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Albion Chambers COURT OF PROTECTION

When is medical treatment 'serious'?

Whilst most health care and treatment decisions are taken and executed through the collaborative workings of P and all those caring for and about them, inevitably there are some which need the court's intervention, either because of disagreement between family or professionals, or because they amount to 'serious' medical treatment.

Practice Direction 9E gives guidance about cases which should be put before the Court. They include cases where there is a fine balance between the benefits and risks of the treatment, those where there is a fine balance between competing treatments, and those where there are serious consequences to P. In itself that gets a definition in the Practice Direction as "[consequences] which could have a serious impact on P, either from the effects of the treatment, procedure or investigation itself or its wider implications" and gives further examples such as serious pain or distress or a serious impact on P's future life choices.

There are some specific categories of treatment listed which should be brought to court - withdrawing/withholding artificial nutrition, organ or bone marrow donation, and non-therapeutic sterilisation – and a non-exhaustive list of other examples namely termination of pregnancy, treatments involving use of restraint, experimental or innovative treatment, and any ethical dilemma in an untested area. The Practice Direction is keen to point out that whether a procedure is 'serious' or not will depend on the circumstances and the consequences for the patient.

Whilst the guidance therefore contemplates, and is thought of as dealing with, procedures which are in themselves very serious, it can be seen how even relatively minor medical procedures can require the Court's consideration depending on P's reaction to it and the impact it will have on his/her life specifically.

A very good example of the range of situations which the court has to contend with can be found in the recent case of *The Mental Health Trust & Others v DD & Another* [2015] EWCOP 4. DD was a 36-year-old lady with autistic spectrum disorder and learning disabilities. She was in a relationship with BC who had similar difficulties of his own, although his learning difficulties were more profound. DD had recently delivered her sixth child (four of them by caesarean section) and Doctors considered that the prospects of a further pregnancy and delivery could have potentially fatal consequences for DD. She was hostile to professionals, to interference in her life and to ante-natal care. So it was that the court was called upon five times over nine months to determine issues ranging from the apparently benign (how to educate her in contraception) to the most grave (whether she should have an enforced sterilisation).

Cobb J's judgment is a masterpiece of thorough and careful analysis of the law, issues and facts. It is clear and concise in its reasoning and sets out, necessarily graphically, the distressing psychological and physical consequences which will bear on DD whatever course the Court followed on the ultimate issue of sterilisation.

As part of his judgment Cobb J set out the principles (derived from *A Health Authority v DE* [2013] EWHC 2562) which should be considered in a medical treatment case in determining P's best interests;

- The Court must reach its own conclusion. It is not tied to a clinical assessment. The Court is to determine P's best interests overall not just the best medical interests.
- When considering 'all the circumstances' not only is it for the Court to determine the factors to be weighed but also the weight to be given to each.
- There can be magnetic factors.
- The Court must determine the benefits and detriments of the treatment (and indeed Cobb J went on to set out a 'balance sheet' of the pros and cons of each possible treatment as suggested in *Re A (Male Sterilisation)* 2000 1 FLR 549).

The Court must, of course, always have regard to the least restrictive option, although it is not bound to follow it.

The extent of the Court's remit was demonstrated by the various applications which had been made about DD. Administering contraceptive injections, a normal and straightforward procedure in the vast majority of cases and which couldn't ever be said to be, per se, 'serious' medical treatment had, in DD's case, historically needed authorisation for forcible entry to her home, restraint if necessary, and the presence of the police. One set of proceedings had considered how to secure DD's attendance at some education about contraception, again in and of itself a relatively minor occurrence but which, in DD's case, would have a profound impact on her wellbeing. Ultimately the Court had to determine whether she should be sterilised which, on any view, falls within the 9E practice direction. In that particular case the Court felt it was manifestly in her best interests.

Consideration was also given to ancillary orders which should be made. Cobb J authorised the applicants to

withhold the date of the proposed sterilisation from DD and relied on s.16(5) (which enables the court to make 'such further orders or give such directions... as it thinks necessary or expedient' to give effect to the Court's order) to authorise the LA and Health Trust to use forcible entry and restrain or detain DD as necessary, although he endeavoured to put in place as many safeguards as possible noting that:

"Any physical restraint or deprivation of liberty is a significant interference with DD's rights under Articles 5 and Article 8 of the ECHR and, in my judgment, as such should only be carried out:

i) by professionals who have received training in the relevant techniques and who have reviewed the individual plan for DD;

ii) as a last resort and where less restrictive alternatives, such as verbal de-escalation and distraction techniques, have failed and only when it is necessary to do so;

iii) in the least restrictive manner, proportionate to achieving the aim, for the shortest period possible;

iv) in accordance with any agreed Care Plans, Risk Assessments and Court Orders".

Hannah Wiltshire

Time for a change?

Proposed reforms to DoLS and the CoP

In the last edition of this newsletter Hannah Wiltshire detailed the lengths the judiciary are currently going to in order to deal with the huge increase in volume of cases since the decision of the Supreme Court in *Cheshire West*. Now it's the Law Commission's turn, as their Consultation Paper No. 222 looks at reforming the law to try and relieve some of the pressure on courts and local authorities.

Issued on 7 July 2015 and staying open until 2 November 2015, the paper makes a number of proposals which seek to address what it sees as an overly bureaucratic system that is legally complex and fails to work for those who have to deal with its day-to-day implementation.

The scale of the problem

The Law Commission identify two real causes of the current problem: increased applications and a system which isn't suitable to respond.

As all readers will be aware, the Supreme Court decision in *Cheshire West* had a significant impact on the number of applications being made under the DoLS for standard authorisation. The figures provided by the Law Commission are summarised below (Fig 1).

The statistics below make it quite clear that as a result of the decision in Cheshire West, the system just isn't able to cope with the volume of applications it now has to deal with.

But what is it that's so wrong with the current system? The Law Commission focused on the criticisms made by the House of Lords Select Committee in their report on the Mental Capacity Act. Essentially the problem with the DoLS is that they were created as a somewhat reactionary response to the European Court's decision in *HL v United Kingdom*, which focused on the protection of P's Article 5 rights. The result was a system which has a narrow focus, is inaccessible to those that apply it, and contains statutory provisions which earlier this year Baker J described as "tortuous and complex".

Proposed reform

A full analysis is beyond the scope of this article, but the Law Commission's solution is to effectively shift the burden of assessments from social workers and independent assessors to those already involved in a person's care, and to shift the burden of determining appeals arising from those assessments away from the Court of Protection and transfer much of its appellate work to the First-Tier Mental Health Tribunal.

By scrapping the current six-step assessment process by two assessors and replacing it with an assessment which varies according to the level of care proposed, the Law Commission aim to create a more tailored approach to the specific needs of P, which will be denoted by the distinction between 'supportive care' and 'restrictive care and treatment'; the latter being a direct replacement for the DoLS.

Importantly for local authorities, whilst the proposals suggest the definition of mental disorder should be broadened to include more people in supportive care, they allow for the local authority to delegate the assessment function to those professionals already involved in P's care. Where, for example, an assessment has been carried out pursuant to the Care Act 2014, the local authority will be able to rely on this rather than have a social worker conduct a full assessment.

With regards to appeals, the Law Commission has proposed that in the first instance appeals should be heard by the First-Tier Mental Health Tribunal, which consists of a three-person panel of legal member, medical specialist and lay person. An appeal from that tribunal would lie either to the Upper Tribunal or the Court of Protection, the stated aim being to ease the pressure on judicial resources.The table (Fig. 2, following page) shows the Law Commission's analysis of the options.

What is taken for granted, of course, is that the ambit and scope of the Mental Health Tribunal is much narrower than the Court of Protection, giving it the flexibility to include the person, sitting in different places, with less delay. Were it to inherit the DoLS work of the CoP, it is unlikely that would remain the case.

Impact for lawyers

Were the proposals to be adopted in their current form, the consequences for the legal profession would be significant. The first question on everybody's lips will necessarily be "what about legal aid?". In a 220 page report, the Law Commission dedicate two paragraphs to this topic, highlighting that non-means-tested legal aid is available for Mental

Fig 1

	12 months 2013-14 pre-Cheshire West	12 months 2014-15 post-Cheshire West
Applications	11,300	113,300
Granted	6,400 (56%)	40,800 (36%)
Refused	4,600 (41%)	11,300 (10%)
Not yet processed, or withdrawn	300 (3%)	61,200 (54%)

Fig 2	Court of Protection	Mental Health Tribunal
Relevant expertise	Considerable knowledge and expertise, built on its wide discretion to decide on a range of issues	Limited experience in the range of CoP work, as decision-making is limited to whether a patient should be discharged
Participation of the person	Sits in London or regional centres, and it is unusual for the court to receive evidence from P themselves	Sits wherever the person is detained, and the patient almost always attends the hearing
Ability to access the court	No system of automatic referrals, CQC suggests one application is made per 40 cases	Automatic referrals and system for a number of other referrers
Delays and resource considerations	Can be slow and expensive, with some cases taking months or years – see *Re MN* [2015]	Subject to legislative time limits, making delay less of a factor

Health Tribunal proceedings, whereas in the Court of Protection it is only available for reviews of authorisations, rather than authorisations themselves.

Despite the House of Lords Select Committee inviting the Government to review the position last year, the response concluded that cases should remain subject to the means test, with the exception of challenges to DoLS authorisation. Whilst the Law Commission's hope is that funding for representation in the Mental Health Tribunal will continue, this appears to be wishful thinking.

With a less technical assessment process giving greater discretion to professionals involved in a patient's care, the ultimate role of the reforms is likely to be a reduced role for the legal profession, despite the proposals to expand the reach of the new protective care scheme. But of course, the saving grace is that even if these proposals are ever implemented, it's unlikely to be before 2017. Watch this space.

Alexander West

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