HEALTH ISSUES IN THE COURT OF PROTECTION

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Contents

11KBW

Advance decisions to refuse treatment

11KBW

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11KBW

"A decision made by a person ("P"), after he has reached 18 and when he has capacity to do so, that if (a) at a later time and in such circumstances as he may specify, a specified treatment is proposed to be carried out or continued by a person providing health care for him, and (b) at that time he lacks capacity to consent to the carrying out or continuation of the treatment, the specified treatment is not to be carried out or continued."

(Mental Capacity Act 2005, s 24(1))

ADRT conditions (ss 24-25)

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- Can be expressed in "layman's terms" and can be withdrawn or altered at any time person has capacity
- Withdrawal or alteration need not be in writing
- Not applicable to life-sustaining treatment unless this is made clear and ADRT is in writing and it is signed by person and witness in each other's presence
- Not valid if LPA subsequently created giving authority to give/refuse consent to treatment covered by ADRT
- Not valid if person has done "anything clearly inconsistent" with the ADRT remaining his fixed decision

Effect of ADRT (section 26)

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- ADRT which is valid and applicable to a treatment has effect as if person had made it and had had capacity to make it at time question arises whether treatment should be carried out or continued
- No liability for carrying out or continuing treatment unless at that time satisfied valid and applicable ADRT exists
- No liability for consequences of withholding/withdrawing treatment where reasonable belief valid and applicable ADRT exists
- COP can make declaration as to existence/validity/ applicability of ADRT and persons can do anything reasonably believed to be necessary pending any COP procedings

ADRT – Code of Practice, chapter 9

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Important guidance and non-exhaustive criteria to indicate best practice – endorsed in X PCT v XB [2012] EWHC 1390 Fam and in NHS Cumbria CCG v Rushton [2018] EWCOP 41 core features said to be:

- full details of the person making the advance decision including the date of birth, home address and any distinguishing features;
- GP's name and address and whether they have a copy of the document;
- a statement that the document should be used if the person ever lacks capacity to take treatment decisions;
- a clear statement of the decision, the treatment to be refused and the circumstances in which the decision will apply;
- the date the document was written;
- the person's signature (or the signature of someone the person has asked to sign on their behalf and in their presence);
- the signature of the person witnessing the signature, if there is one.

The opposite of ADRT?

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"[T]he balance of medical evidence would support the view that the treatment would bring about no significant improvement in HB's underlying condition… Against that, I have to balance the very clear wishes, expressed by HB to her daughter, that she would want all steps taken to preserve her life… [CPR] is the particular treatment that causes most concern to the medical staff…[The Trust submits] that it would not be in HB's best interests that the potentially last moments of her life were lived with her undergoing the violent and invasive procedures necessary in providing CPR, that it would be a traumatic scene for her children to witness in her final moments. I entirely accept those submissions and the force in them, but key to the decision must be the wishes and feelings of HB and it is plain that administering CPR in the event of a further collapse and giving her, albeit a very, very small chance of life, is what she would wish. In my judgment, at the moment, it remains in her best interests for that treatment to be provided to her. I entirely accept that there will undoubtedly come a time when such treatments would no longer be in her best interests but I am entirely satisfied that that stage has not been reached yet. "

(University Hospitals Birmingham NHSFT v HB [2018] EWCOP 39)

ADRT – practical guidance

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"Manifestly, these are documents of the utmost importance; the statute and the codes provide essential safeguards….[I]t should be regarded as axiomatic, that the medical profession must give these advanced decisions the utmost care, attention and scrutiny… Where advanced decisions have been drawn up and placed with GP records there is an onerous burden on the GP to ensure, wherever possible, that they are made available to clinicians in hospital. By this I mean a copy of the decision should be made available and placed within the hospital records with the objective that the document should follow the patient. It need hardly be said that it will rarely, if ever, be sufficient to summarise an advance decision in a telephone conversation."

(NHS Cumbria CCG v Rushton [2018] EWCOP 41 at [25-26])

When to go to the COP

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Life-sustaining treatment can be withdrawn or withheld without needing to make an application to the court, providing:

- provisions of the MCA 2005 are followed,
- relevant guidance is observed, and
- there is agreement upon what is in the best interests of the patient

(NHS Trust v Y [2018] UKSC 46, [2018] 3 WLR 751)

When to go to the COP

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But Supreme Court also made clear in Y that an application can and should be made if:

- decision at end of above process is finely balanced, or
- there is a difference of medical opinion, or
- lack of agreement to a proposed course of action from those with an interest in the patient's welfare

Completely novel/untested treatment? See UCLH NHS Trust v KG [2018] EWCOP 29

When to go to the COP

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Four other points to note:

(1) Decision does not just apply to life-sustaining treatment, nor just to PDOC patients, nor just to medical treatment cases (although where P disagrees application likely to be necessary)

(2) Life-sustaining (or other treatment) which is *not* in P's best interests is unlawful: Aintree v James [2014] AC 591

When to go to the COP

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Four other points to note (cont.):

(3) Even where an application *is* made, it can be decided on submissions and without evidence where no active objection before court: see SS v CCG [2018] EWCOP 40

(4) Hurdle for appealing best interests decision is a high one: see Re RW [2018] EWCA Civ 1067 (June 2018)

CANH Guidance

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- "Clinically-assisted nutrition and hydration (CANH) and adults who lack the capacity to consent: Guidance for decision-making in England and Wales"

- Published by the Royal College of Physicians and BMA and endorsed by the GMC in 2018 – 94 pages

- Shorter version 'Quick Reference Guide' (22 pages) and 'Five Things GPs need to know' (3 pages) also published

CANH Guidance – key principles

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- CANH is a form of medical treatment and should only be provided when it is in the patient's best interests

- Strong presumption it is in P's best interests but rebuttable by clear evidence P would not want it in the circumstances

- All decisions must be made in accordance with MCA 2005 and must focus on the individual circumstances of the patient and on reaching the decision that is right for that person;

- Second clinical opinion should be sought where proposed to stop or not start CANH and P is not within hours or days of death.

CANH Guidance - summary

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Guidance says it does not cover the following decisions:

- patients for whom CANH is not clinically indicated;
- patients who are expected to die within hours or days;
- patients for whom a decision to stop or not start CANH is part of a broader decision
- about life-sustaining treatment, e.g. mechanical ventilation

CANH (Clinically-assisted nutrition and hydration)

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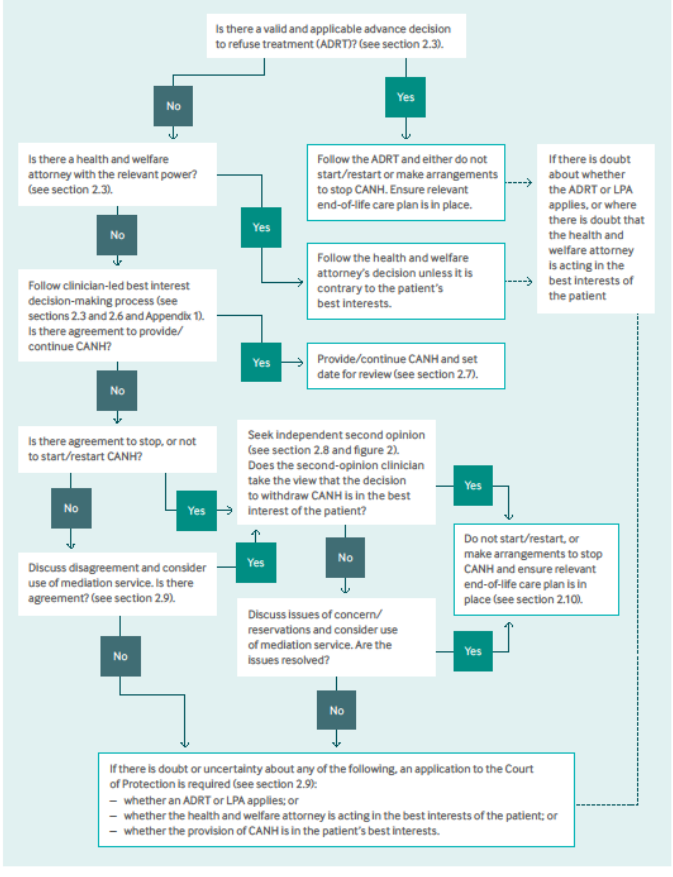
The decision-making process



When to go to the COP - timing

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"The application came before me on an extremely urgent basis on Wednesday 13th March 2019. The application was only lodged with the Court late on the 12th and…said that matter needed to be considered within one day and…that the surgery was required within the next 48 hours.

However, it was entirely apparent from the papers that the application had been in the course of preparation for at least a month, and that the clinical team at the treating hospital had been contemplating the need for the surgery for 9-12 months….Although the matter had become extremely urgent because PW's foot had deteriorated when PW attended the Hospital on 12 March, this deterioration was entirely predictable and indeed had been why the application started to be prepared in mid-February.

In these circumstances this application could and should have been made some weeks ago, even if at that stage it was on a slightly more precautionary basis. The effect of the delay has been detrimental to PW's interests and to a fair process which could fully take into account his wishes."

(East Lancashire Hospitals NHS Trust v PW [2019] EWCOP 10 at [2-5])

Best interests and P's wishes and feelings

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"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…[I]n considering the best interests of this particular patient at this particular time, the decision maker 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."

(*Aintree v James* [2014] AC 591)

Best interests and P's wishes and feelings

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Re M; ITW v Z [2009] EWHC 2525 (Munby J, as he then was) – weight to be attached to P's wishes and feelings depends on context. Relevant factors:

- nearer to the capacity borderline the more weight to be attached
- strength and consistency of P's views
- any impact on P of knowledge that his wishes and feelings are not being given effect to
- extent to which P's wishes and feelings are, or are not, rational, sensible, responsible and pragmatically capable of sensible implementation in the particular circumstances;
- "crucially" the extent to which P's wishes and feelings, if given effect to, can properly be accommodated within the court's overall assessment of what is in P's best interests

Best interests and P's wishes and feelings

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"So everything points to this operation being authorised by me and taking place. The only thing that is against it is SJ's wishes that it does not take place…because he believes that it will cause him further pain. That is not the evidence of the doctors. Indeed, the evidence of the doctors is that he is more likely to be in significant pain if he does not have this operation and I accept their evidence…I am clear that this is an operation that should now take place as being overwhelmingly in SJ's interests. I take the view that, if he had capacity, he would, in fact, see that and would wish to save his life in that way. There is absolutely no indication that he really wants his life to end. I am quite clear that, if he could understand the evidence that I have heard today from the three doctors, he would say "Judge, I do not know why we are in court; of course I must have this operation. Please do it quickly". Because of his incapacity, he is unable to weigh the matters up in this regard. But for that very reason I take the view that I should overrule his wishes, notwithstanding having very carefully considered all the law on this point and the wishes as he has set them out both to the doctors and to the Official Solicitor. I therefore approve the order that is sought on his behalf by the NHS Trust."

Re SJ [2018] EWCOP 28

Best interests and P's wishes and feelings

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"I have thought carefully about the fluctuating wishes that she has apparently expressed since the injury and taken those statements into account up to a point. However, it seems to me impossible for this court to attach any significant weight to them bearing in mind her patent lack of capacity, the manifest difficulties she has in understanding, retaining and weighing up information concerning the pregnancy. Overall, I consider that the clear and unambiguous views that she expressed prior to the injury are the crucial factors in this case."

(An NHS Trust v CS [2016] EWCOP 10)

Best interests and P's wishes and feelings

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- Abertawe Bro Morgannwg University Local Health Board v RY [2017] EWCOP 2 - court must try and ascertain P's wishes and feelings and beliefs and values, but if they are not ascertainable it is wrong to speculate

- SSHD v Skripal [2018] EWCOP 6 – *"I am unable to ascertain on the evidence before me either Mr Skripal's or Ms Skripal's past or present wishes and feelings…and so I am constrained to approach this decision at this moment in time on the basis of assumptions as to how a reasonable citizen would approach matters…Most reasonable citizens in my experience have a quite acute sense of justice and injustice. Most want to secure the best information about what has happened when a serious crime is alleged to have been committed. I accept that such a person would believe in the rule of law; that justice requires that crime or serious allegations of crime are thoroughly investigated; that where possible answers are found as to who, how and why a crime was perpetrated, that where possible truth is spoken to power; that no-one whether an individual or a State is above or beyond the reach of the law and that in these turbulent times what can be done to support the effective operation of international conventions is done. "*

Covert medication

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"It is, it might seem, a strong step for the Court to take: to authorise a course of medication that involves deception…However, on the facts of this case, there can be no doubt that there has to be authorised a course of action that ensures that AB, in her best interests, receives the treatment that will likely save her. It is for this reason that I am happy to approve the order that has been put before me….[H]owever…if the truth emerges to AB and she moves to a position of active resistance then the matter will have to be reviewed, and the Court will have to consider, in that situation, whether to move to forced administration of these drugs, which would be a very difficult decision to make, because it would not be a one-off administration of treatment, but would be a quotidian administration of treatment, which is a very different state of affairs to that which is normally encountered in this Court."

Re AB [2016] EWCOP 66

Covert medication

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"The application…is…for professionals to administer sedation covertly, in the event that FG continues to resist being transferred from the Ward to the Princess Royal Hospital [for surgery on his shoulder in his best interests]. This issue has troubled me somewhat because it is a considerable invasion of one's liberty. It also, it seems to me, involves what I referred to in discussion as "trickery" because what would happen would be that the medication to sedate FG would be mixed with a drink in the hope that he would swallow it without noticing, and be naturally and easily sedated. Conversely, he could be offered sedation and might refuse it and, on the basis of what I have read and been told, he probably would refuse it.

Then there is the question of whether he would be given chemical sedation under restraint. Restraining him not only would have, it seems to me, potential mental health risks, in that it would be a very, very unpleasant experience for him, but restraining him would probably involve restraining him by his shoulders because, after all, if he is jumping up and down or trying to get away from the bed where he is going to be injected with this chemical sedation, it is very likely that there would be injury to his shoulder, the very shoulder which is already dislocated and fractured.

I accept that there can be exceptional circumstances in which the administration of covert medication is better than forced chemical injection under restraint. There would be very few circumstances in which it will be appropriate to administer covert medication in this kind of way and each case will have to be decided on its own facts. I do not imagine there are any rules or specific guidance that one could set out. A judge would have to decide it on a case by case basis. But having regard to the mental health and physical health matters to which I have just referred, I am satisfied that if the surgery is to take place there should be permission to the treating team to administer covert medication in this way to sedate him."

Kings College London NHS Trust v FG [2019] EWCOP 7

S.49 reports – resources issues

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- Section 49 makes no provision in relation to fees or expenses but COP will "carefully consider resources and listen to any argument from the Trust particularly in relation to the time for compliance and the scope of the work to be undertaken" and "every effort will be made to accommodate the preparation and extent of the report so as to limit wherever possible the disruption in healthcare provided by a consultant to his patients" (RS v LCC [2015] EWCOP 56)
- Application can be made in relation to scope and extent of any report ordered and the time for compliance but must be made promptly and supported by evidence (ibid.)
- See also Practice Direction 14E, esp in relation to pre-application steps

Miscellaneous

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- Privacy in hospitals: Southern Health NHS Foundation Trust v AB [2019] EWCOP 11

- Organ Donation (Deemed Consent) Act 2019 – one exception to presumption of consent is adults who "for a significant period before dying lacked capacity to understand the effect" of the deemed consent provision

- Car crash cases: LB Lambeth v MCS [2018] EWCOP 14, [2018] EWCOP 20; Esegbona v King's College NHS Trust [2019] EWHC 77 (QB)