LAW – 40029 – Mental Capacity

MA Adult Safeguarding.

Critical case commentary: Kings College NHS Trust v C [2015] EWCOP 80

Word Count: 4972
INTRODUCTION

The constant friction between capacity and one’s own autonomy has been the subject of much writing and debate in safeguarding. Whether through bias, assumption, mis-interpretation or inadequacy the assessment of capacity turned into an overly clinical and paternalistic arena where the potential for the wishes of the very individual being considered was becoming so eroded as to be almost irrelevant. The Mental Capacity Act 2005 [The Act] intended to replace a previously disjointed approach in common law and practise to the assessment of capacity but clearly case law and practice needed to implement it – and it didn’t.

*Kings College Hospital NHS Trust v C* ¹ [Kings College] marked a watershed moment - for many as a return, and others as a move - to the primacy of patient wishes. To some extent there is merit in this. It did indeed reaffirm the principle that an assessment of capacity is about an engagement with the individual concerned in the full understanding of *their* beliefs and values. Furthermore, it was about an honest assessment devoid of assumptions or super-imposed values no matter how well intended.

However, as will be argued in this commentary, it was also a relatively straight forward and narrow case on both evidence and submission² which left little to be balanced in the end. It was a case which presented few obstacles to the presiding judge by way of conflicting parties or evidence and it would be wrong to get carried away with viewing it as brave or courageous even within its own historical context.

² The Trust application was confined to consideration of section 3(1)(c) only.
Heralded also as a patient empowering approach to the order of consideration of s3(1)(c) of the Act the Judge did little more than pursue an entirely logical and proper approach to the Act and the section. Furthermore, in the context of York City Council v C\textsuperscript{3} he did little more than affirm courageous precedent and wrongly attracts credit for it.

As such it should not be viewed as providing concrete answers to all questions and certainly does not provide guidance for universal application to all cases. This commentary contends it could not and indeed should not in any event. Therefore, its merit is not so much in its specific finding but rather the approach taken in getting there.

**Kings College NHS Trust v C [2015] EWCOP 80**

The “Sparkly” case concerned a patient who lived an “unconventional” life – one she referred to as a life which ‘sparkles’. She “placed a significant premium” on her appearance and looks and on material possessions. In short, she wanted to lead a certain lifestyle and sought it above all else. Following diagnosis of and treatment for breast cancer this life began to fall apart with the loss of material possessions, a business and a long-term relationship. She was at this time aged only 49. In response to these circumstances she attempted to commit suicide and as a result suffered significant and serious damage to her liver and kidneys. Regardless of the damage medical opinion generally was that the prognosis was positive provided she engaged with renal dialysis treatment. Without such engagement the prognosis was extremely poor with a very short life expectancy. She eventually refused to engage on the basis that if she could not retain her looks and lifestyle she did not want to live at all.

\textsuperscript{3} [2014] 2 WLR 1
Kings College Hospital NHS Foundation Trust [The Trust] sought a declaration pursuant to section 15 of the Mental Health Act 2005 that she lacked capacity on the grounds that her personality disorder stopped her from being able to ‘use and weigh’ the information she was being provided. There were five sources of information aside from the patient herself. Two psychiatric experts had concluded that she did lack capacity to use and weigh information and that this was caused by her belief system or personality disorder. The third expert concluded that regardless of the existence of a ‘narcissistic personality disorder’ she did have capacity.

The Official Solicitor confirmed that she had expressed a clear intention to refuse treatment regardless of the prognosis. Her own two elder daughters reported that she had made clear she did not want to lose her ‘sparkly’ lifestyle and become “old”, “ugly” and “poor” and on this basis wanted to die.

The case established a number of principles which will be analysed in greater detail in due course. However, Mr Justice MacDonald, sitting alone, dismissed the application made by the Trust. He did so having first considered section 3 of the Act and the extent to which C was using and weighing the information and evidence in arriving at the decision she had. Indeed, this was the agreed legal question to be considered. He decided that she had acknowledged a generally positive prognosis and provided a number of reasons why she did not want recommended treatment. He further found that not only was there not enough evidence as to the precise nature of the impairment being alleged but more importantly in many ways no evidence to establish to the required standard any nexus.
The historical context

It is important before considering both the Act and the case, to have an understanding of the historical context and the general trend which formed through it. Prior to the Act the law had generally been criticised in its thinking and approach. Described as being overly fragmented and complex (in particular for practitioners) it was viewed as an area of “incoherence, inconsistency and historical accident.” It is not difficult to understand the basis for this assessment. Caselaw ventured slowly in process and thought to an overly paternalistic approach through the use of ‘inherent jurisdiction’. Furthermore, the view of clinicians was paramount.

That the court understood and was willing to protect autonomy in principle was not in issue. Indeed, in *Re T*\(^5\) Lord Donaldson enunciated a principle which finds its echo in *Kings College*.

> “An adult patient who...suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another of the treatments being offered...This right of choice is not limited to decisions which others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent.”

Confirmed in *Bland*\(^6\) also, as a central contention neither case posed a proposition which was controversial or novel. They left open however an obvious question – what of the wishes of someone of unsound mind or someone who does suffer mental incapacity? Is respect for their

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\(^{5}\) *Adulthood: Refusal of Medical Treatment* [1992] 4 All ER 649 (at 653).

\(^{6}\) *Airedale NHS Trust v Bland* [1993] 1 All ER 821.
wishes less? And furthermore, how does the assessment of incapacity sit with the determination of whether someone was actually making a decision or had the ability to do so with such an impairment?

In *Re F*\(^7\) the court, under inherent jurisdiction, was still trying to grapple with this issue and formed the two-part test of capacity and best interest. The Court decided that sterilisation could be carried out on someone who lacks capacity if it was necessary. To be necessary it had to be in the individual’s best interests – this was to be decided by the medical profession. One could be forgiven for thinking the actual balancing exercise was being moved out of the process, along with the wishes of the individual themselves. For all the promise shown by its statement of fundamental principle the Court in *Re T*\(^8\) was prepared to find a lack of capacity where they deemed the individual in question to be under the effect of undue influence.

*Re C*\(^9\) appeared to demonstrate a move to a more illuminating approach. Whilst still intrinsically linking the presence of ‘impairment’ to the ability to make the decision, the focus at least moved to the nature of the decision making process itself:

“...it has been established that C’s capacity is so reduced by his chronic mental illness that he does not sufficiently understand the nature, purpose and effects of the proffered amputation.”

The requirement to take in and retain information, to accept it as being the true position and to be able to weigh that information in a balancing exercise with understanding of the

\(^7\) [1990] 2 AC 1
\(^8\) (Adult: Refusal of Medical Treatment) [1992] EWCA Civ 18
\(^9\) (Adult: Refusal of Treatment) [1994] 1 WLR 290.
consequences of decisions was at least being considered. However, this ad hoc approach was absent any form of statutory framework and lead not only to inconsistency but made legal literacy virtually impossible.

The extension of this to other areas including deprivation of liberty\textsuperscript{10}, contact with family\textsuperscript{11}, residence\textsuperscript{12} and marriage\textsuperscript{13} demonstrated clear deficiencies if the assessment of capacity was going to remain issue specific, universal in approach and based on the patient rather than the impairment. In relation to the matter of liberty at least, the ECHR made clear their reluctance to allow the common law to continue to govern an area which clearly created conflict with Article 5 of the convention. The concern was that regardless of good intentions in each case the absence of some form of proper structure and guidance was leading to an over reliance on medical opinion and finding with little regard for the actual wishes of the patient. In other words, the route to a finding of incapacity was being made independent of the patient and leading to a conclusion based on what others thought best for the patient. In the case of Re A\textsuperscript{14} it had moved beyond paternalism in medical issues to emotional and “all other welfare issues.” There remained nothing to stop decisions being made on the basis of other social norms or what the individual assessing believed.

\textit{Mental Capacity Act 2005}

\textsuperscript{10} R v Bournewood Community and Mental Health NHS Trust, ex parte L [1999] 1 AC 458.
\textsuperscript{11} Re G [2004] EWHC 2222 (Fam).
\textsuperscript{12} Re F [2000] EWCA Civ 192.
\textsuperscript{13} Re SA [2005] EWHC 2942.
\textsuperscript{14} Re A (Mental Patient: Sterilisation) [2000] 1 FLR 549.
Changing social context lead to increased importance of autonomy, the normalisation of mental disabilities and the de-institutionalisation of mental health and the Act sought to codify in some form the approach which should be taken in assessing capacity. It sought to remove the previously disjointed and complex web of case law. In clearly outlining the principles of the Act in section 1 explicit reference is made to the assumption of capacity, the need to assist someone in making the relevant decision using all practicable steps and the fact that an unwise decision should not be used in a circular fashion as evidence of an inability to make that decision. Of course, it might well be a basis to question the decision but it cannot of itself form evidence to nullify it.

Section 2 states:

“a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.”

Whilst on the face of it clear as to the purpose it did not assist in guiding the assessor in practice as to which needs to be established first – the inability to make a decision (the functional test) or the impairment (the diagnostic test). What was clear was the need for a nexus between the two. Without it there would be an overwhelming temptation to assume incapacity to make a decision upon failing the diagnostic test. Or for that matter temptation to disregard the decision made simply because it is based on beliefs or values deemed foreign or irrational. This would clearly be inherently wrong contrary to the assertions of Savulescu and Momeyer.  

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It is however in Section 3 that the true difficulties arise and indeed was the forum for the legal question posed in *Kings College*.

Section 3 states outlines specific bases upon which an inability to make a decision might be found – inability to understand the relevant information, to retain it, to use or weight it as part the process and to communicate it. These requirements are clearly an echo of *Re C*. Because of the order of the words in section 2 and the content of the Code of Practise\(^{16}\) allowed a trend to begin which considered the impairment first and the decision or inability to make the decision second. The risk of patient wishes being put second again are clear.

**Moving to a social model which sparkles?**

*Kings College* came before the Court at a time when there had already been a shift in approach from a paternalistic and medical view to a social model. Had there not been it would have been easy for the Court to simply dismiss the application of the Trust on the basis that the evidence of ‘impairment’ was insufficient. Indeed the Judge commented on this *in obiter.*\(^{17}\) The application was brought however with agreement between the parties that the issue to be decided by the Court in terms of capacity related solely to section 3(1)(c). Its value must therefore be considered within those confines.\(^{18}\)

As such the outcome itself should not have been a surprise. Close analysis of the evidence before the court left little room for the Judge to allow the application of the Trust. He was presented with two experts who were cautious in both their finding of incapacity but also being

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\(^{16}\) *MCA 2005, Chapter 14 of the Code of Practice (DCA, 2007)*

\(^{17}\) paragraph 93

\(^{18}\) As opposed to *A Mental Health Trust v DD* [2015] EWCOP 4 where Cobb J found incapacity on other grounds too.
drawn on the presence of a disorder at all. He was presented with a third, who although clearly unimpressive to the Court found there was capacity. But just as importantly in the shift to the social model he had clear indications from C herself supported in entirety by her family who gave clear and cogent evidence as to their mother’s personality and traits – all of which were generally negative. Finally, he was presented with a clear indication that should he allow the application, the medical opinion was that it would be virtually impossible to enforce without actually endangering both C and the medical team seeking to help her.19

As a clear statement of the law relating to assessment of capacity the case rightly remains at the fore and is likely to remain the most useful for practitioners – at least as a starting point. Having considered the same sections of the Act outlined above MacDonald J outlined “cardinal principles” which flow from statute20. First he reiterated the presumption of capacity and the burden of proving otherwise being on the person asserting a lack thereof.21 Second, with reference to PC v City of York Council22 he reaffirmed the principle that the assessment is in relation to the specific decision at the time and not generally. Third, as per the Act, he emphasised the requirement to take all practicable steps to help the individual make the decision. Fourth, he emphasised that an individual should not be treated as unable to make the decision simply because others viewed their decision as unwise.23 Furthermore the outcome of the decision is not a relevant factor in deciding ability to make it.24 Fifth, he outlined the

19 Paragraph 22
20 At paragraphs 25 to 39 inclusive with reference made to PH v A Local Authority [2011] EWHC 1704 (COP).
21 KK v STC and Others [2012] EWHC 2136 (COP) and section 2(4) of the Mental Capacity Act 2005.
22 [2014] 2 WLR 1.
‘diagnostic test’ and the nexus requirement. Finally, he outlined the ‘functional test’ and again reiterated the need for a nexus.

Whilst he then outlined the proper order to consider the requirements outlined in the Act this case should not be given the credit for taking that approach. He simply followed the approach clearly outlined by McFarlane LJ (without dissent) in York City Council v C.

“The order in which the relevant terms of the Mental Capacity Act 2005 are drafted places the ‘diagnostic test’ in s2(1) before the ‘functional test’ in s3(1). However, having regard to the wording of s2(1) namely, “he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the function of, the mind or brain” the order in which the tests are in fact applied must be carefully considered.”

In so considering he makes direct reference to the York case and the concern that to follow the order of the sections rather than order of the words would necessarily precipitate a watering down of the causative element and the required nexus. Clearly this was the correct approach, not simply because of precedent but because of a proper reading of the statute. One cannot consider whether an impairment is causing something which they have yet to determine exists. The inability to make a decision must therefore come first – followed by an analysis of what might be causing it. But as Alex Ruck-Keene properly points out there are also clear policy reasons for taking this approach. Although enunciated as two separate points they are

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25 Re SB (A Patient: Capacity to Consent to Termination) [2013] EWHC 1417 (COP)
26 RT and LT v A Local Authority [2010] EWHC 1910 (Fam)
27 [2014] 2 WLR 1 (at paragraphs 58 and 59).
28 At paragraph 33.
intrinsically linked as one – finding a mental disorder first runs the risk that not only will it pre-
determine an inability to make decision at all but will also fail to properly consider whether or
not the disorder has anything to do with the inability if it does exist. There is however a greater
and far more dangerous concern which he does not address. The very process of assumption
warned above allows an easy super-imposition of one’s own views, beliefs and values in to the
assessment and consideration of the decision making process.

Although he necessarily avoids what would have been the much more difficult issue of
whether, on the evidence, the personality traits exhibited amounted to a personality disorder
and therefore an impairment MacDonald J clearly takes the correct approach. He considers first
the ability of the decision maker to make the decision in question.

Relevance, weight and values

In considering what information was relevant to the decision-maker he referred to the earlier
ruling of Hedley J\textsuperscript{30} in the context of s3(1)(c):

\begin{quote}
“it is not necessary for a person to use and weigh every detail of the respective
options available to them…merely the salient factors…even though a person may
be unable to use and weigh some information relevant to the decision in question,
they may nonetheless be able to use and weigh other elements sufficiently to be
able to make a capacious decision.”
\end{quote}

\textsuperscript{30} In \textit{PCT v P, AH and The Local Authority} [2009] COPLR Con Vol 956 at [35]
As a general statement of principle it assists to some extent and must in itself be correct. MacDonald J worked through all of the evidence clearly and methodically but focused in the main on the trend of response from the patient herself to decide whether she was understanding what was said to her by family and medical experts. He was analysing her understanding of the information and her use of it with specific focus on the things she was saying in response which acknowledged a generally positive outlook (although the advice was by no means unanimously so).  

Beyond the statement however how is one to know what information one should deem relevant in respect of each decision or indeed how many of them a person needs to have weighed to be considered capable of making the decision? Difficulties in cases outside of the medical arena e.g. sex\(^{32}\), marriage\(^{33}\) and contraception\(^{34}\) have consistently demonstrated difficulties identifying such matters and this case does not offer any wider guidance if one is hoping for it. Frankly however, nor should it. As demonstrated by *A Local Authority v A*\(^{35}\) including a requirement to consider factors outside of the proximate medical issues could prove counter-productive by increasing the tests ones needs to pass to demonstrate autonomy. Surely this is best left to those safeguarding in daily practice.\(^{35}\)

His approach to the weight attributed to each of the relevant factors was equally nuanced and again focused on C.\(^{36}\) In considering the issue of weight, MacDonald J again stated clearly the position:

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31 Paragraphs 70-85  
33 *Sheffield City Council v E* [2004] EWHC 2808.  
34 *A Local Authority v A* [2010] EWHC 1549.  
36 paragraphs 86-88
“If a person is able to use and weigh the relevant information, the weight to be attached to that information in the decision making process is a matter for the decision maker.”

It is here one should see the echo of and extension of principles in Re T and Bland. But more than that he sought to make sure C’s own process was being considered fully and fairly, devoid of assumption:

“...in my judgment it is also important in this case not to confuse a decision by C to give no weight to her prognosis having weighed it with an ability on her part to use and weigh that information.”

Again, a sensible warning and indeed a good example however how does one know the difference between someone not weighing a factor at all and weighing it but giving it no weight? Furthermore, it seems unrealistic for this to be the case regardless of any and all circumstances. In this case it was again straightforward as the Judge disagreed with the assessment that the advice on prognosis was generally positive but also because notes made in the hospital and comments to at least one friend were available to the Court in evidence and demonstrated cogent evidence of a clear thought process.

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37 At paragraph 38
38 Paragraph 86.
40 Paragraph 87.
Whilst there was little expansion as to what to look out for, what to consider or indeed how to carry out that process generally MacDonald J concluded his assessment of weight in Kings College with a statement consisting of five lines of his own judgement on all of the evidence.\textsuperscript{41} It was simply based on his reading of the evidence – no rules and no tests.

A proper consideration of the above, in particular weight, requires a full appreciation of the decision makers beliefs and values. It is contended that this is where McDonald J excelled. The real value in Kings College is the approach taken in deciding this issue – regardless of how restricted it was. He rightly observed:

\begin{quote}
“a person cannot be considered to be unable to use and weigh information simply on the basis that he or she has applied his or her own values or outlook to that information and chosen to attach no weight to that information”
\end{quote}

In a recitation of Heart of England NHS Trust\textsuperscript{42} MacDonald J cited:

\begin{quote}
“The temptation to base a judgment of a person’s capacity upon whether they seem to have made a good or bad decision, and in particular on whether they have accepted or rejected medical advice, is absolutely to be avoided. That would be to put the cart before the horse or, expressed another way, to allow the tail of welfare to wag the dog of capacity.”
\end{quote}

\textsuperscript{41} Paragraph 88.
\textsuperscript{42} [2014] EWHC 342 (COP) at paragraph 7
The proposition therefore seems that provided the relevant information is clearly absorbed, both the weight attached to that information and the rationale for that weight, should be strictly irrelevant to the assessment. Evidence would suggest this is not the approach being taken in practice. Furthermore one can appreciate the difficulties faced in so doing in practice. How does one truly separate their own values from an assessment of another’s thoughts or actions?

*Kings College* offers little assistance as MacDonald J had the significant advantage that both of C’s daughters provided evidence of her life long traits which accorded with the evidence of C herself. He had a clear benchmark to view whether or not the views expressed by C had changed as a result of diagnosis or prognosis and no evidence at all contradicting it. In other words he had before him family members able to give valuable insight and to stand testament to C’s true values and beliefs. The question therefore was whether he was going to honour them or use them to find irrationality. In the face of at least one expert arguing that that C had an ‘over-valued idea’ that her quality of life would not improve he chose to honour her values rather than impose his own. He was persuaded by her ability to voice various reasons for wanting the outcome she claimed and clearly the evidence of her family corroborating her beliefs and values – even though her decision might be deemed unwise. It is here where *Kings College* finds its place.

He makes little comment on what he would have done absent that evidence however we are able to obtain insight into the Court's approach by considering a case proximate in time - *Wye*

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44 Paragraphs 89-91
Valley NHS Trust v B [2015]. The Court managed to side step the issue with tact. In finding that B lacked capacity to make a decision about whether to have his leg amputated or not the court cited his refusal to engage in conversations about his treatment and therefore an inherent inability to consider the “pros and cons” of the treatment options presented to him. However close analysis of the evidence in the case calls this into question. Although there can be no doubt that his suspicion of the medical team might be worthy of consideration in capacity, his decision was in the main being premised on other good and sound reasons – much like Kings. He stated he did not want an operation – he therefore knew what was being discussed. He stated that he was not afraid of death – he therefore knew the ramifications of not having the amputation. He stated he did not want to go into a nursing home as his partner died there – he therefore knew the practical consequences of the operations. It was his faith and reference to angels and “the Lord” which created concern in the context of hallucinations. Given that this was only part of his reasoning – what then for his beliefs and values?

It is hard to see how these two cases can be reconciled. Given that the reality of common law is that cases will always be decided on their own facts and by different judges, cases will never be reconciled. The truth is that Kings College managed to put patient wishes first because there was little evidence to the contrary or indicating he should not. There may well be few cases where the evidence is so clear.

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45 EWCOP 60
46 See also Nottinghamshire NHS Trust v RC [2014] EWHC 1317 (COP)
47 See A Local Authority v E [2012] EWHC 1639 (COP) which involved the impact of anorexia nervosa on the ability to make decisions and more pertinently in respect of overriding an individuals views F v F [2013] EWHC 2783 (Fam).
**Conclusion: The sparkly principles – do they really sparkle after all?**

*Kings College* was given far more credit than it truly deserved. Without properly considering the context, previous case law and indeed the argument and evidence in the case, one can see why it was greeted with such wonder. *Kings College* was a confined, narrow and generally straightforward case which actually left little room for McDonald J to allow the application by the Trust.

*Kings College* does however stand virtually alone as a judgement which honoured the beliefs and values of the patient, even if the circumstances were entirely favourable to do so. It did not simply honour them by refusing the application but by demonstrating a genuine attempt to engage C, consider all of her responses and arguments, place them in a proper context which included her beliefs and values and remove all prejudice and personal opinion. It should therefore stand, quite rightly, as an example of the approach to take rather than a source of rules or tests. The truth is the process was one which could be easily reflected in practice and required little legal expertise given earlier case law. Whether this does assist in practice remains to be seen. If it does not, regardless of the limited enthusiasm with which this author views *Kings College*, McDonald J will not be to blame.
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