (being in his best interests) for him to continue receiving it. Had Newton J ordered the Trust to continue providing such treatment, that would have represented a very significant step over the well-respected dividing line between the roles of the court and clinicians. For those who want to read more about this, an article by Alex should be appearing in the next issue of the Medical Law Review.

Establishing necessity in deprivation of liberty – Strasbourg speaks again

Hadžimejlić and Others v. Bosnia and Herzegovina (Application no 3427/13) ECtHR (Fourth Section)

Article 5 ECHR – deprivation of liberty – DOLS authorisations

Summary

Three citizens in Bosnia and Herzegovina were deprived of their legal capacity and deprived of their liberty in a social care home because their families were not prepared to take care of them and they needed social assistance. The Constitutional Court had previously decided that this breached Articles 5(1) and 5(4) because such psychiatric detention had to be authorised by a decision of the civil courts and there was a lack of judicial review of the lawfulness of the detention. When the deprivation of liberty was reviewed, the relevant civil court decided that their state of health did not warrant continued confinement in the care home. However, they were not released

because their continued placement was considered to be in their best interests for reasons of social protection.

The ECtHR repeated its well-rehearsed principles regarding Article 5(1)(e), cited the 2007 report of the European Committee for the Prevention of Torture etc (which criticised the process of admission to social care homes in the country), and referred to Articles 14 and 19 of the CRPD as well as Recommendation No. Rec(2004)10. In light of the Constitutional Court's decision, the ECtHR had no difficulty in concluding that there had been a breach of Article 5(1) in not securing the citizens' release from detention (paras 54-59).

Comment

This is another ECtHR decision that confirms that deprivation of liberty in a care home can only be justified if the unsoundness of mind is of a kind or degree to warrant it. Sadly missing from the judgment are details as to what less restrictive alternatives to the care home were available. The Constitutional Court had ordered the social work centre (which placed them there) to "take measures to ensure respect for the applicants' rights" under Article 5. The government contended that their continued placement was in their best interests. However, the ECtHR took the unusual step of ruling that the State "must secure … release from the Drin social care home without further delay". Perhaps such muscular flexing of the Article 5 protection in the absence of concrete alternatives demonstrates the paramountcy of physical security.

BIA Time Survey

In July 2015 Cornwall Council DoLS team started a BIA Time Survey looking at how long DOLS assessments take. The link to the report is now available here. The headline finding is that The average time taken per DOLS assessment by the 507 respondents to this survey is 12.1 hours, but we would recommend that the full study is read carefully to see precisely how the assessors in question approached their tasks.

Emma Goodall and Paul Wilkins are to be congratulated on undertaking a really valuable piece of work which gives an actual evidence base upon which to build policies in the future.

CQC 6th annual report on monitoring DOLS

The 6th annual reporting on monitoring DOLS is now available.

The key findings are reproduced below.

> ***There has been a tenfold rise in Deprivation of Liberty Safeguards applications in 2014/15***
>
> *Since their introduction in 2009, numbers of applications to use the Deprivation of Liberty Safeguards were consistently low. However, this changed in March 2014 following the ruling of the Supreme Court which clarified the test for when people are deprived of their liberty. Since then, applications have increased tenfold from 13,715 in the year ending March 2014 to 137,540 by March 2015.*
>
> ***Providers' use of the Deprivation of Liberty Safeguards is variable***
>
> *Through our inspections in 2014/15, we found that staff training and awareness of the Deprivation of Liberty Safeguards varies across providers, as do the existence and implementation of policies and processes. We found examples where some providers may be unlawfully depriving people of their liberty.*

> ***Improvement is needed across the health and social care sector***
>
> *We believe that the current pressures on the system are unsustainable. We welcome the Law Commission's consideration on the process for authorising deprivations of liberty and await its final proposals for reforming the system. It is also important that providers and local authorities follow the current legislation and Codes of Practice to the Mental Capacity Act and the Deprivation of Liberty Safeguards to ensure that people's rights are protected.*
>
> *We will continue to monitor the response of providers and the wider system going forward. We will continue to use our inspections and reports to encourage improvements in practice, and challenge providers if they are not meeting legislative requirements which may include taking enforcement action.*

There is also a useful – and revealing – map indicating visually just how rates of applications vary across England and Wales.

In the body of their report, the CQC give their initial reaction to the Law Commission's provisional proposals thus:

> *We agree that the proposed 'protective care' scheme should better serve the needs of people affected, and provide a better framework for their families and representatives to become involved in the care being offered. However, we are concerned that some aspects of the current proposals are complex, and may not be easily understood by everyone who will be affected by them, including those involved in their implementation. We look forward to the Law Commission's recommendations for reform after they have considered the consultation feedback. A draft Bill is expected to be published in 2016*

The CQC recommend, in the interim, that "[l]*ocal authorities must not advise providers to delay or inappropriately minimise their applications as this increases the likelihood of people being unlawfully deprived of their liberty*."

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Conferences at which editors/contributors are speaking

International Protection of Adults

Alex and Adrian will be participating in a seminar at the British Institute of International and Comparative Law on 11 February on Hague 35 and cross-border matters. More details will be available soon on the BIICL website.

Fatal Accidents Inquiries and Psychiatric Patients

The next seminar in the Centre for Mental Health and Incapacity Law series will be on Fatal Accidents Inquiries and Psychiatric Patients, to be held on 27 January 2016, the speakers being Jill and Dr John Crichton. More details can be found 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 Mind in return for postings for English and Welsh events. For Scottish events, we are inviting donations to Alzheimer Scotland Action on Dementia.

Chambers Details

We are taking a break over the New Year, so our next Newsletter will be out in early 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 Newsletter in the future please contact marketing@39essex.com.

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THE QUEEN'S AWARDS FOR ENTERPRISE INTERNATIONAL TRADE 2013

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Anna regularly appears in the Court of Protection in cases concerning welfare issues and property and financial affairs. She acts on behalf of local authorities, family members and the Official Solicitor. Anna also provides training in COP related matters. Anna also practices in the fields of education and employment where she has particular expertise in discrimination/human rights issues. 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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