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Court of Protection: A Reflection on Geriatrics

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Court of Protection Series

Today's seminar: A reflection on Geriatrics and the Court of Protection

Upcoming seminars:

- 15 October 24: A reflection on Psychiatry and the Court of Protection
- 12 November 24: Court of Protection Case Update

Today's Agenda

1. Court of Protection Basics
2. Geriatricians in the Court of Protection
3. Geriatric Practice and Reflections
4. Q and A

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Court of Protection Basics

What is the Court of Protection

- The Court of Protection is a creature of Statute created by the Mental Capacity Act 2005 ("**MCA 2005**"). Section 45(1) MCA 2005 states "*There is to be a superior court of record known as the Court of Protection.*"
- Section 47(1) MCA 2005 states that "*The court has in connection with its jurisdiction the same powers, rights, privileges and authority as the High Court.*"

Broad Powers

- Section 15 of the MCA 2005 grants the Court of Protection the power to make declarations as to whether someone has capacity or not. It also empowers the Court to make a declaration as to the lawfulness of an act towards such a person.
- Section 16 of the MCA 2005 grants the Court of Protection the power to either make a decision on an incapacitated person's behalf or appoint a deputy who may do so.
- A person who has a lasting power attorney may make decisions on behalf of a person who lacks capacity. The Court has wide powers under section 22 and 23 MCA 2005 to restrict them if necessary (e.g if the LPA proposes to act contrary to P's best interests)

Section 1-3 MCA 2005 in outline (read in full)

- Section 1 contains a rebuttable presumption that a person has capacity. It makes clear that any decision in relation to an individual who lacks capacity must be (i) in that person's best interests and (ii) be done in the way that is the least restrictive of the person's rights and freedom of action.
- Section 2 limits the applicability of the act's powers to those who are 16 or above (subject to narrow exceptions). It defines lack of capacity in a way that is often described as containing two stages (i) diagnostic – is there and impairment of, or a disturbance in the functioning of, the mind or brain (ii) functional - is the person, at the material time unable to make a decision for themself in relation to the matter as a result of the impairment/disturbance of the mind.

Section 1-3 MCA 2005 in outline (read in full)

…continued

- Section 3 fleshes out the functional test. It indicates that one should identify the information relevant to a decision (including the foreseeable consequences of the decision) and then consider whether a person can (i) understand the information relevant to the decision (ii) retain that information (iii) use or weigh the information as part of the decision making process or (iv) communicate their decision (a multitude of cases illustrate what relevant information may be in respect of different decisions)

Section 4 in outline (read in full)

This section requires those making a best interests determination to follow a non-exhaustive checklist. It includes:

- Considering whether the person will regain capacity and if so, when.
- Ensuring that the person effected is permitted and encouraged to participate as fully as possible with any act or decision affecting them.
- Ensuring a decision about life sustaining treatment is not motivated by an intension to bring about death.
- Consider, insofar as reasonably ascertainable, the person's past and present wishes and feelings, beliefs and values if they had capacity, and any other factors that they would be likely to consider relevant.
- Take into account what those close to the person consider to be in their best interests. This includes seeking the views of (i) anyone named for that purpose by the person who lacks capacity (ii) any LPA or deputy (iii) any person engaged in caring for the person or interested in their welfare.

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Geriatricians in the Court of Protection

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Geriatricians in the Court of Protection - *UF v X County Council & Ors* (No.2) [2014] EWCOP 18

UF v X County Council & Ors (No.2) [2014] EWCOP 18 – Background Facts

- This case concerned UF, who was 84 years of age and had been diagnosed as suffering from vascular dementia of a moderate level, with associated behavioral and psychological symptoms. She resided in a care home where she was deprived of her liberty under a standard authorization (§1).
- UF was expressing a strong desire to ”*go home*” (though it was unclear what precisely UF meant by ”home”) (§88).
- UF’s GP reported that she had previously responded aggressively to visits from the GP (§17). Her son reported that she could be verbally aggressive and had on one occasioned threatened to stab his sister and set the house on fire (§57)

UF v X County Council & Ors (No.2) [2014] EWCOP 18 – The issue

- The Court was being asked to grapple with four issues:

  i) Is it in UF's best interests to return to her home to live with a contingency plan of maintaining her current placement for a period of time?
  ii) Should a direction be given to the property and financial affairs LPA about releasing equity from UF's property to pay for her care?
  iii) Should the LPA for property and financial affairs be replaced by a Deputy appointed by the Court?
  iv) Would any care regime at home still represent a deprivation of liberty? (§2)

UF v X County Council & Ors (No.2) [2014] EWCOP 18 – Key Evidence

- There was a considerable evidential dispute as to what UF meant when she said that she wished to return home and whether she was in fact referring to the care home. UF appeared, at times, not to know where she was and at other times indicated that she believed the care home to be her home (§32-§50).
- Dr Pace, Consultant in Community Geriatric medicine appeared to support the Court's view that UF viewed the Care Home as her emotional and physical home (§41).
- Dr Pace noted that if UF were to move home then she would require care from a team with specific mental health skills with specialist support from psychiatric services (§51).

UF v X County Council & Ors (No.2) [2014] EWCOP 18 – Judgment

- The Court considered that UF would likely have wanted to live and die at home but that it was not clear that she would have wanted others to live at home with her. This was important because she was assessed as requiring two carers around the clock (§42 and §45). There was a real risk that UF would not tolerate being cared for by two live-in carers (§57).
- The Court ultimately ruled that it was in UF's best interests to remain at the care home (§86). Central to this was the Court's interpretation of UF's wishes and feelings. The Court's view was however reinforced by grave doubts that a community placement would work in practice given the significant likelihood of UF not tolerating interventions (§92).

UF v X County Council & Ors (No.2) [2014] EWCOP 18 – Judgment

…continued

- The Court variously then addressed the other issues finding (i) that UF should remain in her care home (§86) (ii) that no equity release was therefore necessary (§95) (iii) that no party seemed to be seeking a deputy to replace the LPA (§96) (iv) while not deciding it, taking the view that a return home would likely have involved to a deprivation of liberty.

UF v X County Council & Ors (No.2) [2014] EWCOP 18 – Reflections

- This case highlights some of the complexity of interpreting wishes and feelings when everyday words may have multiple meanings (in this case what was meant by "*home*").
- The viability of a care package in the community will often be an important factor.
- The disruption and adverse consequences that might be caused by transitions often weigh against commencing a trial move.

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PW v Chelsea And Westminster Hospital NHS Foundation Trust& Ors (Rev 1) [2018] EWCA Civ 1067

PW v Chelsea And Westminster Hospital NHS Foundation Trust& Ors (Rev 1) [2018] EWCA Civ 1067 per Lady Justice Sharp – Background Facts

- The case concerned how P should spend the last stages of his life. He was a 77 year old man with end stage dementia (§2 and §5). The evidence before the Court suggested that P's mobility had declined such that he was largely confined to bed (§21).
- His executive function had worsened to the point he required hand feeding, and his oral intake gradually reduced. The cause of this was described as being twofold by Dr Levy (consultant geriatrician) *"The first is an impaired swallow mechanism which is a neurological impairment reflective of the underlying neurodegeneration. The second is reduced appetite or lack of hunger thought to reflect the neurodegeneration in pathways governing hunger. A combination of these factors leads to people with dementia chewing their food for a long time or pocketing it in their mouth and forgetting to swallow"* (§21)

PW v Chelsea And Westminster Hospital NHS Foundation Trust& Ors (Rev 1) [2018] EWCA Civ 1067 per Lady Justice Sharp – The issue to be decided

…continued

- At the time of the hearing in first instance before Parker J it had been agreed that P should return home for the last stages of his life. The dispute was whether P should return home with (a) clinically assisted nutrition and hydration via a nasogastric tube (i.e a tube passing through P's nose and into his stomach) or (b) palliative care and oral comfort being provided instead (§7-§9).

PW v Chelsea And Westminster Hospital NHS Foundation Trust& Ors (Rev 1) [2018] EWCA Civ 1067 per Lady Justice Sharp – Key Evidence

- Dr Levy was jointly instructed by the parties. She was described in the following terms: **"***a consultant geriatrician and general physician at Hammersmith Hospital; she is the Chair of the British Geriatrics Society special interest group in Ethics and Law and a member of the British Medical Association's core writing group on CANH guidance, currently in preparation.*" (§16)

- Dr Levy's view, shared by the Trust, was that "*it is not in RW's best interests for him to be discharged home with the NG tube in place*" (§19)

PW v Chelsea And Westminster Hospital NHS Foundation Trust& Ors (Rev 1) [2018] EWCA Civ 1067 per Lady Justice Sharp – Key Evidence

- Dr Levy noted that nasogastric tube feeding in the community for adults with dementia is unusual and very rare. She noted that there were risks namely "*Nasal trauma, aspiration of feed, dislodgment and (rarely) intracranial passage of the tube or oesophageal perforation are all associated complications*". She considered that the tube would likely regularly become dislodged and require P's regular return to hospital for its replacement. She did not consider this option safe (§25).
- Dr Levy's evidence was described as nuanced and careful including the following analysis: "*Offering potentially life lengthening treatment in the form of CANH is no different ethically in this scenario than offering other forms of treatment …. Prolonging RW's life, with no recognition of his pain, indignity or suffering and with no potential for recovery from his progressive illness is unjustifiable to my mind and represents a futile, overly burdensome intervention. RW can't communicate, he can't manoeuvre himself in his bed, he can't swallow more than tiny amounts, he is likely to experience discomfort in his pressure areas from his urinary catheter. I do not think I am projecting my personal view about his quality of life in saying his existence is undignified*." (§26)

PW v Chelsea And Westminster Hospital NHS Foundation Trust& Ors (Rev 1) [2018] EWCA Civ 1067 per Lady Justice Sharp – Key Evidence

- One notable feature of the case, identified by Dr Levy was that PW's sons displayed confrontational and aggressive behaviour towards professionals caring for PW (§79).
- The family position was (1) that they had experience placing a nasogastric tube (2) that they would provide P with 24-hour care (3) that a nasogastric tube risks aspiration pneumonia if incorrectly placed but that this risk is even higher if PW does not have a nasogastric tube (§32)
- P's beliefs were described in the following terms by one of the sons "*My father is a religious man. He believes in God, angels and spirits. He is a very spiritual man. He brought us all up throughout childhood to believe in God." "My father is not scared of death and has always been ready for it, whenever that time may come. My father does not believe in quitting. His family motto has always been: 'As long as we do our best, God will take care of the rest, no matter what, until the bitter end.'*" (§34)

PW v Chelsea And Westminster Hospital NHS Foundation Trust& Ors (Rev 1) [2018] EWCA Civ 1067 per Lady Justice Sharp – Judgment

- The Court considered that the first instance Judge had been entitled to conclude that P would wish to die at home, but it was not clear what P's view would have been about continued clinically assisted nutrition and hydration. The Court declined to speculate about what P's views might be (§53).

- The Court did not find error in the first instance Judge's view that the benefit of continued clinically assisted nutrition and hydration by way of nasogastric tube would be the opportunity to live longer but that this benefit was outweighed by "*the risk of displacement of the tube, the risk of aspiration of food etc., discomfort, and nasal erosion*" The Court of Appeal saw no issue with the Judge' conclusion that *"palliation would make RW as comfortable as possible and ensure his dignity and comfort. He will pass away with palliation in a dignified way*" (§57-58)

PW v Chelsea And Westminster Hospital NHS Foundation Trust& Ors (Rev 1) [2018] EWCA Civ 1067 per Lady Justice Sharp – Judgment

- Sharp LJ questioned whether return home with a nasogastric tube was in fact an available option since clinicians might refuse to replace or re-site the tube given that it would need to be replaced every 4-6 weeks even if it was not dislodged or pulled out (§60). Jackson LJ agreed (§97).
- Jackson LJ added poignantly "*As a society, we rightly treat life as precious, but the ultimate purpose of our existence cannot be to live as long as we possibly can, regardless of suffering and indignity. Even for those who see illness and death as a battle, the true mark of a 'fighter' will sometimes be the courage to accept that treatment can no longer bring benefits.*" (§93).
- As such the first instance Judge's decision for return home without a nasogastric tube was upheld.

PW v Chelsea And Westminster Hospital NHS Foundation Trust& Ors (Rev 1) [2018] EWCA Civ 1067 per Lady Justice Sharp – Judgment

- The importance of considering what treatment clinicians will in fact offer and so what the "*available options*" in fact are.
- Clear evidence of belief is required and it is difficult to construct this if there haven't been discussions on the practicalities of care at an early stage.
- Confrontational dynamics between professional staff and emotional family members can be features of cases like this.

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AB v XS [2021] EWCOP 57; [2022] 4 WLR 13

AB v XS [2022] 4 WLR 13 – Background Facts

- This case concerned XS, a 76 year old woman residing in Lebanon and who was a dual UK and Lebanese citizen (§1). She was diagnosed with Alzheimer's Disease in 2013 (§2). She continued to have capacity in September 2014 and travelled to Lebanon, initially moving into a flat close to her brother R (§4-§5).
- R died in April 2016 and XS moved into a care home in Beirut. The evidence before the Court was indicative of XS having lost capacity as of April 2016 (§5).
- The Applicant, AB, sought an order to effect XS' return to the UK on the basis that this is what she would have wished (§7) and on the basis that the situation in Lebanon risked XS suffering due to shortages of medical supplies (§11).

AB v XS [2022] 4 WLR 13 – Geriatric Evidence

- Dr Karam, an adult and geriatric psychiatrist in Beirut produced a report where he concluded, amongst other matters, that:

  (a) XS suffered from "severe and advanced stages of dementia"

  (b) XS had very little reactivity to her environment and a change of environment and loud noises (from the plane) may be disturbing.

  (c) An improvement in her medical and mental condition was unlikely to result if she returned to the UK. However, if XS developed "*an acute complication requiring immediate intervention this may not be readily available in the Lebanon.*" (§16).

AB v XS [2022] 4 WLR 13 – The Issues

- The Court had to grapple with three issues:

  (a) Whether XS is habitually resident in England and therefore the Court of Protection retains jurisdiction;

  (b) Whether the High Court can make an order for XS to return to the UK under the inherent jurisdiction;

  (c) Whether it is in XS's best interests to be brought back to the UK (§17).

AB v XS [2022] 4 WLR 13 – The Judgment

- The Court ruled that it lacked jurisdiction under the Mental Capacity Act 2005 as XS' habitual residence had moved to Lebanon (§28-29).
- The Court considered whether it should exercise powers under the inherent jurisdiction "*the great safety net which lies behind all statute law, and is capable of filling gaps left by that law*" (§30 quoting from Lord Donaldson of Lymington MR in *In re F (Mental Patient: Sterilisation)* [1990] 2 AC 1, 13). It considered that this was not a case where the inherent jurisdiction should be used because doing to would cut across a statutory scheme (namely the Mental Capacity Act 2005 (§36).

AB v XS [2022] 4 WLR 13 – The Judgment

- The Court considered that it was, in any event, in XS' best interests to remain in Lebanon. Key to the Court's reasoning was the following evidence largely derived from Dr Karam's evidence: "*To bring her to the UK would be extremely disruptive to her and would involve her being cared for by new people and in a new place. It is possible, given her advanced dementia, that XS might not notice these changes, however she might find them very disturbing and upsetting. Equally, even with the best care, she is likely to find the travel and flight physically and possible emotionally exhausting. This will be particularly so given her very frail state*." (§38-39). This was Judged to outweigh the risk of XS potentially not being able to get the medication she needs in Lebanon (§41).

- The Court noted at §40 that XS "*will be wholly unaware of the fact that she has moved to England and will not know either the applicant or any of the other people she knew in England. There is therefore little tangible emotional benefit to her being in England.*"

AB v XS [2022] 4 WLR 13 – Reflections

- A significant move at end of someone's life may have significant harmful effects. Identifying clear benefits of such a move is therefore essential.

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Geriatric Practice and Reflections

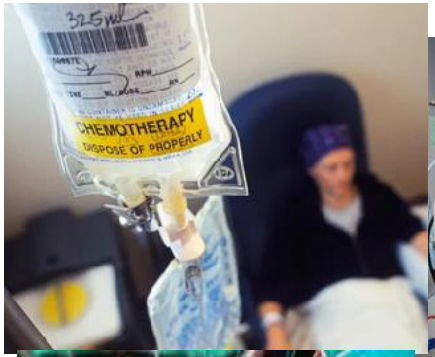
Objectives

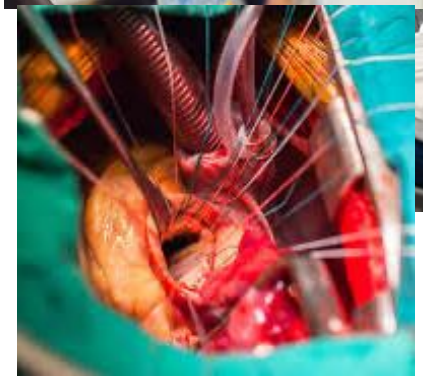
1. Discuss the decisions that geriatricians commonly make in the best interests of patients
2. Discuss three cases
3. Reflect on the challenges of practising medicine for the older person

Medical treatment

Medical treatment

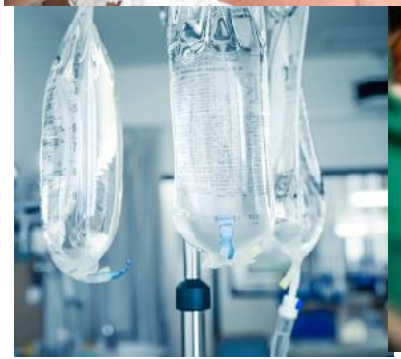
Medical treatment





Medical treatment

Medical treatment



Medical treatment

Medical treatment

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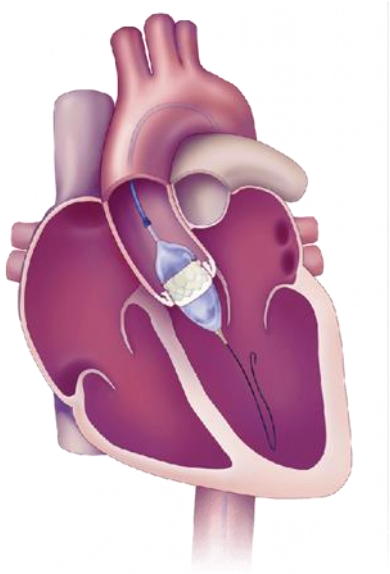
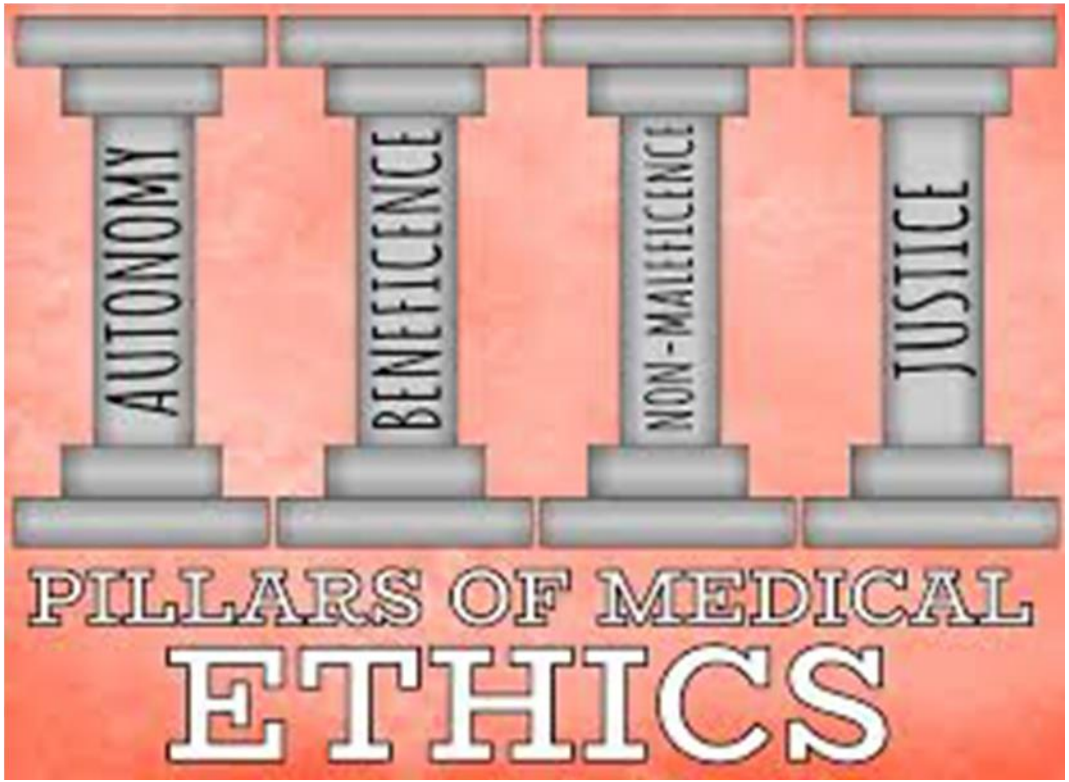
Mrs MJ, 92, Outpatient

MJ Background:

- You are referred a patient with severe aortic stenosis who is short of breath to consider an invasive procedure (TAVI)
- She is 92



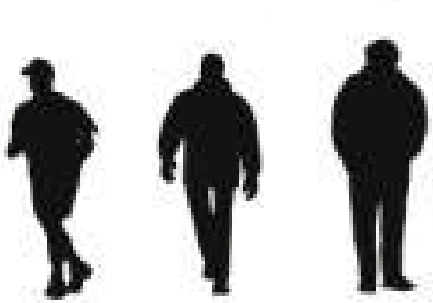
MJ Considerations:



MJ Considerations

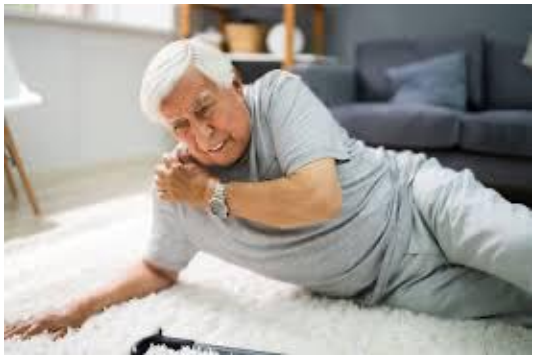
- Best interests MCA 2005 - “must not make it merely on the basis of — the person's age”
- Equality Act 2010
- A person (A) discriminates against another (B) if, because of a protected characteristic, A treats B less favourably…
- If the protected characteristic is age, A does not discriminate against B if… proportionate means of achieving a legitimate aim
- Human Rights Act 1998 Article 2 - the right to life

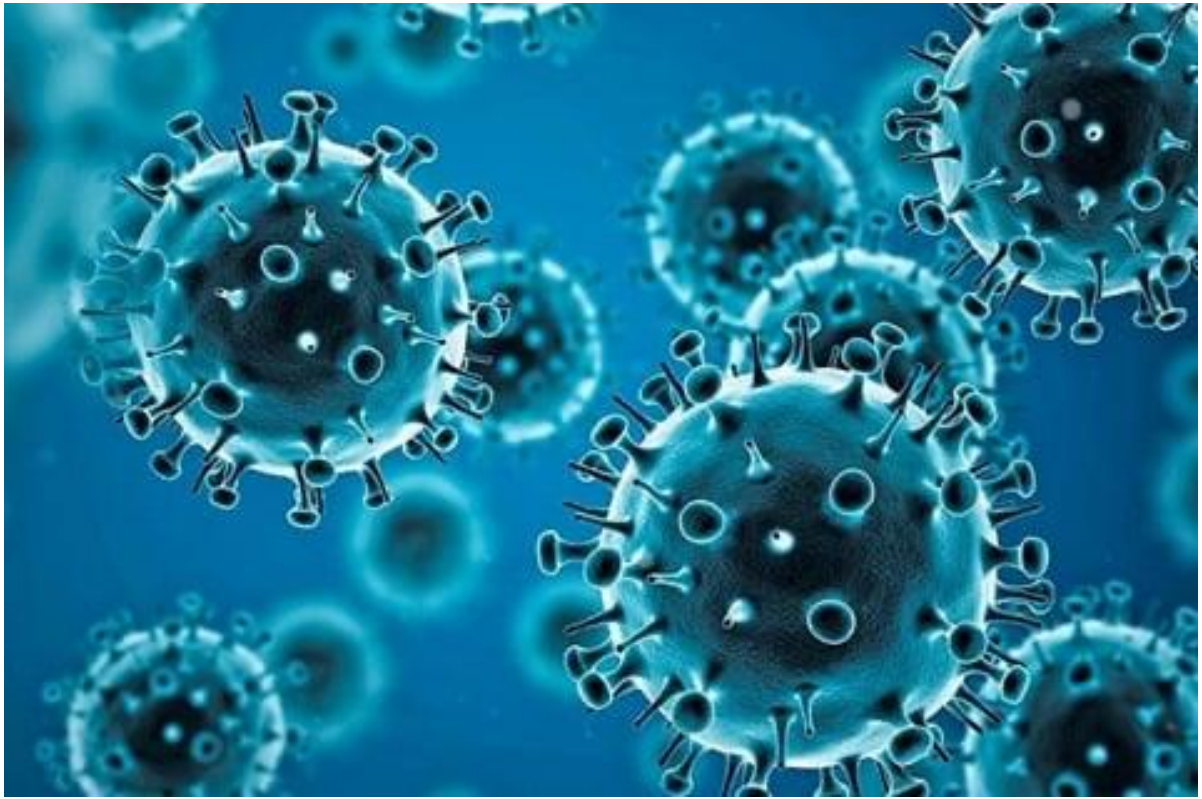
Frailty



Frailty

Decreased physiological reserve
Vulnerable to adverse outcomes





Frailty

Case 1 MJ: Outcome

- Assessed by geriatrician with specialist interest
- Not frail
- MDT discussion
- TAVI possible
- Patient keen to proceed
- Performed 2022
- Improvement in dyspnoea

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W, 90, Outpatient

Case 2: W

- A 90 year old woman wishes to turn off her permanent pacemaker, so that she can die
- History depression, previous Dignitas wish 2017
- No history dementia
- Pacemaker inserted under ‘consent 4’ 2020

Case 2: W Capacity

- Is she fully informed?
- Is she truly able to understand, retain, weigh and communicate a decision?
- Is depression preventing capacity to weigh?

Case 2: W Capacity

- Psychiatrist - not depressed
- Explained likely would not die, risk of blackouts, heart failure, shortness of breath
- Deemed capacitous
- W agreed to consider

Case 2: W Capacity

- Follow-up - capacity called into question
- Not retained previous information
- Not clearly able to retain unlikely to “die today”

Case 2: W Best Interests

- Cardiology MDT
- Highly likely to cause symptoms
- Unlikely to cause death
- Not usually ‘best interests’ of a patient
- No experience turning off a pacemaker
- Some refused
- Legal advice

Case 2: W Best Interests

- “Where the determination relates to life-sustaining treatment he must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.”
- R vs Adams 1957
- “the person's past and present wishes and feelings”
- “A person is not to be treated as unable to make a decision merely because he makes an unwise decision.”
- LPA - felt in best interests, frustrated

Case 2: W Considerations

- “Ethical panel
- Ethical to turn off
- In keeping with longstanding wish not to preserve life
- Probably capacitous
- If medication would be easy
- LPA in support
- Withdrawal not euthanasia (Bland vs Airedale)

Case 2: W Further Capacity Assessment

- “Deteriorated
- Now in Nursing Home
- Deemed capacitous in conversation
- Unable to retain 5 minutes later
- “The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision.”

Case 2:W Outcome

- PPM turned off at home
- Palliative support ready
- No immediate effect
- Died several months later (frailty)

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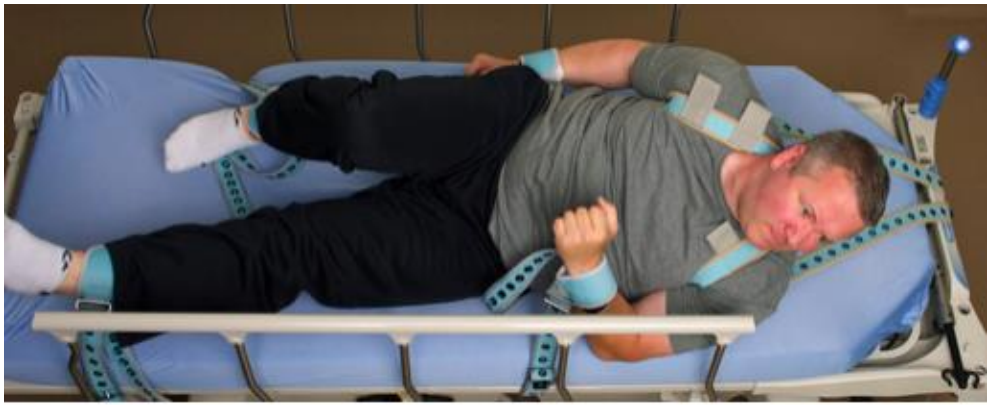
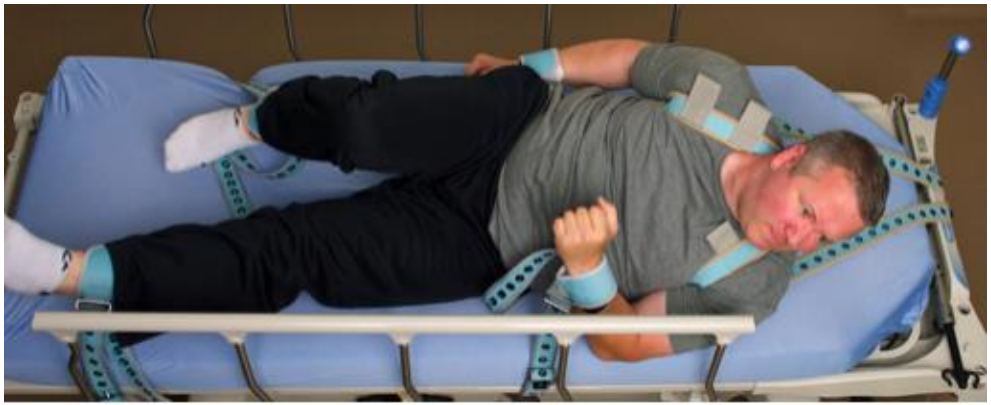
TL, 81, Inpatient

'Invasive treatment?'



'Invasive treatment?'

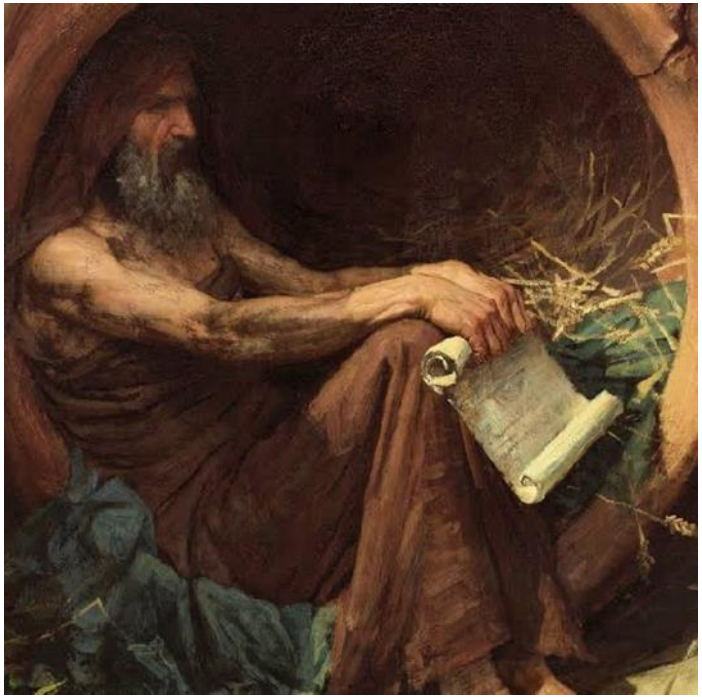


Case 3: TL

- 81 y.o male
- 3rd admission this year
- Falls
- Multiple social concerns
- Alcohol
- Non-concordant with medications
- Family very concerned
- Often sends away carers

Case 3: TL

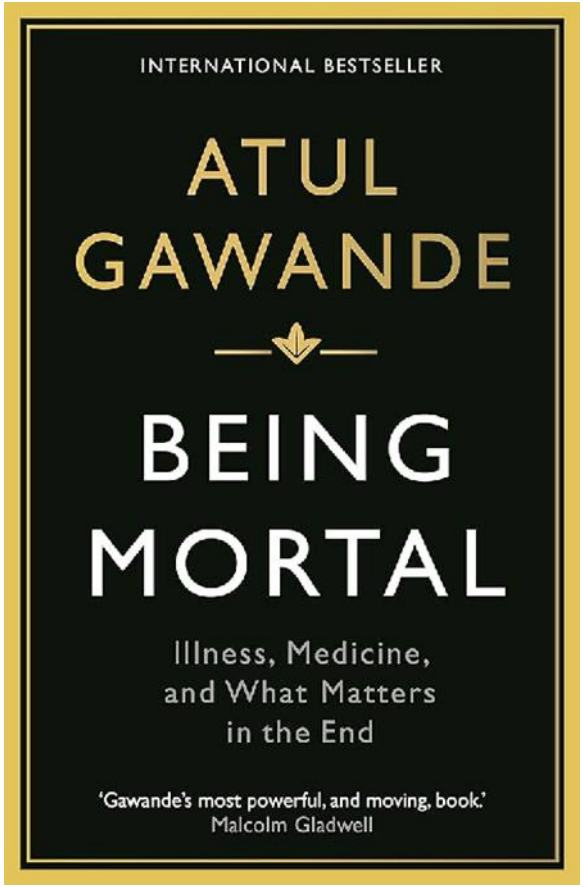
- Lacked insight into risks
- Community Social Worker
- Longstanding Pattern



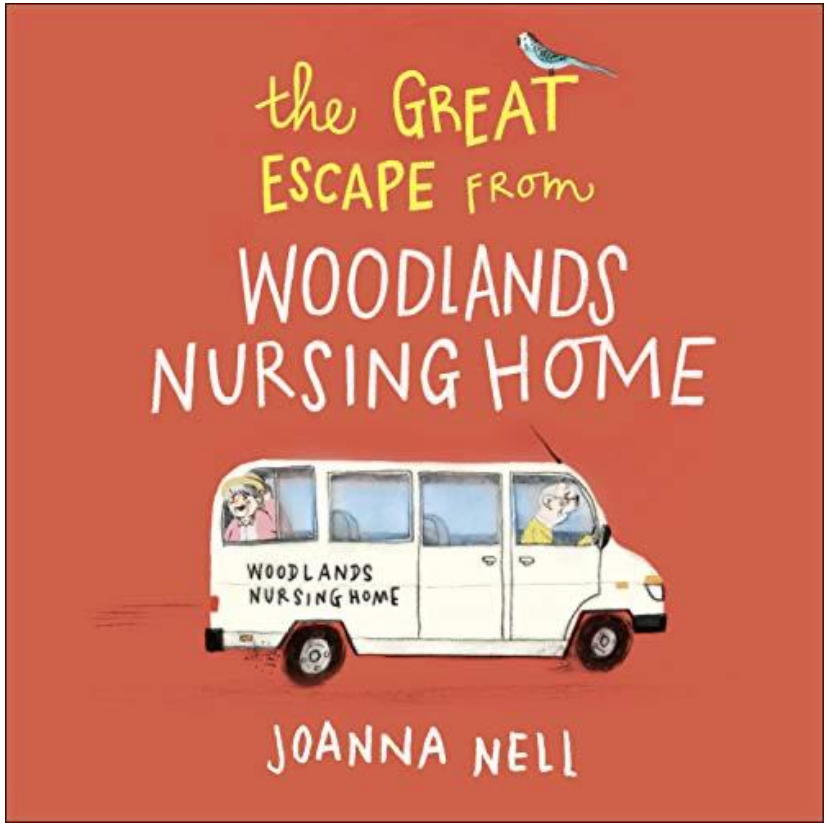
Case 3: TL Best Interests Meeting

- Unlikely to stop falling
- Similar lifestyle when capacitous
- ‘Deprivation of Liberty’ rescinded
- To return home with carers
- Community risk register

‘‘Now you just lie still old fellow… this is nothing whatever to do with you’’



"Nursing home staff like, and approve of, residents who are 'fighters' and show 'dignity and self-esteem' - until these traits interfere with the staff's priorities for them. Then they are labelled as 'feisty'"



"a number of multi-coloured pills, each designed to counteract… a side effect of one of the other pills"
"When he'd wondered… if it was all worth it for a few extra years in a nursing home, the doctor had merely upped his antidepressants"

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Reflections


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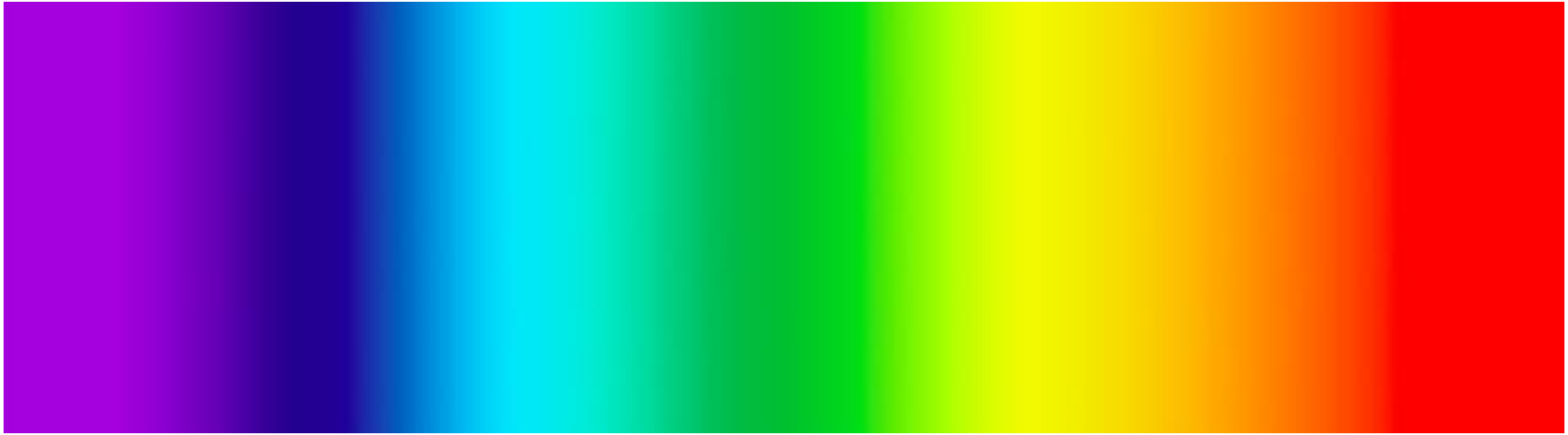

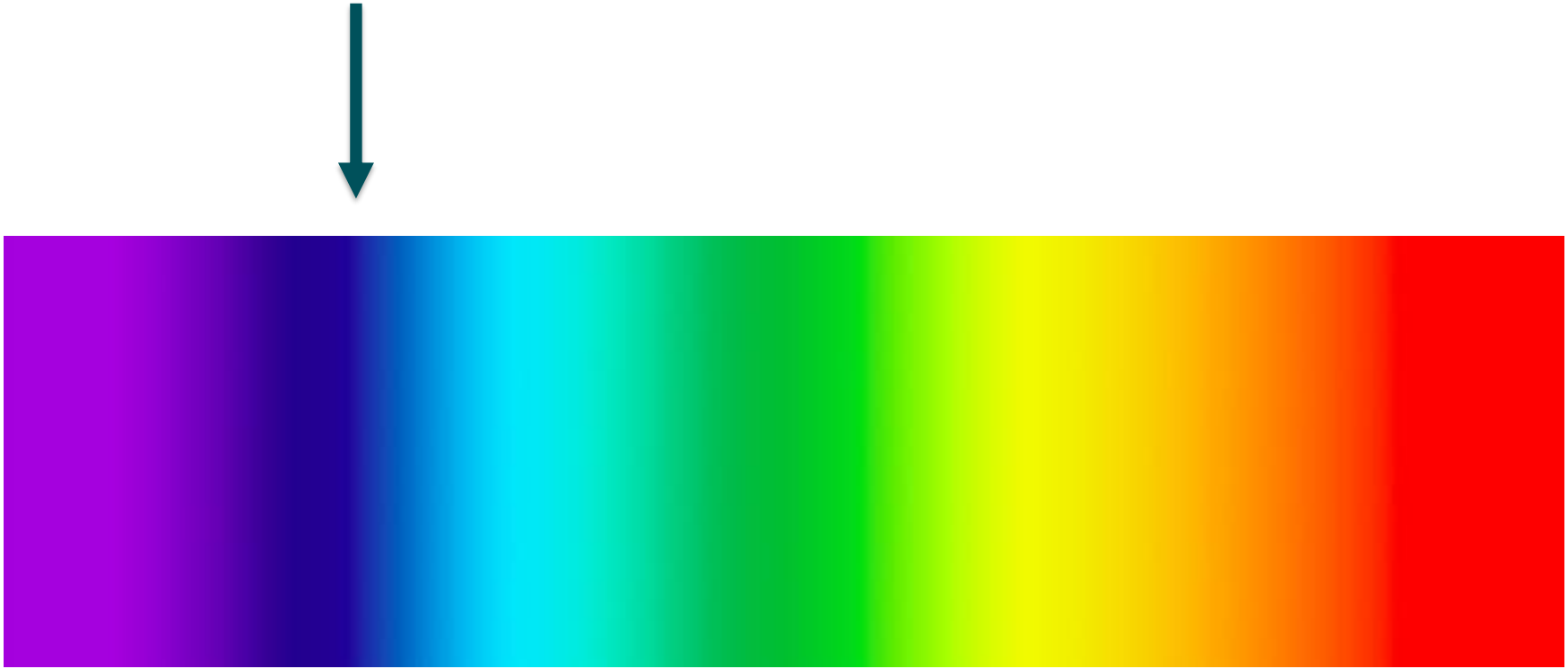

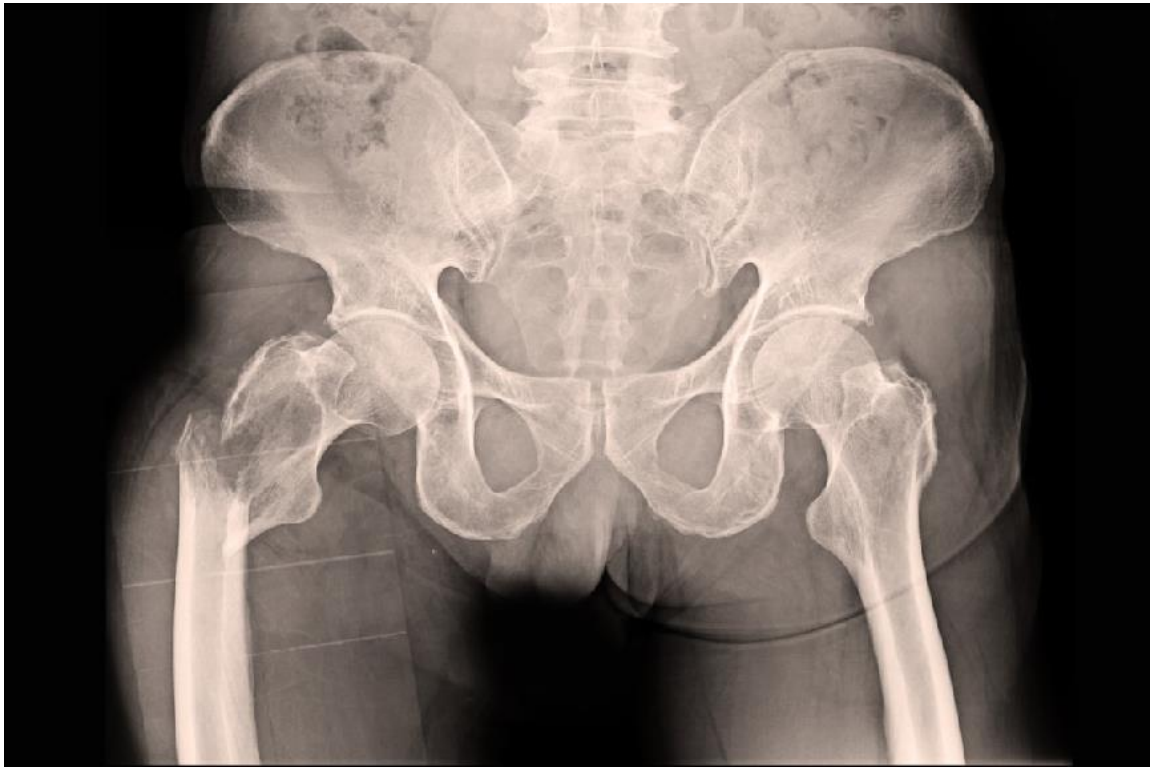


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Outstanding

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