Powers, defences and the 'need' for judicial sanction: an update

Introduction

Case-law has sharpened the focus on s 5 of the Mental Capacity Act 2005 ('MCA 2005') and, relatedly, the questions of: (1) which acts in relation to those lacking material decision-making capacity require judicial sanction; and (2) on what basis. In 2016, I considered in an article for the Elder Law Journal[1] the obiter comments of Sir James Munby P in *Re AG* [2015] EWCOP 78[2] in which he indicated that judicial sanction is required before local authorities move incapacitous adults from their homes based on the local authorities not having the power to do so; and how that approach sits with the understanding of many social and health care professionals as to the s 5 of the MCA[3] and recourse to the court being unnecessary. In his analysis, I argued that whether judicial sanction to move a person is required depends upon the degree to which the move in question is an interference with the autonomy rights enjoyed by the person as an aspect of their rights under Article 8.[4] In certain cases where there was *"true compliance with s 5 of the MCA 2005"* through a properly MCA-compliant assessment of capacity and best interests, I suggested that the sanction of the court would not be required.

In 2018, the Supreme Court considered that there were indeed circumstances in which judicial sanction was not required in medical treatment cases (on the facts that treatment consisted in the withdrawal of clinically assisted nutrition and hydration ("CANH")): *NHS Trust v Y* [2018] UKSC 46, and thus, when a medical professional can rely on s 5 of the MCA 2005. Importantly, the leading judgment of Lady Black indicated that if the provisions of the Mental Capacity Act 2005 are followed, any relevant professional guidance observed[5] and relevant guidance in the Code of Practice followed,[6] including as to the undertaking of the decision-making process, then, if there is agreement at the end of the decision-making process as to: (a) the decision-making capacity of; and (b) best interests of the person in question, then, in principle, medical treatment may be provided to, withdrawn from or withheld in accordance with the agreement, without application to the court, in reliance upon the defence in section 5.

This paper looks at those situations in which applications may still be required.

Section 5: history and relevant case-law

[1] [2016] Elder Law Journal 244.
[2] At para 56.
[3] As reflected in the MCA, Code of Practice, paras 6.10-6.11, which suggest that recourse to the court is unnecessary even where the person is objecting.
[4] See *A Local Authority v E* [2015] EWHC 1639 (COP) at para 124).
[5] In the case of decisions concerning clinically assisted nutrition and hydration, treating clinicians are directed to the BMA/RCP Guidance (endorsed by the GMC): 'Clinically assisted nutrition and hydration (CANH) and adults who lack the capacity to consent,' available at www.bma.org.uk/canh, and (where relevant) *Prolonged disorders of consciousness following sudden onset brain injury: national clinical guidelines* (Royal College of Physicians, March 2020).
[6] Note, the Code of Practice must be read together with any subsequent case-law; the Code of Practice is also under review as at February 2022.

It is important to start with a history lesson (which is usefully set out in more detail in ch 2 of Jordan's *Court of Protection Practice* (2022)). The Law Commission in its original 1995 report and draft Bill (Mental Incapacity: Law Com 231) proposed the creation of a new statutory authority entitled 'the general authority to act reasonably', which would have replaced the defence of necessity as the basis upon which actions could be taken to deliver care and treatment to those who cannot give the consent which is required to prevent those actions otherwise being both civil and criminal law wrongs. Importantly, the Law Commission's intention was not to create any new or additional powers going beyond those that treating professionals already had under existing statute or the common law.

The Law Commission also devoted a part of their draft Bill to creating a comprehensive suite of tools to enable 'public law protection for people at risk' (who included, but went beyond, those lacking capacity). Those included powers of removal for assessment and for temporary protection, hedged about with procedural protections including – in the case of the latter – a duty upon the local authority granting the temporary protection order to return the person to the place from which he or she was removed as soon as that was practicable and consistent with their interests.

None of those provisions was included in the draft Mental Incapacity Bill. Further, when the 'general authority' was included in the draft Mental Incapacity Bill in 2002, that proposal was the subject of considerable concern, primarily on the basis that the term 'implies an imposition of decision making upon an incapacitated individual rather than an enabling process designed to enact decisions taken in their best interests' (*Joint Committee on the draft Mental Incapacity Bill, Report*, HL Paper 189-1, HC 1083-1, para 110). It was therefore recast in the Mental Capacity Bill that was finally enacted as section 5: cast as a defence to liability, rather than an express authority.

Section 5 is therefore, in essence, a codified defence of necessity. In other words, and in line with the intention underlying the original 'general authority,' it does not, itself, provide a formal power to anyone to do anything. Rather, what it provides is that, if reasonable steps are taken by a person, D, to determine whether P lacks capacity in relation to a matter connected with the care and treatment, and D reasonably believes doing the act is in P's best interests, then it is as if P has consented to the act being carried out. Assuming that D is neither negligent nor criminal in the way in which they carry out the action, then D will be protected from any form of liability. As Lady Black put it in Re Y at paragraph 36:

> [Section 5] *provides a significant degree of protection from liability, provided that the act is done in the reasonable belief that capacity is lacking and that the act is in the patient's best interests. If these conditions are satisfied, no more liability is incurred than would have been incurred if the patient had had capacity to consent and had done so.*

Section 5 is, in turn, limited where the act in connection with care or treatment involves restraint, by including additional criteria that must be satisfied before a person can rely upon it.

Although it refers only to acts, it is clear that s 5 of the MCA 2005 provides a defence not just in relation to positive acts but also to omissions. In *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67, [2013] COPLR 492, SC, Baroness Hale

confirmed (at paras 20 – 22) that s 5 is apt to provide a defence to a decision by a clinical team either to withhold or withdraw treatment, because the fundamental question is whether it is lawful to give treatment, not whether it is lawful to withhold it. The reasoning process that she adopted to reach this conclusion is extremely important. She held that, where treatment is not in a patient's best interests, it would not be lawful to give it. It therefore follows (she held) that, provided that the clinical team acts reasonably and without negligence, it will not be in breach of any duty towards the patient if the team withholds or withdraws it. Whilst the judgment was given in the medical context, its logic also applies in any situation where carrying a particular act of care or treatment would not be in the person's best interests.

In practice, and despite the reframing between the Law Commission's draft Bill and the MCA, s 5 is treated as a de facto power, and health and social care professionals regularly describe themselves as acting on the basis of s 5. To some extent, this is hardly surprising: indeed, it is noteworthy that the underlying common law defence of necessity identified in *Re F (An Adult: Sterilisation)* [1990] 2 AC 1 was itself, often, described as a power (see eg the description given by Hale LJ (as she then was) in *R (Munjaz) v Mersey Care NHS Trust* [2003] EWCA Civ 1036 at para 46).

On one view, whether s 5 constitutes a power or a defence may be a sterile debate: see, by analogy, the short shrift given by the Court of Appeal in TTM's case to the arguments as to whether s 6(3) of the Mental Health Act 1983 constitutes a power to hospital managers or a defence against an action for false imprisonment (*TTM v London Borough of Hackney and Others* [2011] EWCA Civ 4 at para 37). To that extent, we could legitimately doubt whether the recasting of the general authority as a defence has in fact solved the problem that the Joint Committee identified, and we should – perhaps – be more concerned to ensure that the defence (or the de facto power) is not abused.

From this perspective, the decision in *Winspear (Personally and on behalf of the estate of Carl Winspear,* Deceased*) v City Hospitals Sunderland NHS Foundation Trust* [2015] EWHC 3250 (QB), [2016] COPLR 161 is therefore particularly important, because it has made clear that a failure to carry out a step which was – on the facts – practicable and appropriate as part of the s 4 of the MCA determination of where a person's best interests may lie will mean that the relevant body or individual cannot rely upon the defence under s 5 of the MCA. In that case, the failure was to consult with Carl Winspear's mother prior to reaching a DNACPR decision and placing a notice in his records, a step which the judge considered would have been both practicable and appropriate for purposes of s 4(7) of the MCA 2005. This decision is also important for confirming both that the steps required under s 4 must be complied with before s 5 can be relied upon, and also that s 5 will also serve as a potential defence to an HRA claim (in that case, a claim for a breach of his Art 8 ECHR rights). Because s 4 and s 5 are always predicated upon the person doing the act having a reasonable belief as to what is in the person's best interests, how detailed and rigorous the steps are that must be taken under s 4 will depend upon both the urgency and the gravity of the nature of the act being done (or not done): see *The Commissioner of Police for the Metropolis v ZH* [2013] EWCA Civ 69, [2013] COPLR 332, in which Lord Dyson MR recognised (at para [6]) that 'a striking feature' of the s 5 statutory defence is 'the extent to which it is pervaded by the concepts of reasonableness, practicability and appropriateness' and 'strict liability therefore has no place here'.

Section 5 and the power to move

In my earlier article, I argued that it makes a significant difference as to whether s 5 is characterised as a defence or a power. In particular, recall that Sir James Munby P appears to have reached the conclusion in AG that judicial sanction is required before moving an incapacitated adult from their own home because local authorities (and by extension NHS bodies) do not have the power to do so. This was, I suggested, a questionable proposition, but to understand why we need to dig a bit more deeply into what 'power' might mean here, because it is an ambiguous term.

Whilst is undoubtedly true that local authorities do not have an express power to move incapacitated adults, I suggested that it was not right to say that public bodies have no power to move a person in such a situation.

This can be tested simply by asking what the point would be in seeking the sanction of a Court of Protection judge if the public body did not have the requisite powers. A Court of Protection judge cannot imbue a public authority with powers that the authority does not have (this is the logical corollary to the clear position that the Court of Protection is discharging the role of deciding on P's behalf, and with the same 'powers' as P, between options actually available: see *Re MN (Adult)* [2015] EWCA Civ 411, [2016] Fam 87). So, even if the judge did agree on the person's behalf that the move should took place, the local authority (or NHS body) would not be able to move them because they had no power to do so. This is in contrast, for instance, to the position under s 135 of the Mental Health Act 1983 where the grant of a warrant by a justice of the peace gives specific authority to a constable to enter the premises specified in the warrant to remove the person in question to a place of safety.

The real question, rather, is whether the public body is exercising its powers properly. That, I suggested, brings us closer to what Sir James Munby P had in mind: in other words, seeking to reinforce the (absolutely correct) proposition that public bodies cannot simply exercise their powers in such a way as to cause enormous interference with the rights of individuals without due cause. By way of an example of a situation where the Court of Protection was clear that powers had been exercised properly – to support the wishes of the person, and rejected the argument by their family that (in effect) the local authority had kidnapped them, see *ZK (Landau-Kleffner Syndrome: Best Interests)* [2021] EWCOP 12.

The need for judicial sanction – medical treatment

That brings us to the decision of the Supreme Court in *NHS Trust v Y* [2018] UKSC 46. Neither in s 5, nor indeed in any other part of the MCA, is a specific requirement set down for judicial sanction in relation to any acts (or omissions) done in connection with care or treatment. Judicial sanction is required for deprivation of liberty outside hospitals and care homes, but that is, in essence, because Parliament failed to provide in DoLS the necessary statutory process to allow such deprivations of liberty to take place lawfully otherwise. Public bodies (and those who are otherwise required to comply with the ECHR in the discharge of their functions) must therefore seek orders of the Court of Protection as the only way in which they can obtain the necessary lawful authority to deprive a person of their liberty. It would also appear that deputies are required to seek such orders (*SSJ v*

Staffordshire CC & Ors [2016] EWCA 1317), although the precise basis upon which this obligation is imposed on them is not entirely clear from the judgment of Charles J or the Court of Appeal.

Other than that, I argued in my earlier article, that when properly analysed, there was no obvious requirement of law (whether by way of a directly imposed duty or sanction for a failure) to seek judicial sanction in respect of any act of care or treatment. That proposition was confirmed by Lady Black in *Re Y,* following her review of the relevant case law. She determined that there was *"no requirement in domestic law for an application to Court of the type that the Official Solicitor says is imperative for the protection of patients"* (at para [102]). In the course of her judgment, she referred to *R (Burke) v General Medical Council* [2005] EWCA Civ 1003, [2005] 2 FLR 1223, CA (an appeal against a decision of Munby J, as he then was) for the proposition that there is no legal duty to obtain court approval to the withdrawal of CANH in the circumstances that Munby J identified.

In that case, Munby J had declared that the prior authorisation of the court was 'required as a matter of law (and thus [artificial nutrition and hydration] cannot be withheld or withdrawn without prior judicial authorisation)' in five specific categories of case, each essentially relating to situations where there was doubt as to the capacity or best interests of the individual patient.

However, the Court of Appeal held that he was wrong to postulate that there was a legal duty to obtain court approval to the withdrawal of clinically assisted nutrition and hydration ('CANH', as it would now be called) in the circumstances. The Court of Appeal held that:

> *71. … So far as the criminal law is concerned, the court has no power to authorise that which would otherwise be unlawful – see, for instance, the observation of Lord Goff of Chievely in Bland at p. 785 H. Nor can the court render unlawful that which would otherwise be lawful. The same is true in relation to a possible infringement of civil law. In Bland the House of Lords recommended that, as a matter of good practice, reference should be made to the Family Court before withdrawing ANH from a patient in a PVS, until a body of experience and practice had built up. Plainly there will be occasions in which it will be advisable for a doctor to seek the court's approval before withdrawing ANH in other circumstances, but what justification is there for postulating that he will be under a legal duty so to do?*
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> *…*
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> *72. The true position is that the court does not "authorise" treatment that would otherwise be unlawful. The court makes a declaration as to whether or not proposed treatment, or the withdrawal of treatment, will be lawful. Good practice may require medical practitioners to seek such a declaration where the legality of proposed treatment is in doubt. This is not, however, something that they are required to do as a matter of law*.

Lady Black then reviewed post-2005 Act case law. Regarding *In re M (Adult Patient) (Minimally Conscious State: Withdrawal of Treatment)* [2012] 1 WLR 1653, she considered that Baker J relied upon a misinterpretation of the *Bland case* [1993] AC 789 and therefore does not assist.

She referred to the obiter comments of King LJ in *Re Briggs* [2018] Fam 63, expressing the view that treating doctors can take a decision without recourse to the court where there is no dispute about it. In *Re M (Incapacitated Person: Withdrawal of Treatment)* [2018] 1 WLR 465, Peter Jackson J observed that the decision as to what was in M's best interests could have been taken without reference to the court.

After determining that there is no domestic law requirement for an application to court, she then considered the next question: whether the European Convention on Human Rights generates a need for an equivalent provision to be introduced (at para 102). She answered with a resounding no – she did not accept the argument that the system in the UK was not what the European court was looking for, in contrast to the French system, which the court had been satisfied was sufficiently protective of article 2 and 8 rights and did not require an application to court, as follows:

a) The regulatory framework in the UK, consisting of the combined effect of the 2005 Act, the Mental Capacity Act Code, and the professional guidance (particularly from the GMC) was designed to protect the human rights of patients and families; and was compatible with article 2 (at para 105).
b) Further, the regulatory framework requires the patient's previously expressed wishes and those close to him/her to be taken into account (at para 108).
c) If there is doubt as to the best decision to take in the patient's interests, then an application can be made to the court (at para 109).

The Supreme Court held that (at paras 125-126):

> *125. If, at the end of the medical process, it is apparent that the way forward is finely balanced, or there is a difference of medical opinion, or a lack of agreement to a proposed course of action from those with an interest in the patient's welfare, a court application can and should be made. As the decisions of the European court underline, this possibility of approaching a court in the event of doubts as to the best interests of the patient is an essential part of the protection of human rights. The assessments, evaluations and opinions assembled as part of the medical process will then form the core of the material available to the judge, together with such further expert and other evidence as may need to be placed before the court at that stage.*
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> *126. In conclusion, having looked at the issue in its wider context as well as from a narrower legal perspective, I do not consider that it has been established that the common law or the Convention, in combination or separately, give rise to the mandatory requirement, for which the Official Solicitor contends, to involve the court to decide upon the best interests of every patient with a prolonged disorder of consciousness before CANH can be withdrawn. If the provisions of the 2005 Act are followed and the relevant guidance observed, and if there is agreement upon what is in the best interests of the patient, the patient may be treated in accordance with that agreement without application to the court. I would therefore dismiss the appeal. In so doing, however, I would emphasise that, although application to court is not necessary in every case, there will undoubtedly be cases in which an application will be required (or desirable) because of the particular circumstances that appertain, and there should be no reticence about involving the court in such*

cases.

More difficult is applying *Re Y* and assessing the individual circumstances of a case to ascertain whether or not an application is required – the key question is that assessment is whether section 5 does not provide a defence.

The Code of Practice to MCA 2005 is under review at the time of writing and will address the question of when cases should come to court, in light of the Supreme Court's judgment in *Y*. In the meantime, and expressly on an interim basis, Serious Medical Treatment Guidance[7] ('the Guidance') issued by the Vice-President of the Court of Protection identifies situations in which consideration should be given to bringing an application to court. The Guidance expands upon the decision in *Y* to add to the 'triggers' that there is a potential conflict of interest on the part of those involved in the decision-making process.[8] The Guidance reiterates that where one of the triggers arises, and the decision relates to life-sustaining treatment, an application to court must be made. In relation to situations that do not relate to life-sustaining treatment, the Guidance identifies that consideration must be given to bringing an application include:

(a) where a medical procedure or treatment is for the primary purpose of sterilisation;

(b) where a medical procedure is proposed to be performed on a person who lacks capacity to consent to it, where the procedure is for the purpose of a donation of an organ, bone marrow, stem cells, tissue or bodily fluid to another person;

(c) a procedure for the covert insertion of a contraceptive device or other means of contraception;

(d) where it is proposed that an experimental or innovative treatment be carried out;

(e) a case involving a significant ethical question in an untested or controversial area of medicine.[9]

As the Guidance notes,[10] this is because the procedure involves the serious interference with the person's rights under the ECHR, such that it is highly probable that, in most, if not all, cases, professionals faced with a decision whether to take that step will conclude that it is appropriate to apply to the court to facilitate a comprehensive analysis of capacity and best interests, with the person having the benefit of legal representation and independent expert advice. Importantly, this is so even where there is agreement between all those with an interest in the person's welfare.[3]

Separately to the matters set out above, an application to court may also be required where the proposed procedure or treatment is to be carried out using a degree of force to restrain the person concerned and that restraint goes beyond that permissible under MCA 2005, ss.5-6

[7] [2020] EWCOP 2.
[8] At para. 8(d). It is suggested that this means a potential conflict that cannot be appropriately managed: see, by analogy, the consideration of this position in *Prolonged disorders of consciousness following sudden onset brain injury: national clinical guidelines* (Royal College of Physicians, March 2020) at. p 118.
[9] At para.11.
[10] At para.10, citing *A Local Authority v. P (by her litigation friend, the Official Solicitor) and others* [2018] EWCOP 10, [2019] COPLR 44 at para 56, concerning the covert insertion of a contraceptive device.

and constitutes a deprivation of liberty. [11]

It is to hoped that, in due course, the courts in these categories of cases that come before them will move from observing that it is "*right*"[12] that the decisions should be dealt with by them to identifying the basis – in common law and/or the ECHR (as informed by the Convention on the Rights of Persons with Disabilities) to require any such applications to be brought.

Conclusion

In my earlier article, I suggested that the end result must – and must rightly – still require consideration of the individual circumstances of the case. From the perspective of the person, I was as, and am, less troubled whether the rigorous, MCA-compliant determination of their capacity and best interests takes place under the auspices of a public body-convened process or before a court – so long as it is indeed both rigorous and MCA-compliant. The Supreme Court confirmed that thesis, but left open the question of whether there nonetheless remain a class of cases in which court scrutiny is still necessary to satisfy wider societal concerns.

Alex Ruck Keene
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[11] Serious Medical Treatment guidance at para.12 An example would be the degree of sustained restraint envisaged to secure the feeding of Dr A in *An NHS Trust v Dr A* [2013] EWCOP 2442, [2014] Fam 161.
[12] See *University Hospitals of Derby And Burton NHS Foundation Trust v J (Medical Treatment: Best Interests)* [2019] EWCOP 16, concerning a procedure to undergo a hysterectomy and bilateral salpingo-oophorectomy and a colonoscopy, including a transfer plan including sedation and a level of deception to ensure her presence at hospital for the procedures to be undertaken, in which Williams J observed at para 45 that "[i]*t is entirely right that cases such as this, where medical decisions and the plan for their implementation impact so profoundly on P's personal autonomy, bodily integrity and reproductive rights, should be considered by the Court of Protection at High Court level, and as this case demonstrates, once in the hands of the court and the Official Solicitor they can be dealt with rapidly.*"