MEDICAL TREATMENT CASES

The legality of all medical treatment is founded on the existence of consent or some lawful authority. Medical treatment cannot be given without consent. Consent is given either by the competent adult or if the patient is a child or an adult that lacks capacity then either with the consent of someone with authority to give consent on the patient's behalf or the authority of the court; or if the patient is incompetent and aged 16 or over by reason of the common law doctrine of necessity (as applied within the statutory regime of the MCA 2005).

There are limits to the extent to which consent is capable of providing a defence in criminal law to offences of assault (*see R v Brown* [1994] 1 AC 212*; R v Wilson* [1996] 3 WLR 125). It is generally accepted that 'reasonable surgical interference' is lawful and would not render the surgeon open to a criminal prosecution. The so-called medical exception is justified on the basis of public interest or for therapeutic purposes. However, there are examples of surgery such as cosmetic surgery which arguably has no therapeutic purpose and is not necessarily in the public interest but which has always been accepted as lawful where a patient with capacity gives consent.

No consent can be obtained without the nature and effect of the proposed treatment being communicated to the patient or other person giving proper consent. Sufficient information must be given to enable the person consenting to understand in broad terms what is to be done and the effects of it. The information may be given orally or in writing. In practice it is nearly always oral but may be supplemented in writing. Where a surgical or invasive procedure is contemplated it is usual to for a consent form to be used. Clearly, consent is not valid if it is obtained by fraud; by duress or from a person who lacks capacity.

Selection of recent cases where applications have been made in relation to treatment.

An NHS Trust v L & Ors

8 October 2012
Citation: [2013] EWHC 4313 (Fam)
Judge/s:
Moylan J

The case concerned an application by an NHS Trust for declarations that it would be lawful to withhold life-sustaining treatment from a 55 year old man who suffered from a number of medical problems, and had sustained a severe hypoxic brain injury following cardiac arrest. L was said by his treating doctors to be in a vegetative state at the time of the application, and to have a less than 1% chance of a meaningful recovery. It later transpired that there was some question over his diagnosis, and it was possible that he was at the lower end of the spectrum of minimal consciousness. In any event, his family was adamant that he was aware of himself and his environment, and that he would have wanted to have all possible life-sustaining treatment provided, not least in view of his religious beliefs as a practising Muslim.

The treating doctors took the view that resuscitation or the use of the ventilator would be a cruel and unnecessary way of prolonging L's life. Their stance was supported by an independent expert instructed by the Official Solicitor on behalf of L, who said that his death would be characterised by a series of harmful interventions if the declarations sought were not granted. It was said that there was unlikely to be any clinician in the country who would provide the relevant life-sustaining treatments to L.

The judge accepted that it was unrealistic to imagine that L would emerge from a minimally conscious state, and that further life-sustaining interventions were unlikely to be effective - even if they were, they would at best only return L to his present level of awareness. The judge indicated that since there were no doctors willing to provide the treatment at issue, there were in fact no treatment options for the Court of Protection to make a declaration about. None of the parties had pursued the case on this basis however, so the judge carried out a balancing exercise and concluded that it

was not in L's best interests for further life-sustaining treatment to be given. L's wishes could not simply be followed – the test the court had to apply was that of best interests, not substituted judgment. The administering of life-sustaining treatment would prolong L's death, it would not prolong in any meaningful way, his life.

This case is an interesting contrast to the first reported case concerning a patient in a minimally conscious state – the case of **W v M** [2011] EWHC 2443 (COP). In M's case, her family was unanimous in its view that M would not have wanted to be kept alive in that state. Yet the court decided it was in her best interests for artificial nutrition and hydration to continue. In L's case, the family was unanimous in its view that L would have wanted further treatment. Yet the court reached the opposite conclusion. In L's case, the court's decision was perhaps inevitable given that there were no doctors willing to provide treatment, but the issue of how to deal with P's likely wishes in end of life scenarios remains a difficult one.

An NHS Trust v Mr. and Mrs. H & Ors
5 October 2012
Citation: [2012] EWHC B18 (Fam)
Judge/s:
Peter Jackson J

In these proceedings the Court was asked to consider an application by an NHS Trust for best interests declarations approving a medical treatment plan withholding treatment relating to KH.

KH was a three and a half year old boy. When he was just over a month old he contracted a Herpes virus infection which caused viral encephalitis. As a result, he sustained a serious brain injury and now functions below the level of a new born baby. He had a number of complex additional medical

complications, is unable to communicate and was entirely dependent on his foster carer.

The medical treatment plan at issue provided that life sustaining treatment should be withheld from KH when (as inevitably it would), his medical condition deteriorated on the basis that it would not be in his best interests aggressively to treat him in those circumstances. The plan was supported by the Trust and his foster carer. His parents lacked capacity to make decisions about his medical treatment and were represented in the proceedings by the Official Solicitor. They were unable to support the plan fully. The plan was opposed by the Children's Guardian and the Local Authority who were unable to support a medical treatment plan which proposed to withhold life sustaining treatment.

The NHS Trust invited the Court to declare that it was lawful and in KH's best interests "to have medical treatment withheld in the circumstances as described in the attached Advanced Care Plan."

In his judgment, Peter Jackson J summarised the state of the law in relation to the withdrawal of or withholding of medical treatment from children, endorsing in so doing the guidance produced by the Royal College of Paediatrics and Child Health upon "Withholding or Withdrawing Life Sustaining Treatment in Children: A Framework for Practice" (Second Edition) May 2004. He also indicated that he found some guidance as to how best to approach the question of the "best interests" test applicable by reference to s.4 MCA 2005 (although it had no legal application with regard to the Court's inherent jurisdiction in this regard).

As regards the fact that KH's parents lacked litigation capacity, he had this to say:

"10. In this case, KH's parents have been found to lack litigation capacity and it is understood that they are to be represented by the Official Solicitor as next friend. In these circumstances it is submitted that to be consistent with the

Mental Capacity Act 2005 as amended, and in particular section 4(6) of that Act, regard should be had to the parents' wishes and feelings, but only to the extent that these relate to KH's best interests, which are for the Court to assess objectively. As stated by Holman J at 8x) above, 'Their own wishes, however understandable in human terms, are wholly irrelevant to consideration of the objective best interests of the child save to the extent in any given case that they may illuminate the quality and value to the child of the child/parent relationship'. A fortiori, this caveat must apply more forcefully to the views or wishes of parents without capacity who are not themselves looking after the child in question. The Official Solicitor, acting as litigation friend for KH's parents, should of course seek to advance a position in the 'best interests' of KH's parents rather than KH himself. It is important to note, therefore, that whilst the Official Solicitor's views in this regard may well elide with the 'best interests' of KH, there is this distinction to be made. This contrasts with the Official Solicitor's usual role in Court of Protection proceedings, where he seeks to advance P's best interests (rather than those of other Respondents to such proceedings).
[…]

16. My only other comment relates to the statement in paragraph 10 of Mr Hallin's summary that: 'A fortiori, this caveat [i.e. the irrelevance of the wishes of others, save to the extent that they cast light on objective best interests] must apply more forcefully to the views or wishes of parents without capacity who are not themselves looking after the child in question.' I readily accept that an involved and capacitous parent may be better placed to express views that assist in assessing best interests than one who is less involved or capacitous, but that is a matter of evidence and not one of principle. Parents who lack capacity may still make telling points about welfare and it would be wrong to discount the weight to be attached to their views simply because of incapacity. It is the validity of the views that matter, not the capacity of the person that holds them. In the present case, I have not discounted the views of the mother on the ground that she is represented by a litigation friend (the Official Solicitor) who does not oppose the declarations sought by the Trust, but have tried to approach her views on their merits."

Peter Jackson J held that it was appropriate that the matter had been brought to Court whilst KH was in relatively good health such that the issues could be fully explored in a way which would not have been possible if the parties had waited until he had deteriorated and been forced to make an urgent application. However, the corollary of that approach was that the medical issues had not fully crystallised. He went on to hold that there were difficulties with the request that the Trust had made, as the Court's function was to make decisions about specific issues on the basis of a factual substrata. Accordingly, open ended declarations should be avoided by Judges as they might need to be revisited in the future: Wyatt v Portsmouth Hospital NHS Trust [2005] EWCA Civ 1181 at paragraphs 117 and 188 per Wall LJ. Accordingly, his approach was to identify the treatment issues that needed to be determined and that were not likely to change over time and in respect of which declarations can be made.

On the facts of KH's case, those treatment issues were clear as his condition was well understood, the scope for improvement was almost nil, and the prospect and manner of deterioration was inevitable. Had there been a major issue over which there was uncertainty, it would not have been possible to resolve it in theory ahead of it crystallising in reality.

Re E (Medical Treatment Anorexia) [2012] EWHC 1639 (COP)

These were proceedings concerning capacity and continued medical treatment and whether it would be in the interests of a severely malnourished adult suffering from anorexia nervosa to be fed, forcibly, if necessary.

E, a 32-year old woman suffering from extremely severe anorexia nervosa and other chronic health conditions including alcohol dependence.

Proceedings were brought by the local authority in May 2012 when E was severely malnourished, refusing to eat and receiving only palliative care. E had

a history of treatment both in residential placements and in the community which had not been successful in curing her eating disorder. Previously, in 2011, E had twice attempted to make advance decisions refusing treatment.

E was diagnosed as suffering from a very rare triad of anorexia, alcoholism and personality disorder. Her parents, although not wanting E to die, did not support any further medical intervention unless there was a real prospect of success. The health authority adopted a neutral position; E's treating doctors were doubtful about further coercive treatment but were willing to support the court's decision. The Official Solicitor relied on the advice of the instructed expert, who advised that highly specialised treatment was available, which had not been tried, that although not without significant risk might return E to relatively normal life. The local authority, initially neutral, ultimately supported that position.

Jackson J considered that although E was an intelligent and articulate woman, by virtue of her anorexia she lacked capacity to accept or refuse treatment in relation to any interventions that are necessary in conjunction with forcible feeding. Equally, she lacked capacity at the time of her advance decisions in 2011. On the question of best interests, His Lordship weighed the advantages and disadvantages of continued palliative care against treatment by forcible feeding. His Lordship considered that, put simply, a balance must be struck between the value of E's life in one scale and the value of her personal independence on the other. Although struck by the fact that those who knew E best, including E herself, did not favour further treatment, His Lordship did not consider that further treatment to be futile; the presumption in favour of the preservation of life should not be displaced. Declarations were therefore made that E lacked capacity and that it would be lawful and in E's best interests for her to be fed, forcibly if necessary.

An NHS Foundation Trust v VT and A

13 November 2013

Citation: [2013] EWHC B26 (Fam)
Judge/s:
Hayden J

This medical treatment case concerned a male patient who had previously suffered a stroke which had rendered him housebound. He sustained a cardiac arrest which caused his brain to be deprived of oxygen for some 17 minutes, resulting in a further serious deterioration in his condition. The NHS Trust sought declarations that it would be unlawful to provide intensive care and/or resuscitation other than bag and mask resuscitation to address an acute episode, should VT's condition deteriorate any further. VT's family considered that it was in VT's best interests for such treatment to be provided. The judge summarised their position thus: They all believe that VT would have wanted to avail himself of every possible opportunity for survival in its crudest, most basic sense, no matter what the pain involved, no matter what the prospects for long-term survival might be, no matter what quality of life might lie at the end of the journey or, indeed, during it. Those ultimate decisions they believe to be for Allah alone. They believe that VT's suffering would also cleanse him from sin, would prepare him for death and would be borne by him with stoicism, in recognition of that process.

The unanimous medical evidence, including that from an expert instructed by the family, was that VT was minimally conscious, that he had suffered a severe brain injury, and that there was very little prospect of any meaningful recovery for example communicative ability or motor function. At most, he might live for a further year if provided with all possible treatment, most probably still in a minimally conscious state. The court heard graphic evidence of what are often simply described as the 'burdens' of intensive care treatment, and noted the evidence that less than 1 in 5 people resuscitated in hospital survives to discharge. VT's treating clinician told the court that even if VT's family "had accurately described what VT's view would have been, were he able to communicate them", pursuit of those wishes would be "…against all the things I stand for as a doctor."

The judge accepted that the interventions at issue would be "wholly contrary to the central medical objectives of intensive care," noting that treatment would "at best only preserve the existing parlous situation." CPR, even if successful, would result in further damage to VT's brain. Even bearing in mind VT's likely wishes, to administer CPR would be "to expect doctors to cause pain for no justifiable medical reason other than to accommodate the religious or other beliefs of a patient. It would require those who, through medical training and personal beliefs, want to help the patient, to do the exact opposite – that would be neither ethical nor lawful in my judgment." However, the use of manual suction to remove respiratory blockages was lawful. Admission to intensive care would be 'wholly futile' because it would be:

Likely to cause distress, discomfort and probably pain;

Unable to achieve any positive medical benefit;

Life-threatening, in and of itself;

To further compromise VT's vital organs, and therefore medically harmful.

Hayden J rejected attempts by the Trust and Official Solicitor to suggest that VT himself would have agreed with the medical view, accepting that the family was most likely to be correct, particularly having regard to their religious beliefs, particularly the 'right', if necessary, to suffer in accordance with his faith. Nevertheless, VT's likely wishes could not require doctors to provide futile and harmful treatment to him.

Aintree University Hospitals NHS Foundation Trust (Respondent) v James (Appellant)

30 October 2013

Citation: [2013] UKSC 67

Judge/s:

Supreme Court (Lord Neuberger, President, Lady Hale, Deputy President, Lord Clarke, Lord Carnwath and Lord Hughes)

Mr James was a 68 year old man who was seriously ill and had been in intensive care for some 7 months when his treating clinicians applied to the Court of Protection for declarations as to the lawfulness of withholding further invasive treatment and CPR. Regular readers will recall that the first instance judge refused to make the 'absolute' declarations sought, but the Court of Appeal was satisfied, having had regard to new evidence as to Mr James' condition, that the declarations were in his best interests. The Supreme Court granted permission to appeal, notwithstanding that Mr James had died shortly after the Court of Appeal hearing.

The Supreme Court's judgment (given by Baroness Hale, with whom the other Supreme Court Justices agreed) reaffirms a number of well-established propositions concerning the MCA 2005 and, in particular, medical treatment decisions:

1. the MCA 2005 is concerned with enabling the court to do for the patient what he could do for himself if of full capacity, but it goes no further. On an application under the Act, therefore, the court has no greater powers than the patient would have if he were of full capacity. Patients cannot demand that doctors administer treatment which the doctor considers is not appropriate;

2. any treatment which the doctors do decide to give must be lawful. The question for the Court of Protection is not whether it is lawful to withhold treatment, but whether it is lawful to give it, since without consent (or a best interests decision on behalf of an incapacitated treatment) medical treatment of any sort cannot be administered;

3. P's own wishes are of central importance in best interests decision making, notwithstanding that the MCA 2005 does not impose a test of substituted judgment. There is a need to see the patient as an individual, with his own values, likes and dislikes, and to consider his best interests in a holistic way.

The Supreme Court considered what the meaning of the terms 'futility' and 'no prospect of recovery' in the Code of Practice to the MCA 2005 meant, in the

context of the provision of life-sustaining treatment. The approach taken by the Court of Appeal, which viewed futile treatment as treatment that would not cure or at least palliate the life-threatening disease or illness from which the patient is suffering, was rejected. Futility was to be considered as treatment which is 'ineffective' or 'of no benefit to the patient'- 'A treatment may bring some benefit to the patient even though it has no effect upon the underlying disease or disability'. When considering whether a patient has a prospect of recovery, 'recovery' meant the resumption of a quality of life which that patient would regard as worthwhile, not one that others (including doctors) would regard as worthwhile. The question is not whether there is a prospect of recovering 'such a state of good health as will avert the looming prospect of death if the life-sustaining treatment is given.'

Recognising that the definition of 'best interests' is necessarily elusive, the Supreme Court stated that:

'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.'

The Supreme Court also rejected the suggestion made by the Court of Appeal that the test of the patient's wishes and feelings was an objective one, or what 'the reasonable patient' would think: "The purpose of the best interests test is to consider matters from the patient's point of view. That is not to say that his wishes must prevail, any more than those of a fully capable patient must prevail. We cannot always have what we want. Nor will it always be possible to ascertain what an incapable patient's wishes are. Even if it is possible to

determine what his views were in the past, they might well have changed in the light of the stresses and strains of his current predicament. In this case, the highest it could be put was, as counsel had agreed, that 'It was likely that Mr James would want treatment up to the point where it became hopeless'. But insofar as it is possible to ascertain the patient's wishes and feelings, his beliefs and values or the things which were important to him, it is those which should be taken into account because they are a component in making the choice which is right for him as an individual human being."

However, having disagreed with the Court of Appeal on its approach to the law, the Supreme Court found that in light of the changed medical position that prevailed by the time that matter had come before the Court of Appeal, it had reached the right conclusion, and so the appeal was dismissed.

Re AA

23 August 2013 Citation: [2012] EWHC 4378 (COP)

Judge/s: Mostyn J

The judgment in the 'forced C-section' case has now been published, and reveals what many suspected at the time of the media storm namely that the facts were very far from those which were reported. As Sir James Munby P has noted, however, in the decision upon reporting restrictions in the proceedings relating to the child [2013] EWHC 4048 (Fam):

"43. … there are two points that require to be addressed with honesty and candour. Both relate to the fact that, when this story first 'broke' on 1 December 2013, none of the relevant information was in the public domain in this country.

44. The first point is this: How can the family justice system blame the media for inaccuracy in the reporting of family cases if for whatever reason none of the relevant information has been put before the public?

45. The second point is, if anything, even more important. This case must surely stand as final, stark and irrefutable demonstration of the pressing need for radical changes in the way in which both the family courts and the Court of Protection approach what for shorthand I will refer to as transparency. We simply cannot go on as hitherto. Many more judgments must be published. And, as this case so very clearly demonstrates, that applies not merely to the judgments of High Court Judges; it applies also to the judgments of Circuit Judges.

The mother was Italian, with two previous children. We now know that she is (and can be named as) Alessandra Pacchieri. Ms Pacchieri had had problems with her mental health since 2007, and there were admissions to psychiatric hospitals in Italy. As of 2011, her two children were in the care of their grandmother, and proceedings relating to the children were on foot in 2012 when the mother came to England. The woman, who suffered from bi-polar disorder, became very unwell during a work-related visit to England in 2012, a visit she undertook whilst pregnant. On 13 June 2012 she was detained under s.2 and subsequently s.3 of the Mental Health Act, and was profoundly unwell.

From the transcript and the judgment delivered at the hearing on 23 August 2013 (together with the unusual covering note drawn up by Mostyn J on 4 December 2013), the following further information becomes clear:

It was an urgent application first made at 16:16 on 23 August 2012 by the NHS Trust with responsibility for Ms Pacchieri, supported by the evidence of a consultant obstetrician and the patient's own treating consultant psychiatrist, seeking a declaration and order that it would be in her medical best interests that Ms Pacchieri, who had undergone two previous elective caesarean sections, but was incapable of making decisions about the birth method, to have this birth, the due date of which was imminent (she was 39 weeks pregnant), in the same manner on the next day;

The primary risk identified by the NHS Trust was that of uterine rupture with a natural vaginal birth. Mostyn J identified the risk – put at as much as 1% -

as 'significant.' Mostyn J also took into account that he considered that it would be in the 'mental health best interests' of the mother that her child be born alive and healthy, and that it not be exposed to risk during his or her birth;

In holding that it was in AA's best interests to undergo a Caesarian section (including by use of reasonable force if required), Mostyn J considered that he was applying conventional principles set down by the Court of Appeal in the case of Re MB (Medical Treatment) [1997] 2 FLR 426; Essex County Council were not represented before the Court, but it appeared that the Trust understood that the Council intended to invite the police, under s.46 Children Act 1989 to exercise their powers to remove the child into police protection for a period not exceeding 72 hours, as the Act provides, on the basis that the police would, by virtue of information supplied by the local authority, have reasonable cause to believe that the child, once born, would be likely to suffer significant harm.

The Official Solicitor raised his concerns via Counsel about this course of action; Mostyn J agreed that it would be 'heavy handed,' and instead required that the local authority be advised by way of preamble to the order made to make an application on notice to the Official Solicitor to him for an interim care order. It appears that, in fact, an interim care order was applied for in the Chelmsford County Court on 24 August, immediately after the baby was born; Mostyn J then consented to the application being dealt with by the relevant Circuit Judge in Chelmsford.

It is not clear from the transcript of the judgment why it was that the application was only made the day before the procedure was scheduled. It should have been evident to the NHS Trust – who had been caring for Ms Pacchieri for several weeks under the provisions of the MHA 1983 – that (a) she was in the later stages of pregnancy; and (b) she had had at least one previous Caesarean section. Given that the primary basis upon which the procedure was said to be in her best interests was the risk of uterine rupture if she underwent a vaginal birth following her previous Caesarean sections, it

would therefore on one view seem rather obvious that the Trust should have moved with greater speed to bring the matter to Court in advance of the procedure.

The Court of Appeal in Re MB and in St George's Healthcare NHS Trust v S [1999] Fam 26 stressed the importance of bringing applications regarding Caesarean sections to Court in a timely fashion. Assuming that the procedure had to take place on 24 August, and hence the proceedings could not be adjourned, the fact that the application was only issued the day before radically limited the ability of the Official Solicitor to take steps to investigate and (if appropriate) consult with Ms Pacchieri to obtain her views;

It is not entirely clear from the transcript whether the fact that Ms Pacchieri appears not to have been consulted in advance (and was not to be informed subsequently) was the result of a considered decision that such was not in her best interests. If it were then one would have expected to see this recorded in the judgment. If not, then some potentially difficult questions arise as to whether the decision could be said to have complied with s.4(4) MCA 2005.

Re SB

21 May 2013 Citation: [2013] EWHC 1417 (COP)

Judge/s: Holman J

The issue in this case was whether the mother (P) had the capacity to decide to terminate her pregnancy at the twenty-third week of its term. P was a 37 year old woman who suffered from bipolar disorder which had at times been controlled by medication, although she had also suffered from relapses and remitting symptoms. She became pregnant in December 2012 and her evidence was that at that point she had wanted to have a baby. The evidence also suggested that until April 2013, she had conscientiously attended scans and had showed every sign of wanting to keep the baby. She had then ceased taking her prescribed medication. She started to exhibit behaviours which led members of her family including her husband and mother to believe that she had become unwell. On 17 April 2013, P attended a clinic seeking to have an

abortion. For various reasons, although appointments were made on two separate occasions for the procedure to be carried out, she did not in fact have the termination. At the beginning of May 2013 she was compulsorily detained under s.2 Mental Health Act 1983. Despite that, she had maintained her wish to terminate the pregnancy and therefore not only consented to the abortion but was herself "very strongly" requesting it.

The hospital where she was detained believed that she did not have capacity in the relevant regard and issued proceedings in the COP seeking a determination by the Court and associated declarations as to whether (1) she lacked capacity to make decisions about the desired termination of her pregnancy; and (2) if she lacked capacity, whether it was in her best interests to undergo an abortion procedure.

In an ex tempore judgment, Holman J began by setting out a number of principles defining the parameters of his decision. In particular, he noted that the decision was being taken within the framework of the existing law and in accordance with the provisions of the Abortion Act 1967.

Regarding the question of capacity, Holman J reiterated the cardinal principles that a person is presumed to have capacity in the relevant regard unless it is established that they do not and further that if they have capacity then they also have autonomy to make a decision which may be unwise or which others do not agree with.

Holman J noted that the evidence of P's treating consultant psychiatrist was very clear that P lacked capacity in the relevant respects. That view was shared by the independently instructed Psychiatrist, Dr Smith. Dr Smith's evidence was that P perfectly understood the procedure and what would be involved as she had previously had a termination. She understood the finality of the decision. However, Dr Smith considered that P lacked capacity as the basis of her decision was flawed evidence and paranoid beliefs, particularly but not exclusively in relation to the future support she believed her husband would provide. In reaching her conclusion, Dr Smith relied on the temporal

relationship between P stopping her medication, developing paranoid ideas about her husband and mother and deciding to opt for a termination of pregnancy.

Holman J emphasised that, once the issue was before a court, the overall assessment of capacity is a matter for the judgment of the court. Whilst acknowledging that in most cases the evidence of two psychiatrists would be determinative, he reached a different overall conclusion as to P's capacity in this case.

Where Holman J disagreed with the experts was as to the "level of the bar as to capacity", the relevant question under s.2 MCA 2005 being whether P is "unable" to make a decision. The judge considered that the evidence was that P had reached a decision some weeks previously and had maintained her position and so "there is no doubt that she has capacity to 'make' a decision." The more complex question was whether P was unable to use or weigh the information, as s. 2 had to be read in light of s. 3, and the psychiatric evidence was that she could not.

However, Holman J considered it of significance that, even if it was correct that certain of P's beliefs in relation to her husband and mother were paranoid, she had cited a number of discrete rational reasons as to why she did not wish to carry the child to term. These included the fact of her current situation (as a person detained), her ability to care for the child in the future and that the fact that carrying the child made her feel suicidal. Holman J concluded that P was a person who had made and maintained for an appreciable period of time a decision. He concluded that it would be:

"…a total affront to the autonomy of this patient to conclude that she lacks capacity to the level required to make this decision. It is of course a profound and grave decision but it does not necessarily involve complex issues. It is a decision that she has made and maintains; and she has defended and justified her decision against challenge. It is a decision which she has the capacity to reach. " The proceedings were dismissed.

LB Redbridge v G, C and F

[2014] EWHC 485 (COP) (Russell J) MARCH 1, 2014

This case deals with the dividing line between the Court of Protection and the inherent jurisdiction of the High Court.

Russell J had to consider two applications made by the London Borough of Redbridge in relation to an elderly lady, G, considered to be a vulnerable adult. The first was an application for relief under the inherent jurisdiction. The second was a proposed application under the MCA 2005 in respect of the same woman following psychiatric evidence of lack of capacity to take the material decisions.

The local authority and the Official Solicitor (who acted as litigation friend for G) submitted that G lacked capacity and fell within the MCA 2005. C (her current live-in carer) submitted that she did not lack capacity under the MCA nor had she been deprived of it by duress or the influence of C and F.

Russell J helpfully gave a summary of the case at the outset which suffices to identify the major points of significance:

"2. In this case the local authority were under a duty to investigate the circumstances of an old and frail lady following reports regarding the behaviour of C and F and their influence over G, her home and her financial affairs and with respect to her personal safety from multiple sources including private citizens and professionals, from agencies providing care support and from a lawyer engaged by C to act for G (to change her will in C's favour). The complaints came from G too; although she would later retract them. The obstruction met by the social worker when she tried to carry out her duties led to the attendance of the police more than once.

3. The local authority had no alternative but to visit on numerous occasions and to attempt to see G on her own. Anything else would have been a dereliction of their duty to her as a vulnerable person about whom they had received complaints about possible financial predation. Local authority staff must be permitted to carry out their duty to investigate reports relating to safeguarding unhindered.

4. The court has decided for reasons set out in full below that G lacks capacity under the provisions of the Mental Capacity Act 2005 and that further investigation needs to be carried out to decide how her best interests will be met and her comfort and safety assured. Her wishes and feelings will be taken into account at every stage as will her desire to remain in her own home. It is the court's intention that every measure that can be put in place to secure her in her own home is put place. There is an equal need to ensure that she is not overborne or bullied and that she can lead her life as she wants it led.

5. All the expert evidence put before the court was of the opinion that G was a vulnerable person who lacked the capacity to conduct this litigation and to decide on her financial affairs and the disposition of her property without the assistance of an independent professional appointed by the court. There was disagreement as to the reason for the lack of capacity; the court decided, on the balance of probabilities, that it was due to a impairment of G's mind or brain."

There are a few points that require explanation and/or which stand as useful practice points for the future:

Orders were initially made under the inherent jurisdiction in respect of C and F forbidding them from harassing or intimidating G or damaging or disposing of her possessions. The Court also made orders for the local authority to arrange and file an assessment of G's litigation capacity and capacity to manage her property and affair. Orders were made that C and F had to allow full access to G for the assessment to be carried out.

In the event that G was found to lack litigation capacity the Official Solicitor (OS) was invited to act as litigation friend. These orders were made by a Circuit Judge, sitting as a Deputy High Court judge (paragraph 39): this is helpful confirmation that a Circuit Judge (whether or not they have the requisite designation to sit as a Court of Protection judge) can make such orders if they have a 's.9 ticket' – i.e. an authorisation granted by the Lord Chief Justice under s.9 Senior Courts Act 1981;

Russell J allowed C to rely upon the evidence of an educational and clinical psychologist, a Dr Lowenstein, who had been instructed by C with the assistance of a third party, despite the fact that his report was not approved by the court nor was disclosure to him of documents produced and filed within the proceedings. He had not received any formal instructions. Russell J agreed to allow the evidence so long as Dr Lowenstein's evidence could be challenged by cross-examination, because G was aware of it, having been taken to see Dr Lowenstein. As Russell J noted, "[i]t is important for her to be aware that the court had heard all the available evidence about her capacity," although she noted that "[t]here can be little doubt that had the local authority sought to adduce evidence in this way Ms Hewson [Counsel for C] would have been vociferous in her condemnation of such an attempt" (paragraph 41);
G was present in court "displaying dignity and determination to get her views across" (paragraph 49). The proceedings were also held in open court (it seems, because they were held under the inherent jurisdiction), with members of the public and the media present, although subject to a reporting restriction order;

Both an independent psychiatrist and an independent social worker had been instructed to report upon G's capacity to make decisions in the following areas as regards (1) the people who live with her; (2) contact with others; and (3) financial matters. Both agreed that G's capacity to reach decision was undermined by the influence and presence of C and F. The independent social worker was of the view that the lack of capacity was as a result of the undue influence, whereas the independent psychiatrist was of the view that G was

suffering from an impairment or disturbance in the functioning of her mind or brain.

Russell J preferred the evidence of the psychiatrist "given his speciality, expertise and knowledge of the functioning of the mind and brain. The differences in their views reflect the difference in their disciplines and field of expertise" (paragraph 62). Russell J placed little weight upon the evidence of Dr Lowenstein because he had received no formal instructions, had conducted an entirely inadequate interview in the presence of C (which he acknowledged he should not have done), had not read or assimilated the documents that he been shown (without the leave of the court) and had minimal experience working with the elderly. He had, in any event, expressed concerns about her ability to manage her own affairs and to conduct litigation;

Russell J applied the two-stage diagnostic and functional test to decide whether G had capacity. She found, on the basis of the evidence of the independent psychiatrist, that G suffered from significant cognitive impairment which rendered her incapable of taking the relevant decisions. In particular, whilst G understood some of the information relevant to decision-making, for instance that "C and F have taken control of her finances and has complained about being shouted at and physically shaken but she is unable to use the information to make a decision about her own welfare and care and allows them to remain in her home. This information about C and F living with her or not is relevant for the purposes of s3 (4) as it includes the reasonably foreseeable consequences of deciding one way or another or failing to make the decision. The decision as to contact with others and whether or not she should see other people falls into this same category. She does not foresee that to allow visitors would have benefits including oversight of her care and treatment at the hands of others. I accept that the influence and controlling behaviour of C and F described by the witnesses and in the documentary evidence before the court will have further compromised the ability of G to make decisions and understand what is happening to her" (paragraph 81).

A final wrinkle is that G had executed two LPAs in favour of C, relating to property and affairs and health and welfare. There was a defect on the instrument for the property and affairs LPA which meant that it could not be registered (C not having submitted the relevant documentation to remedy the defect): Russell J did not therefore need to take any steps in relation to this LPA but could proceed immediately to appoint an independent panel deputy to administer G's property and affairs. The LPA was, however, registered because no objections were received within the statutory time frame – an order was made by the Circuit Judge hearing the case some seven days outside that time frame requesting that the OPG did not register the LPA, but this was too late. Rather, Russell J acceded to the proposal set out in a position statement filed by the OPG to direct C not to exercise any of the powers under the LPA pending the determination of the applications before the Court of Protection.

R (David Tracey) v Cambridge University Hospitals NHS Foundation Trust & Ors

24 January 2014 Citation: [2014] EWCA Civ 33

Judge/s: Master of the Rolls, LJ Longmore, LJ Ryder

David Tracey, acting personally and on behalf of the estate of his deceased wife, Janet Tracey, brought an application for judicial review against (i) Cambridge University Hospitals NHS Foundation Trust in relation to the placing of two Do Not Attempt Cardio-Pulmonary Resuscitation ("DNACPR") Notices on Mrs Tracey's medical notes at Addenbrooke's Hospital and (ii) the Secretary of State for Health for failing to promulgate a national policy in relation to DNACPR notices.

Mrs. Tracey was diagnosed with lung cancer on 5 February 2011 and, at that time, it was estimated that she had approximately nine months to live. On 19 February 2011 she sustained a serious cervical fracture after a major road accident and was admitted to Addenbrooke's Hospital. She also developed a chest infection and pneumonia and it was the view of her treating clinicians

that it would not be appropriate for her to be resuscitated in the event of cardiac arrest. Mrs Tracey died on 7 March 2011 and no resuscitation was given.

There was a factual dispute between Mrs Tracey's family and the responsible clinicians over the circumstances in which two DNACPR notices had been placed on Mrs Tracey's notes and what prior consultation had taken place. Nicola Davies J conducted a 7-day fact-finding hearing to determine these issues. She found, amongst other things, that the doctor who completed the first DNACPR notice believed that Mrs Tracey's daughter had agreed to the imposition of such a notice but rejected the doctor's evidence that he spoke to Mrs Tracey about resuscitation before he signed the first notice. That first notice was subsequently withdrawn when it became apparent that Mrs. Tracey strongly objected. Nicola Davies J found that Mrs. Tracey did not herself wish to discuss the second DNACPR notice with professionals, nor did her daughters wish to discuss it with her, but all members of her family who were present or available understood and agreed with the responsible professionals that that it was the appropriate course.

Having made those findings of fact, Nicola Davies J held that no further substantive hearing of the original application for judicial review should take place. She ruled that any breach of Mrs Tracey's Article 8 rights that arose because of the failure to consult with her about the first DNACPR notice was academic as any failure to follow policy or have the right policy did not cause Mrs Tracey's death. She also held that the determinations sought by Mr Tracey, including in relation to his allegations that the Hospital failed to communicate its DNR policy and that its policy was, in any event, defective and confusing, "would involve the court grappling with issues of policy and clinical decision-making upon the basis of limited evidence such that the court would not have a full appreciation of all relevant considerations, still less the implications resulting from such determinations."

Mr Tracey appealed to the Court of Appeal and his appeal was allowed. Longmore LJ (with whom LJ Ryder and the Master of the Rolls agreed) held

that the submissions made on behalf of Mr Tracey could not be dismissed out of hand and the judicial review application (which was substantially refocused before the Court of Appeal), should therefore go forward to a hearing. Longmore LJ said (at paragraphs 17-19):

"17. It does not appear that the judge thought that the points in relation to explanation or consultation with the patient or the right to a second opinion were themselves unarguable. She thought that in the light of her findings of fact they were 'academic' and that any failure to follow policy or have the right policy did not cause Mrs Tracey's death. I do not agree that the case can be disposed of in this way. It is not academic because there can be no doubt that … Mrs Tracey was distressed when she learnt that the first notice had been placed on her notes. Part of that distress was because she thought that her family had either asked for it to be so placed or had, at least, agreed to it. When that became plain, it distressed the family as well. In these circumstances, the judgment's reference to the absence of causation is, with respect, misplaced since there were consequences of the first notice. If those consequences had been 'trifling' the judge might have been correct to say the case should go no further but it cannot be right to call the distress suffered by Mrs Tracey and her family as 'trifling.' The points on consultation and a second opinion are, moreover, matters of some general importance.

18. The judge's fear of a wide ranging inquiry which might need expert evidence is likewise misplaced now that Mr Havers [acting for Mr Tracey] has confined his case …. The question whether the absence of explanation or consultation or the failure to offer a second opinion means that the placing of the first DNACPR Notice was unlawful as being an unjustified breach of Article 8 of the Convention is, of course, a question of law on which expert evidence would be neither admissible or appropriate.

19. Mr Havers has argued that the Hospital's policy, the relevant provisions of which were set out at paragraph 14 of the first judgment, was misleading and/or contradictory. I did not, for my part, altogether understand why this

was so, but I would not wish here and now to rule out any argument to that effect."

Longmore LJ held that it was also appropriate for the claim against the Secretary of State to be heard as permission had been granted and nothing emerged during the fact-finding hearing which impinged upon the strength or weakness of the claim. If the court was to conclude, for example, that the doctor's failure to consult Mrs Tracey about the first DNACPR notice meant that the Hospital Trust was in breach of Article 8, it could be said that that failure might show there should be some national policy promulgated by the Secretary of State.

An NHS Foundation Trust v A, M, P and A Local Authority
12 February 2014
Citation: [2014] EWHC 920 (Fam)
Judge/s:
Mr. Justice Hayden

This case from the Family Division which concerned a 15 year old girl sets out some elements of best practice for an NHS Trust when dealing with medical treatment cases; it also gives an opportunity to note a point about the role that the MCA 2005 might play in relation to those under 16.

At the time of the application, the young girl, 'A' weighed just 5 ½ stones and had been in hospital for 10 months. Her weight had become dangerously low because she vomited up to 30 times a day (but not at all during the night). She had been subject to a battery of tests and 3 separate experts had concluded that there was no gastroenterological cause for A's vomiting. A and her mother disputed the view of the experts. There was an emerging concern that A was suffering under a form of fabricated and induced illness. There was evidence that in the absence of immediate intervention A could have no more than around 8 to 12 weeks to live.

The NHS Trust applied for declarations that:

It was lawful and in the best interests of A to have a Nasojejunal tube inserted and reinserted on any occasion that it is removed;
It was lawful and in the interest of A to receive fluids, nutrition and medications through a Nasojejunal tube;
It was lawful and in A's best interest to receive treatment (to include psychiatric, psychological and medication as prescribed by her consultant treating psychiatrist) and assessment by the child and adolescent mental health team.
Mr. Justice Hayden made the orders sought. He also suspended contact between A and her mother for the first two weeks of her treatment and made her a ward of court (on the basis that the relationship between the hospital, social services and A had become conflictual and the judge had heard evidence that A required decision making from an independent authority figure).

The judge held that A was not competent to make decisions as to the appropriate course of medical treatment (on the basis of two psychiatric opinions). He commented that if she were an adult and he were applying the criteria of the MCA 2005 he would conclude that A lacked capacity to take the medical treatment decisions.

The judge stated that the starting point in such cases was that there was a "strong presumption in favour of a course of action which would prolong life, but that presumption is not irrebuttable" (Kevin Wyatt v Portsmouth NHS Trust [2006] 1 FLR 554). The judge then set out the 'intellectual milestones' which Wall LJ (as he then was) identified in that judgment:

The judge must identify what is in the best interest of the child (an objective exercise);
In doing so, the child's welfare is a paramount consideration;
The Judge must look at it from the assumed point of view of the patient;
There is a strong presumption in favour of the course of action which would prolong life but, that presumption is not irrebuttable;

The term 'best interests' encompasses medical, emotional and all other welfare issues.

Hayden J endorsed the preparation of a 'Benefits/Disadvantages Table' for each of the treatment options contemplated. The use of the table, supplemented by oral evidence, led the judge to conclude that the treatment solution proposed by the Trust was in A's best interest. The treatment options proposed by A and her mother contained far greater risks and fewer benefits. The judge annexed the table to his judgment 'in the hope that it might stand as a template for future practice'.

Newcastle-upon-Tyne Foundation Trust v LM
26 February 2014
Citation: 2014] EWHC 454 (COP)
Judge/s:
Peter Jackson J

This case concerns the lawfulness of withholding blood transfusions from a gravely ill Jehovah's Witness. The woman in question, LM, had a background history of depression and paranoid schizophrenia and in the past had received compulsory treatment. She had been a Jehovah's Witness since the 1970s. In the middle of January 2014, LM was seen by a consultant psychiatrist, who had known her for seven years. He felt that her mental health was as good as he had known it for a number of years. On 6 February 2014, LM was admitted to hospital by ambulance, having been found wandering and confused outside her home. She had a number of bruises, suggesting recent falls. From the outset of her admission it was known that she was a Jehovah's Witness and her notes were marked that she was not to receive blood products in any circumstances. Over the days following her admission, LM made some improvement, but on 11 February, she was found to be bleeding from a large duodenal ulcer. Tests revealed a falling and dangerously low haemoglobin level, the lowest figure being 37 against a normal measure of 120-150 and the figure at the time of the hearing being 47. On 11 February, a senior nurse from

the liaison psychiatry team assessed LM. He found no evidence of active psychotic illness but some mild confusion. In general, she was not psychiatrically unwell and her presentation appeared appropriate. On 12 February, LM was seen by two doctors in the gastroenterology team. She told them that she was adamant that she would not want treatment with any blood products. They felt that she had full capacity to make this decision with an awareness of the consequences. A form to complete an advance decision complying with the provisions of s.24 MCA 2005 was available at the hospital, but it does not appear that it was offered to her, and there was no record of her wishes other than that recorded in the notes.

On the afternoon of 13 February 2014, LM's condition markedly deteriorated. She was admitted to the High Dependency Unit under the care of Dr C. By this time her physical condition had deteriorated to the point that she required intubation, ventilation and sedation and clearly lacked capacity to make or communicate a decision.

The Trust made an application for a declaration that it would be lawful to withhold blood transfusions from LM. They did so on the basis that LM had clearly made her wishes known even with knowledge of death. Alternatively, if it was a matter of best interests, the Trust did not wish to act against her wishes, being concerned to respect her individual dignity.

The matter came before Peter Jackson J on 18 February in the urgent applications list, at a hearing conducted by video-link from Newcastle, with evidence being given by Dr C. Also present in Newcastle were Mr R, an elder of the Jehovah's Witnesses who had known LM since 1975, and Mr P, the Chairman of the Hospital Liaison Committee for Jehovah's Witnesses. In London, the hearing took place in open court and was attended by a representative of the Press Association.

By the stage that the matter was before Peter Jackson J, profound anaemia was significantly compromising LM's survival prospects. The medical view was that LM might not survive for as long as a day in the absence of a blood

transfusion and that even if one was given, she might still die. As Peter Jackson J noted: "[a] decision had to be taken there and then." He took the view that it was not practicable or necessary for a litigation friend to be appointed. He granted the application at the end of the hearing, declaring that "It shall be lawful for the doctors treating LM to withhold blood transfusions or administration of blood products notwithstanding that such treatments would reduce the likelihood of her dying and might prevent her death."

LM died a few hours before the judgment giving Peter Jackson J's reasons was to be handed down on 26 February 2014.
In his reasons for granting the application, Peter Jackson J found that:

"Prior to the afternoon of 13 February, LM had the capacity to decide whether to accept or refuse a blood transfusion. There is no evidence that her underlying mental illness rendered her unable to make a decision (MCA s.2(1)). The presumption of capacity (s.1(2)) was not displaced and the criteria for capacity (s.3) were on the balance of probabilities met. I am satisfied that LM understood the nature, purpose and effects of the proposed treatment, including that refusal of a blood transfusion might have fatal consequences." Further, "[t]he decision taken by LM prior to her loss of capacity was applicable to her later more serious condition. There was no difference in kind and I am satisfied that she intended her decision to be effective in the circumstances that subsequently arose" (paragraph 22).

He therefore found that "LM made a decision that the doctors rightly considered must be respected" (paragraph 22).

In the alternative, Peter Jackson J found, "if LM had not made a valid, applicable decision, I would have granted the declaration sought on the basis that to order a transfusion would not have been in her best interests. Applying s.4(6) in relation to the specific issue of blood transfusion, her wishes and feelings and her long-standing beliefs and values carried determinative weight. It is also of relevance that a transfusion might not have been effective

to save her life" (paragraph 23). As he noted "[t]he right to life (Art. 2 ECHR) is fundamental but it is not absolute. There is no obligation on a patient with decision-making capacity to accept life-saving treatment, and doctors are neither entitled nor obliged to give it" (paragraph 24).

As regards the question of whether the reporting restriction order that the Trust applied for on 24 February (i.e. two days before LM died) should be granted. As Peter Jackson J noted "[t]he court has jurisdiction to make an order during the lifetime of a patient that will continue to have effect after death unless and until it is varied: Re C (Adult Patient: Restriction of Publicity After Death [1996] 1 FCR 605. The situation here is different in that the patient is no longer alive. The unusual circumstances raise interesting questions about the court's jurisdiction to restrict the reporting after a person's death of information gathered during proceedings that took place during her lifetime" (paragraph 26).

Whilst he had invited legal submissions upon the question Peter Jackson J took the entirely pragmatic step of making "an order that preserves the situation until the time comes when someone seeks to present full argument on the question. I will say no more than that for the present" (paragraph 27). He therefore granted a Reporting Restriction Order on materially identical terms (it would appear) to that which he would have granted had LM still been alive.

Nottinghamshire Healthcare NHS Trust v J

9 April 2014 Citation: [2014] EWHC 1136 (COP) Judge/s: Holman J

In this case the judge was asked to consider an urgent without notice application in a medical treatment case.
The case concerned J, a young man aged 23 who was in prison but detained under the Mental Health Act 1983. He suffered from what was described as a serious personality disorder, a symptom of which was that he had engaged in significant self-harm on a number of occasions which resulted in profuse

bleeding due to the fact that he was on anticoagulant drugs because of a history of thrombosisk. The judge considered sections 24 – 26 of the MCA 2005 and declared on an interim basis that the written advance decision was valid and applicable to that treatment notwithstanding that (a) the young man's life may be at risk from the refusal of treatment and (b) that he was a patient detained under the Mental Health Act.
The second limb of the application brought by the NHS Trust related to the interrelation of the provisions of the MCA 2005 in relation to advance decisions to refuse treatment and the applicability in this case of section 63 of the Mental Health Act 1983 which provides: "the consent of a patient shall not be required for any medical treatment given to him for the mental disorder from which he is suffering…if the treatment is given by or under the direction of the approved clinician in charge of the treatment."

Holman J noted that there was clear authority to the effect that the words "medical treatment given to him for the mental disorder from which he is suffering" were wide enough to extend to medical treatment for physical conditions caused or arising as a result of the underlying mental disorder (B v Croydon Health Authority [1995] Fam 133). It followed that if a detained patient cut himself as a result of a self-harming mental disorder, then it may be lawful under that section to treat and stitch up the cuts. The judge held that it was little or no extension of that approach that if, as a result of the mental disorder from which he is suffering, a patient cuts himself and bleeds so profusely that he needs a blood transfusion, that transfusion would be covered by s.63. Hence this case squarely raised the issue of the interrelation between the provisions of the MCA 2005 in relation to advance decisions and the power under s.63 MHA 1983 to give medical treatment notwithstanding the absence of consent.

The man's responsible clinician described having 'some ethical difficulty' in using the MHA 1983 to override a capacitous patient's wishes based on religious wishes and stated that she "would not chose to use [her] Mental Health Act powers to override his advance decision." Holman J stressed (at paragraph 15) that it was not the business of a court to make any kind of

ethical decision: "all the court can do is state the applicable law and, where appropriate, apply it in the form of a legal, though not necessarily an ethical, decision."

The second limb of the application asked the judge to make an interim declaration that "it is lawful for those responsible for the medical care of the respondent to act in accordance with his written advance decision and withhold treatment by blood transfusion or with blood products in accordance with his expressed wishes notwithstanding the existence of powers under section 63 of the Mental Health Act 1983."

Holman J held that he did not feel equipped or willing to make the declaration as he had only heard representations from one side without notice to the patient or any other person. He listed a hearing for the next day having made a preliminary inquiry of the Official Solicitor. He also directed that the NHS Trust use its best endeavours to facilitate and promote that the patient himself be represented at the hearing and to ensure that the patient's father be informed of the hearing and encouraged to attend.

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COP or High Court

Is the patient 18 or over

Yes | No

Does the patient lack capacity Under the MCA | How old is patient

15 or less | 16 or 17

Yes | No | High Ct | Why is it Being made

COP | Not COP
Consider High Ct
Under Inherent Jurisd.
To protect vulnerable adults

Lacks Capacity Under MCA | lacks maturity to decide | to impose treatmnt despite compet.

Both COP
High Ct | High Ct | High Ct