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Albion Chambers COURT OF PROTECTION

Mental Capacity Act, The Mental Health Act

What happens at birth?

This article explores the interplay between the Mental Capacity Act 2005 ('MCA') and the Mental Health Act 1983 ('MHA') (as amended), when you are faced with a mentally disordered pregnant woman who may or may not lack capacity to make decisions concerning her obstetric care and subsequent delivery.

At all stages the practitioner must remember two matters:

- The person is deemed to have capacity unless the contrary is shown;
- The test for capacity is very low – see S. 1(2) MCA – the presumption of capacity and it is a two stage test with the standard of proof being that of the civil standard;

(i) there is an impairment of, or disturbance in the functioning of the person's mind or brain; and

(ii) that impairment or disturbance of the mind or brain is sufficient to render the person incapable of making that particular decision at that particular time.

This is an issue which the Courts are having to deal with more and more frequently, and sadly highlights the lack of appreciation of need and process between the medical authorities and statutory bodies, such as social services. I have been involved in two recent cases, one in North Somerset, *North Somerset Council v LW* and others [2014] EWHC 1670 (Fam) and one in Norfolk where this exact point has arisen. However, it is important to remember that each case is fact specific, and decisions must be made on the basis of the facts and circumstances of each individual.

Unfortunately, what has become very apparent is that hospital trusts read and interpret the provisions of the Mental Capacity Act – particularly Section 5 and Section 4(7) or Section 4B of schedule A1 in a manner which may not always be lawful. It is of critical importance that trusts do not rely inappropriately on the provision of S.5 of the Mental Capacity Act 2005.

This is not stated in a critical way because Court proceedings are expensive and it is not wholly clear to date as to when such matters need to be brought to the attention of the Court for determination.

It appears that there are a number of groups of cases which cause particular problems and these can be identified as follows:

(i) Where intervention proposed by the hospital trust might amount to "serious medical treatment" within the meaning of CoP Practice Direction 9E (this is whether such treatment could otherwise be provided by MHA or MCA). The interventions proposed by the Trust(s) probably amount to serious medical treatment within the meaning of CoP Practice Direction 9E, irrespective of whether it is contemplated that the obstetric treatment would otherwise be provided under the MCA or MHA. The fact, in itself, that a mentally disordered woman is due to give birth, does not amount to "serious medical treatment".

(ii) Restraint – where more than transient forceful restraint may be required.

(iii) Where there is a serious dispute between the treating clinicians and the patient as to the care to be provided, the patient's views must be taken into account, pursuant to Section 4(7) Mental Capacity Act. If the treatment proposed will result in a real risk of a deprivation of liberty, and without a Court order would be otherwise unlawful (that is to say not authorised under Section 4B or of schedule A1 to the MCA), the Trust is unable to deprive her of her liberty under Schedule A1, and no other legal justification for that deprivation of liberty is available, they have a duty to seek the authorisation of P's deprivation of liberty from the Court. Although the Court will not be able to make a welfare order depriving P of her liberty under S.16(2)(a) of the MCA, it will be able to exercise the inherent jurisdiction of the High Court to make such an order provided that it complies with Article 5: see *A NHS Trust v A* [2014] 2 WLR 607, per Baker J, §89-96.

In looking at the different groups as set out above, what does it actually mean for each case?

Group I – Caesarean Section where the merits of it are finely balanced or the provision of a caesarean section is likely to involve restraint which is more than forcible transient restraint.

Group 2 – see below.

Group 3 – this potentially can be an evidential nightmare. Different clinicians will invariably have different views and it is important that their views are soundly evidenced based so that the Court can fully determine the application. Clinicians need to be aware that it is the Court in those circumstances that makes the decision, and if the Court determines a course different to that of a particular clinician then that clinician must not view it as a failure on their part. The Court must apply the principles set out in the Mental Capacity Act 2005. Peter Jackson J observed in *London Borough of Hillingdon v Neary* [2011] 4 All ER 584 at paragraph 33 a case concerned with the DOLs regime, that:

"Significant welfare issues that cannot be resolved by discussion should be placed before the Court of Protection, where decisions can be taken as a matter of urgency where necessary".

If an application needs to be made, what do you do?

If an application needs to be made, doing nothing is not an option. Procrastination will not assist anyone, least of all the Court and anyone subsequently

instructed to make the application. After all, there are, in essence, nine months in which to make the application. There is no good reason why an application should be made at the last minute by way of an emergency out-of-hours duty judge. Such applications have serious consequences in costs (as in the North Somerset case).

There will be an interference with the patient's articles 5, 6, and 8 rights (deprivation of liberty, fair trial and family life). It must be obvious that if there is a plan to deliver a child by way of caesarean section then this is a matter which will be discussed with the treating clinicians and, as much as possible, the patient well before the due date. Surely, all such decisions should have been made four weeks prior to the due date and at which point it will be very apparent whether an application to the Court must be made. It is only where there is opposition from a capacitous woman who objects to such proposed intervention against medical advice with consequential serious medical implications for the woman and unborn child, an incapacitous woman (within the definition of MCA 2005) or a dispute between clinicians that an application to Court needs to be made.

It is important to recognise that the Official Solicitor will have an important role where the patient is assessed as lacking capacity to litigate. All practitioners and treating clinicians have to bear in mind that each decision asked of the patient is capacity specific. Each decision asked of the patient must be regularly reviewed (each decision is time and issue specific) and thus, a decision recorded say six months into the pregnancy may be very different to one at eight months.

Section 5 MCA - impact

It is important that trusts do not rely inappropriately upon the provisions of Section 5 of the Mental Capacity Act 2005.

A number of conditions must be met before clinicians could lawfully provide Obstetric care or treatment under S.5 MCA, namely:

The clinicians must have taken reasonable steps to determine whether P lacks the capacity to decide whether or not to undergo the obstetric care in question (S.5 (1)(a)).

The clinicians must reasonably believe that P lacks the requisite capacity (S.5(1)(b)(ii)).

The clinicians must reasonably believe at the time they provide the Obstetric care in question that is in P's best interests to do so (S.5(1)(b(ii)).

Section 5 of the Mental Capacity Act provides "five acts in relation to care or treatment":

(1) If a person ("D") does an act in connection to another person ("P") the act is one to which this section applies if;

(a) before doing the act D takes responsible steps to establish whether P lacks capacity in relation to the matter in question; and

(b) when doing the act D reasonably believes;

(i) that P lacks capacity in relation to the matter; and

(ii) that it will be in P's best interest for the act to be done.

(2) D does not incur any reliability in relation to the act that he would not have incurred if P:

(a) had had capacity to consent in relation to the matter; and

(b) had consented to D's doing the act.

(3) Nothing in this section excludes a person's civil liability for loss or damage or his criminal liability, resulting from his negligence in doing his act.

(4) Nothing in this section affects the operations of Sections 24-26 (advanced decisions to refuse treatment).

Section 63 MHA

Equally, it is important that practitioners have knowledge 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 which he is suffering, not being a form of treatment to which Section 57, 58 or 58A above applies, if the treatment is given by or under the direction of the approved clinician in charge of the treatment."

Therefore, the primary purpose of S.63 is to authorise medical treatment which has the primary purpose of alleviating or preventing a worsening of patient's psychiatric illness or its symptoms. Curiously, one may think, obstetric treatments can also be provided under S.63 without the patient's consent using proportionate and necessary restraint as set out in *Tameside and Glossop Acute Service NHS Trust v CH* [1996] 1FLR 762 – Wall J (as he then was).

"In cases in which the question of restraint arose or was likely to arise, and the doctor was doubtful about the lawfulness of the application of restraint or the use of force, an application should be made to the Court for declaration that the treatment would be lawful."

Section 17 MHA

Of course Section 17 of the MHA can be used to provide conditional leave for a patient from a psychiatric hospital. S.17 provides *"(1) The responsible clinician may grant, to any patient who is, for the time being, liable to be detained in a hospital under this part of this act, leave to be absent for the hospital subject to such conditions (if any) as that clinician considers necessary in the interest of the patient, or for the protection of other persons (3) where it appears to the responsible clinician that it is necessary so to do in the interest of the patient or for the protection of other persons, he may, upon granting leave of absence under this section, direct that the patient remains in custody during his absence, and where leave of absence is so granted the patient may be kept in custody of any officer on the staff of the hospital, or of any other person authorised in writing by the managers of the hospital or, if the patient is required in accordance with conditions imposed on the grant of leave of absence to reside in another hospital or any officer on the staff of that other hospital..."*

"(7) for the purpose of giving effect to a direction or condition imposed by virtue of the provision corresponding to the subjection (3) above, the person may be conveyed to a place in, or kept in custody or detained at a place of safety in, England and Wales by a person authorised in that behalf by the direction or condition."

So S.17 provides time limits imposed upon P by the responsible clinician (RC), but the RC cannot make the patient lawfully subject of a condition which require her to undergo obstetric or other treatment outside the scope of S.63 MHA 1983, or to impose conditions forcing the patient to follow instructions of obstetric staff in relation to such treatment.

Restraint

Defined in Section 6(4) MCA – restraint not restricted to the threat or use of force restricting P's liberty of movement, whether or not she resists the same. Provided it does not amount to a deprivation of liberty, restraint can be used under S.5 MCA provided that it is:

(i) necessary to prevent harm to P (S.6(2)): and

(ii) is a proportionate response to the likelihood of P suffering harm and the seriousness of that harm (S.6(3)).

Note however, the legal difference of restraint versus deprivation of liberty Section 4A(1) which amount to a deprivation of liberty as part of care and treatment under S.5 and total restraint for very short periods may amount to a deprivation of liberty; *ZH v Commissioner of the Police for the Metropolis* [2013] 1 WLR 3021;

Deprivation of liberty is fact sensitive. Lady Hale in *P v Cheshire West and*

Others [2014] UKSC 19 paragraph 49 referred to it as the "acid test".

The "acid test" identifies two elements of the deprivation of liberty:

(i) she is subject to continuous supervision and control, and

(ii) she is not free to leave.

This test is highly relevant when one is considering a mentally disordered patient and the provision of obstetric care. The Trusts must, therefore, plan how P is to receive obstetric care in sufficient detail to identify whether there is potential for a deprivation of liberty to arise. When trusts identify there is a real risk that P will suffer an additional deprivation of her residual liberty during transfer to and from the acute hospital, and/or when present at the acute hospital, the Trusts must take steps to ensure the deprivation of liberty is authorised in accordance with the law. 'Real risk' means that "judged objectively there is a risk that cannot sensibly be ignored that the relevant circumstances amount to a deprivation of liberty": *AM v South London v Maudsley NHS Foundation and Anthr* [2013] UKUT 365 (AAC) per Charles J at para 59.

Where the Trusts identify there is a real risk that P will suffer a deprivation of liberty in these circumstances it is for them to decide whether the same is achieved by a standard authorisation under schedule A1 of the MCA, by an application to the Court or under another lawful jurisdiction.

There are only three circumstances where a deprivation of liberty would be lawful without the Court's authorisation:

(i) If it has been authorised by a valid standard or urgent authorisation under Schedule A1 to the MCA (S.4A(5)).

(ii) If it is necessary, and undertaken wholly or partly for giving P life-sustaining treatment or for preventing a serious deterioration in P's condition, but only for a limited period whilst a decision in respect of any relevant issue is sought from the Court (S.4B(2)-(5)) under the common law doctrine of necessity.

(iii) The mere fact that a deprivation of liberty could be authorised under Schedule A1 does not absolve the Trusts from making an application to the Court where the facts of the individual case would otherwise merit the same.

Who should bring the application?

It may seem obvious to some that it should be the hospital trust which brings the application. Social Services have no locus until the child is born, save in exceptional and unusual circumstances – one such circumstance would clearly be a decision by a local authority to withhold the proposed care plan from the expectant mother. Hospital trusts cannot, and should not, expect child care social services to take it upon themselves to take the lead and have to apply to the Court for the permissive order in relation, for example, to caesarean section with or without restraint and/or the necessary anaesthesia which goes with such a surgical procedure.

A checklist for such an application might look something along these lines:

(i) Issue the application – in the High Court/Court of Protection. The applicant will be the hospital trust not the Local Authority.

(ii) Accompany the application and evidence in support with a draft order(s) – the permissive orders sought and, if appropriate, a reporting restrictions order.

(iii) In the application that has been issued it would be sensible to put in a note that a directions hearing is requested within a very short timeframe, so that the Court, in exercising its case management powers, can determine the scope of the hearing and the evidence required in order for the Court to reach a determination.

(iv) It would be good practice to have contact with the Official Solicitor prior to issuing an application – this is particularly so if you are coming within certain holiday periods.

(v) Disclose the evidence that the hospital trust has to the Official Solicitor so that the Official Solicitor is in the position of knowledge concerning the application and can provide proper assistance to the court.

(vi) Close liaison with the Clerk of the Rules is essential. The Clerk of the Rules should be in a position to give guidance as to which Judge the matter is likely to come before. This will be particularly so during vacation periods as there will be specific vacation Judges. It probably goes without saying but the treating clinicians need to have close liaison with their legal advisors and vice versa.

What evidence is required?

(i) Psychiatric – from the treating psychiatrist who has knowledge of the person concerned. The Court should have before it an up to date full mental state examination, diagnosis and treatment plan for the mental disorder. A psychiatrist should be in a position to advise the Court as to the impact upon the patient and ongoing psychiatric treatment of the proposed obstetric interventions. Clearly, if the patient is currently an in-patient in a mental health hospital and needs to be transferred to a general hospital to receive obstetric care and subsequent delivery, then the transportation to and from, effect and what interventions will be required is of crucial importance. All details concerning the manner of transport, the number of people required and any psychotropic medication/sedation will be important factors for the Court to determine, bearing in mind the article 5, 6, and 8 rights potentially being infringed.

(ii) A care plan needs to be provided in relation to the proposed obstetric care of the patient by a consultant gynaecologist. This should include the exact nature of proposed intervention, any anaesthesia to be used, any sedation, the circumstances of the delivery of the treatment and, crucially, the risks of the proposed treatment upon the particular patient concerned. Due to the very serious nature of the proposed treatment, if restraint is proposed, the Court must be looking at the least restrictive plan possible. A detailed analysis of the types of restraint thought to be required, how they should be delivered, and timings are critical. The trust should operate a "step up" approach as opposed to a "step down" approach i.e. that is to say talking therapies, reassurance and then, at the other end, sedation and forcible restraint - the last restrictive option first not last.

(iii) A statement from the lead consultant gynaecologist, preferably from the person who it is intended will undertake the procedure. This consultant should, as a matter of good practice, have been identified at a very early stage in the patient's pregnancy so that that consultant will be able to give a very clear gynaecological overview of the confinement to date and have liaised with the patient's psychiatric team and community midwives. This is to enable the Court to have a full picture of the patient so that the Court can form a picture of the patient's wishes in so far as they are able to be ascertained. An analysis of the advantages and risks of the proposed intervention is essential. This is particularly so if patient has at times indicated a wish to have a vaginal birth, but given the concerns as to the psychiatric stage of the patient it is considered necessary that there should be a planned caesarean section. An analysis of the patient's best interests has to be ascertained by the clinical obstetric team of which the consultant will be the lead.

(iv) Social services pre-birth care plan and minutes of all meetings attended to discuss the developing situation. *The treating obstetric clinicians will be the lead in such meetings.*

(v) Witness statements from the lead midwife in the community and social worker. That evidence will provide crucial information for the Court as it will span the length of the

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pregnancy and will enable the court to have a good overview of the patient when not in the stressful confines of a medical facility in which proposed gynaecological intervention, possibly against their wishes, is being proposed.

Withholding the care plan from the patient

In the event that the Local Authority considers it necessary for the proposed care plan to be withheld from the patient, it will necessitate an application for the Court. It is an extremely draconian application to be made and should not be undertaken lightly. It clearly engages Art 6 and 8 rights of the patient. This application will be made under inherent jurisdiction of the High Court, and may well ultimately be linked with that of the hospital trust under the Court of Protection. There needs to be good, proper professional liaison between the local authority solicitor and the hospital trust solicitor. Matters can become very complicated where the patient moves between different hospital trusts. It is to be remembered that every professional is working to the same end – that is to provide the least interventionist, and most transparent care for the patient and the unborn child, as possible. It should not become a "them and us" attitude where there can be point scoring between legal advisors. All that does is to increase the cost to the public purse.

Any other applications

A reporting restrictions order – if the application by either the trust or the Local Authority is one to not notify the patient then consideration needs to be given as to whether there needs to be a reporting restrictions order. Full and proper notice needs to be given to the press and broadcast media whereas the national papers can be served by copy direct, local media has to be served individually. There is a wealth of reported authority on this now – most notably led by Baker J.

Finally, it is important to note that orders made, either by the High Court or in the Court of Protection are permissive – that is to say they permit certain actions to be taken as authorised by the Court. They do not have to be utilised.

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