MENTAL CAPACITY REPORT:
HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

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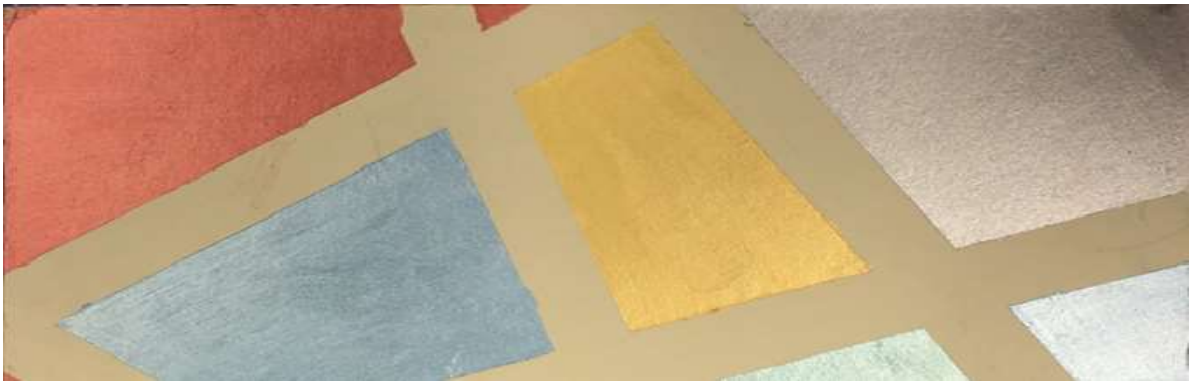

Welcome to the March 2020 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: a cautionary tale about re-using material for DoLS assessment and capacity complexities in the context of medical treatment;

(2) In the Property and Affairs Report: an important case on the limits of powers of professional deputies to act without recourse to the Court of Protection;

(3) In the Practice and Procedure Report: medical treatment – delay, neglect and judicial despair, developments relating to vulnerable parties and witnesses, and Forced Marriage Protection Orders under the spotlight;

(4) In the Wider Context Report: Mental Capacity Action Days, when not to presume upon a presumption, and a number of important reports from bodies such as the CQC;

(5) In the Scotland Report: the DEC:IDES trial.

We have also recently updated our capacity guide and our guide to the inherent jurisdiction. You can find them, along with our past issues, our case summaries, and more on our dedicated sub-site here.

If you want more information on the Convention on the Rights of Persons with Disabilities, which we frequently refer to in this Report, we suggest you go to the Small Places website run by Lucy Series of Cardiff University.

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The picture at the top, "*Colourful*," is by Geoffrey Files, a young man with autism. We are very grateful to him and his family for permission to use his artwork.

Contents

Sir Andrew McFarlane

We trust our readers will join us in wishing Sir Andrew, the President of the Family Division and Court of Protection, well in respect of his forthcoming open heart surgery.

DoLS forms – a cautionary tale

An experienced best interests assessor has been suspended by Social Work England for 12 months after plagiarising DOLS Form 3s and/or doctor's Form 4s. Concerns were raised by the DOLS team and an audit revealed forms for 8 people were identical in various parts of the capacity assessment and not all relevant to the individuals involved. There was a risk that people could have potentially been unlawfully deprived of liberty.

The BIA said he had used a "stock template" for Form 3, recognised he had placed people at risk of harm, but maintained he had not acted dishonestly. The fitness to practise panel found:

> *36.* […] *that the social worker had plagiarised large aspects of the Forms, with wholesale movement of information from one service user to another. These contained inaccurate information including comments attributed to them, incorrect assessment in things such as communication and wrong historical backgrounds including information about past safeguarding issues. The justification for the ultimate decision was copied almost in its entirety.*

The panel's conclusion was that he had acted dishonestly and must have been aware that the information for the individuals was wrong and incorrect at the time he prepared and signed the forms. As a social worker and fully trained BIA it was his responsibility to ensure this was done properly and failed to do so. On that basis it concluded that an ordinary and decent person would consider such conduct to be dishonest. His fitness to practise was impaired on both public protection and public interest grounds, and he was suspended for 12 months.

Medical treatment, due haste, and capacity complexities

Sherwood Forest Hospitals NHS Foundation Trust v C [2020] EWCOP 10 (Hayden J)

Best interests – medical treatment – Practice and procedure (Court of Protection)

Summary

Possibly as a result of lessons learned in relation to the case of Mrs H, the same NHS Trust has

brought a further application in relation to the treatment for cancer of another person, this time with very significantly greater speed. In the present case, the Trust were concerned with a woman, C, in her 60s. For some time, she had had paranoid schizophrenia. She had been admitted, most recently, between June and October 2019, when she had stopped taking her medication. Although the precise mechanism was not explained in the judgment, it appears that in consequence of that decision, she had suffered kidney failure, which could have been fatal. Happily, it was not. The woman attributed her recovery to God's intervention.

Shortly afterwards, she presented to her GP with symptoms of post-menopausal bleeding. This led to a referral to the Trust. As Hayden J noted:

> *Two features require to be highlighted. Firstly, it was C who decided to seek out medical treatment in the first place and, secondly, C who pursued further treatment at the hospital to investigate the cause of the bleeding. All agree that, in this period, C appeared capacitous in her decision making. It requires to be clarified, though, that what she was determined to do was to investigate the source and cause of her bleeding and to see what the treatment options were. That, as emphasised by Ms Paterson, on behalf of Official Solicitor, is different from what has been in focus at this hearing, namely whether C should have a hysterectomy.*

C underwent two investigations, to both of which it was considered she was able to give consent. They revealed Grade 2 endometrial cancer. She was referred to the cancer MDT, although the team were not aware of C's diagnosis of paranoid schizophrenia. Hayden J considered that, "[a]*s far as a treatment pathway is concerned, it is irrelevant. But it is a troubling omission.*" When it was explained what the proposed treatment pathway was for her cancer, C

> *was markedly unresponsive and incommunicative: he describes her as "almost mute". Because he was not alert to her underlying mental health difficulties, Mr Dudill* [the consultant gynaecologist] *was unsure as to whether this response was an indicator of shock at hearing such news or related to something more significant. He told me that, in those circumstances, he thought it best for C to spend some time with the cancer nurse, Ms Halsall, for a more informal chat in which she might feel more comfortable in articulating her concerns or expectations. Having facilitated that meeting, Mr Dudill later re-joined them, but noticed that C continued to be very withdrawn. However, despite her presentation, C agreed to go ahead with the operation and also signed the necessary consent forms.*

However, it became clear in the following weeks that C had disengaged. When it was pursued, she was adamant that she did not want the treatment:

> *She expressed the view that "only God could cure [her] cancer" and, though properly and, in my judgement, sensitively challenged, she rejected any idea, for example, that God might act through the intervention of medical treatment.*

A joint assessment of her capacity was undertaken on 19 February 2020 by a Mr Srini Vindla, a consultant gynaecologist and a Dr

Caroline Innes, a consultant psychiatrist, described by Hayden J thus:

> *16.* […] *Although neither is C's treating clinician, it is perhaps significant to note that C was happy to engage with them, albeit constraining herself to her already expressed view. Dr Innes reminded C of a previous occasion when she had been treated by the doctors following an admission pursuant to the Mental Health Act, once when she experienced kidney failure and on another occasion, infected abscesses. C remembered these and told Dr Innes that she had recovered because it had been God's will. She said that God had made her start drinking again. She attached no significance to the impact of the depot antipsychotic medication. At the interview Dr Innes reports C as being calm. She did not appear physically unwell and she had not obviously lost weight. There was no evidence of self-neglect. The pauses in her conversation might indicate some auditory hallucination but I did not get the impression from her statement that Dr Innes was convinced of this. Dr Innes described C's presentation as "objectively flat but not depressed". Her speech was said to be "quiet but coherent". She refused to explain any of her reasoning but her concentration did not appear to be impaired.*
>
> *17. Dr Innes concluded that C still had symptoms of chronic schizophrenia and that there were suggestions of delusional beliefs. She considered C is unable to weigh the evidence required to make an informed decision in relation to her treatment and her inability to engage in weighing the consequences indicated a lack of capacity relating to her consent to treatment. It is important that I emphasise that Dr Innes considered whether a change in C's treatment or medication for her mental illness might serve to promote capacity, but concluded that it would not.*

The Trust therefore brought an application for a decision as to C's capacity to consent to the treatment, and for endorsement (by way of a decision under s.16(2)(a)) of the plan. It is not quite clear when the application was brought, but as it was seen by Hayden J on 26 February, it is must have been brought within a matter of days after the capacity assessment.

Hayden J was initially:

> *22.* […] *very concerned that with a diagnosis of this kind, made on 30th December 2019, surgery was not contemplated until March 2020. I was also concerned that what was anticipated in these proceedings, by the lawyers, was a series of investigations, envisaging a hearing in a few weeks' time. There has been delay. However, having heard all the evidence, particularly emphasising the limited aggression of the cancer (stage 2), I am satisfied that the delay will not have had adverse impact on C. By this I mean the cancer has not been neglected.*
>
> *23. Here, the delay was attributable primarily to the fact that C appeared, up to and including 9th January 2020, to have been entirely capacitous. Only when suspicions were aroused did it emerge that she was not. Although the initial referral to the hospital had flagged up the fact of her paranoid schizophrenia, it is clear that the information relating to that diagnosis was not shared to the extent that it should have been with the team of treating clinicians. I see no reason why*

that should have occurred. In the future, where there is such a diagnosis, it should be regarded as requiring prominence in the medical records. This is not intended in any way to stigmatise the patient, but to seek to ensure that they are provided with treatment in a way which places them on an entirely equal footing with capacitous individuals in the same situation.

24. The second reason leading to the delay arises from the anxiety that all medical professionals understandably face when they are required to contemplate the restraint or coercion of a resistant, incapacitous patient. These are incredibly difficult challenges, but delay only serves to compound that challenge. Those faced with these difficulties must always recognise that delay is likely to be inimical to their patient's care and that the time scales for intervention constructed around the patient must focus unwaveringly upon that patient's best interests. The delay here has not exacerbated the risk arising from the cancer but it may have, indeed I consider it likely to have added avoidable stress to C and her family.

[…]

27. Because I was not prepared to countenance delay, the case was called in and it has been possible, with the assistance of extremely experienced counsel, to resolve the issues today.

In considering C's best interests, Hayden J noted the following:

18. When C was a younger woman, before the cloud of paranoid schizophrenia descended upon her life, she was noted to have been a very happy and outgoing young person. Her interest in religion began only after her mental health problems developed. I hope that these religious beliefs may, in some way, have been a comfort to C. But it requires to be identified that her expressed religious beliefs have become a facet of her mental health problems and a channel for delusional thoughts. For example, she has in the past believed herself to be pregnant, carrying the child of God. This has been a delusion of such vibrancy for her that she has carried it through to purchasing baby clothes for the child she believed she was carrying. It is important therefore to disentangle capacitously held religious beliefs from the delusional views here. It requires some sensitivity.

19. The preponderant evidence that I have sought to highlight indicates a woman who wanted to address her post-menopausal bleeding, to identify the appropriate treatment and cooperate with the investigative process. As I have stated, whilst C still appeared capacitous she signed forms consenting to treatment. Subsequently, perhaps in consequence of the shock, she clearly lacked capacity and her rejection of the treatment, which is clinically so manifestly in her best interests, is predicated on a delusional belief structure which manifests itself in the language of religion.

20. Of course, the fact that the clinical best interests are clear does not mean, automatically, that C's 'best interests' more generally, lie in her having the surgery. That can only be determined by a wider examination of C's circumstances, consideration of her relationships, endeavouring to

> *understand who she is and the code by which she lives her life.*
>
> *21. In considering this wider canvas it emerges that C, with the support of her mother, has a full and varied life. She plainly has a strong, important relationship with her mother and she has an enduring commitment to her niece, of whom she speaks with affection. When capacitous, there is nothing at all to indicate that she is in any way disenchanted or weary with life. On the contrary, the indicators are that she is enthusiastic for it, notwithstanding the challenges that her mental health condition has posed to her over the years.*

Hayden J was therefore:

> *27* […] *satisfied that it is in the best interests of C to have the surgery. I do not find that to be a delicate balance. There is amongst all lawyers, doctors and judges a strong instinct to preserve human life (Aintree University Hospital NHS Trust v James [2013] UKSC 67; Kings College Hospital Foundation Trust v Haastrup [2018] EWHC 127 (Fam)). Here there is clear evidence of a likely prospect of a successful outcome, where the alternative is that C would die. Moreover, as I have indicated, there is much to indicate that C, when capacitous would want to live. Her decision, as I have detailed above, to seek out treatment and in fact consent to it orally and in writing I consider to be a powerful indicator of her wishes when capacitous. Accordingly, I am able to make the declarations the Trust seeks.*

However:

> *28. In this case, it has not been possible for the Trust to put a plan together outlining the details of the coercion and/or restraint that would be considered to be proportionate in the event of C's resistance. The absence of this plan is a direct consequence of my decision to cause the case to be heard quickly. I am able to make the best interest declarations I have indicated but they are not to be given effect until the plan has been put together and approved initially by the Official Solicitor and subsequently by this court. In the event that such approval is not forthcoming the case is to be restored before me, on short notice if necessary.*

Comment

Procedurally, this case indicates how it is possible for clinicians to work effectively with the Trust's legal services to move speedily when it has been recognised that an application is required (as to which, see further the recent Practice Guidance).

On the facts of the case, as presented here, it is not entirely easy to escape the impression that a certain amount of (understandable) intellectual footwork was required to address the position that the doctors had proceeded on the basis that C had had capacity to make the decision until such point as she had disengaged. Such a phenomenon is not uncommon (see also the discussion of this, again in the context of paranoid schizophrenia, in *Heart of England NHS Foundation Trust v JB* [2014] EWCOP 342). The recording of the capacity assessment carried out by the Trust did not explain the change in position, and it is interesting that Hayden J clearly felt that he did need to give an explanation – suggesting that it was "perhaps in consequence of the shock." Although it is not possible, nor – for these purposes – relevant, to

reconstruct the earlier position, it may equally be said on the logic of the recording of the capacity assessment before the court that C had not had capacity at any point to make the decision.

Although for different reasons, this might be thought to put into context Hayden J's observation that a diagnosis of a mental health condition should be given prominence in medical records. On one view – and as he himself recognised – this could be seen as stigmatising. On another view, this could be seen as precisely the sort of situation in which there was cause to consider whether or not any consent given by C would be capacitous – at which point the cancer MDT should have been alerted to it. After all, had she consented, not disengaged, and the treatment gone ahead, we might legitimately want to know whether this was on the basis that she had given consent, or on the basis that there was no such consent, but the doctors could rely upon the provisions of s.5 MCA 2005.

Finally, and as Hayden J was aware the case is another example of how the law finds the interplay between mental disorder and religious belief complex. In centuries past, and indeed in many communities today, the sentence "*her rejection of the treatment* […] *is predicated on a delusional belief structure which manifests itself in the language of religion*" might not make immediate logical sense.

Short note: deprivation of liberty and false imprisonment

In *R (Jalloh) v Secretary of State for the Home Department* [2020] UKSC 4, the main issue was whether the meaning of 'imprisonment' at common law should be aligned with the concept of 'deprivation of liberty' in article 5 ECHR. In short, the answer was 'no'. Jalloh was subject to immigration restrictions, requiring him to report to an officer three times a week, to reside at a specified address, to wear an electronic tag, and to be subject to a curfew for 8 hours every day.

Lady Hale, giving the judgment of the Supreme Court, noted that the essence of the tort of false imprisonment is being made to stay in a particular place by another person whereas the Article 5 ECHR concept of deprivation of liberty is multi-factorial in its approach:

> *24…* [The] *essence of imprisonment is being made to stay in a particular place by another person. The methods which might be used to keep a person there are many and various. They could be physical barriers, such as locks and bars. They could be physical people, such as guards who would physically prevent the person leaving if he tried to do so. They could also be threats, whether of force or of legal process… the person is obliged to stay where he is ordered to stay whether he wants to do so or not.*

Thus, the classic understanding of imprisonment is very different to the more nuanced ECHR concept and at common law there was no need to distinguish between restricting and depriving liberty. Moreover, common law imprisonment can be justified in circumstances not covered by the permissible grounds of Article 5. It follows that one could be imprisoned at common law without being deprived of liberty under Article 5. The opposite

seemed most unlikely.[1] And the court held that Jalloh was imprisoned.

The opening of paragraph 24 might raise a wry smile amongst some, given what Lady Hale had said previously in *Secretary of State for the Home Department v JJ & Ors* [2007] UKHL 45:

> *What does it mean to be deprived of one's liberty? Not, we are all agreed, to be deprived of the freedom to live one's life as one pleases. It means to be deprived of one's physical liberty: Engel v The Netherlands (No 1)(1976) 1 EHRR 647, para 58.* ***And what does this mean? It must mean being forced or obliged to be at a particular place where one does not choose to be: eg X v Austria*** *(1979) 18 DR 154. But even that is not always enough, because merely being required to live at a particular address or to keep within a particular geographical area does not, without more, amount to a deprivation of liberty. There must be a greater degree of control over one's physical liberty than that. But how much? As the Judge said, the Strasbourg jurisprudence does not enable us to narrow the gap between "24-hour house arrest seven days per week (equals deprivation of liberty) and a curfew/house arrest of up to 12 hours per day on weekdays and for the whole of the weekend (equals restriction on movement)": [2006] EWHC 1623 (Admin), para 33, referring to the cases cited by my noble and learned friend Lord Bingham of Cornhill, at paras 14 and 18 above.* (emphasis added)

However, it needs to be understood in this case that the Secretary of State was seeking to align the concepts of (objective) confinement for purposes of Article 5 ECHR and imprisonment for purposes of the tort of false imprisonment so that, in lay terms, he could get an **easier** ride from the courts than he thought he would get under Article 5 ECHR.

Whether that is necessarily correct is perhaps debatable, given that the courts have found that a deprivation of liberty can arise in a very short time indeed (see *ZH* in which the deprivation of liberty arose within 40 minutes).

However, on its face, the decision suggests that the intensity of the care arrangements need not be as severe for a false imprisonment claim as it is for an Article 5 ECHR claim, with the focus then being on whether the imprisonment was justified. Importantly, it also means that a deprivation of liberty is most likely to amount to imprisonment at common law with its more generous 6-year limitation period (by contrast to the position under the Human Rights Act: see this costly lesson learned), and the possibility of aggravated and exemplary damages depending on the facts.

[1] Lady Hale suggesting (at paragraph 34) that the question of whether the Court of Appeal in *Austin* and in *Walker* were right to say that there could be a deprivation of liberty without there being imprisonment at common law "*in the light of the Bournewood saga, but it is not necessary for us to express an opinion on the matter.*"

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Simon has wide experience of private client work raising capacity issues, including *Day v Harris & Ors* [2013] 3 WLR 1560, centred on the question whether Sir Malcolm Arnold had given manuscripts of his compositions to his children when in a desperate state or later when he was a patient of the Court of Protection. He has also acted in many cases where deputies or attorneys have misused P's assets. To view full CV click here.

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Adrian is a recognised national and international expert in adult incapacity law. He has been continuously involved in law reform processes. His books include the current standard Scottish texts on the subject. His awards include an MBE for services to the mentally handicapped in Scotland; honorary membership of the Law Society of Scotland; national awards for legal journalism, legal charitable work and legal scholarship; and the lifetime achievement award at the 2014 Scottish Legal Awards.

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Conferences

Approaching complex capacity assessments

Alex will be co-leading a day-long masterclass for Maudsley Learning in association with the Mental Health & Justice project on 15 May 2020, in London. For more details, and to book, see here.

2020 World Congress in Argentina

Adrian will be speaking at the 6th World Congress to be held at Buenos Aires University, Argentina, from 29th September to 2nd October 2020, under the full title "Adult Support and Care" and the sub-title "From Adult Guardianship to Personal Autonomy." For more details, see here.

Other conferences and events of interest

Mental Diversity Law Conference

The call for papers is now open for the Third UK and Ireland Mental Diversity Law Conference, to be held at the University of Nottingham on 23 and 24 June. For more details, see here.

Advertising conferences and training events

If you would like your conference or training event to be included in this section in a subsequent issue, please contact one of the editors. Save for those conferences or training events that are run by non-profit bodies, we would invite a donation of £200 to be made to the dementia charity My Life Films in return for postings for English and Welsh events. For Scottish events, we are inviting donations to Alzheimer Scotland Action on Dementia.

Our next edition will be out in April. Please email us with any judgments or other news items which you think should be included. If you do not wish to receive this Report in the future please contact: marketing@39essex.com.

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