MCA decision making in the time of COVID-19 for those in care homes and supported living

Court of Protection Bar Association: 28 May 2020

Opening remarks

THE HONOURABLE MR JUSTICE HAYDEN, VICE-PRESIDENT OF THE COURT OF PROTECTION

Best interests decision-making

ALEV GIZ

Best Interests Decision Making (1) Particular Challenges

- Ascertaining P's wishes and feelings
  - Access to P
  - Sources of information
- Risks to P's health
- P's contact with family/friends
- Consultation
- Participation of P
- Time, resources and collaboration

Best Interests Decision Making (2)

- *BP v Surrey County Council* [2020] EWCOP 17
  - Challenges created by pandemic call for increased vigilance in ensuring respect for P's human rights
  - Justified / proportionate interference with P's right to family life / permissible derogation
  - Competing rights and public interest
  - Options must still be realistic

Best Interests Decision Making (3)

- *VE v AO, RB Greenwich & SE London CCG* [2020] EWCOP 23
  - Confirmation that how P dies falls within the ambit of P's article 8 rights
  - Ability to die with family and friends a fundamental part of the right to private or family life
  - Evaluation of the option offered by P's family and determination of P's best interests in her specific circumstances

Public health and the MCA

REBECCA STICKLER

Coronarvirus Act 2020, schedule 21

- Extensive powers to public health officers, constables and immigration officers in relation to persons who are *"potentially infectious"* **(wide scope) (paragraph 2)**
- Powers to direct or remove persons to a place suitable for screening and assessment if *"reasonable grounds to suspect"* **(low threshold)** that a person is potentially infectious **(paragraphs 6 and 7)**
- Powers exercisable by public health officer at a screening and assessment place include a requirement to provide a biological sample, or to allow a healthcare professional to take a biological sample **(paragraphs 8 - 11)**
- Powers exercisable after assessment **(paragraphs 14 - 16)**
  - To remain at specified place for a specified period for 14 days ("*requirement to remain*") – this can be extended for further 14 days **(paragraphs 14(3)(d) & paragraph 15(5))**
  - To remain at a specified place *in isolation* from others for a specified period for 14 days - this can be extended for a specified time (no limit identified) **(paragraphs 14(3)(e) & paragraphs 15(5) & (6))**
- Difficulties with appealing against requirements or restrictions imposed **(paragraph 17)**
- Criminal offence to fail to comply with any direction, reasonable instruction or requirement **(paragraph 23)**

In practice, *will* schedule 21 be applied to individuals with impaired decision making capacity?

- **<u>PRACTICALITIES</u> –** where a requirement to remain is specified, the requirement may only be enforced by by a constable or public health officer removing the person to the place, keeping the person at the place and by a constable returning them to that place **(paragraph 16)**
- Powers can only be used if it is considered *"necessary and proportionate to do so (a) in the interests of the person, (b) for the protection of other people, or (c) for the maintenance of public health"* **(paragraphs 6(3), 7(3), 8(2), 14(2))**
- Where powers are exercised, the person must be informed about why the steps are being taken and that it is an offence to not comply. *Query* - can there ever be compliance with this requirement if someone is unable to understand the information being provided? Without this safeguard, will the schedule ever be able to be lawfully applied? **(paragraphs 6(4), 7(4), 9(2), 11(2), 13(7), 14(5))**
- Before deciding whether to impose a requirement to remain (in or without isolation), the PHO *"must have regard to a person's wellbeing and personal circumstances"* **(paragraph 14(6))**
- Where a restriction is imposed after assessment, including a requirement to remain, the restriction must be reviewed after 48 hours. If the requirement to remain is extended beyond 14 days, this must be reviewed at least once every 24 hours **(paragraphs 15(2) & 15(7))**

Why should schedule 21 *not* be applied to individuals with impaired decision making capacity?

DHSC Guidance (1) *Legal guidance for mental health, learning disability and autism, and specialised commissioning services supporting people of all ages during the coronavirus pandemic* (19 May 2020) and *The Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) During the Coronavirus (COVID-19) Pandemic* (9 April 2020)

- *"….it remains important that at every opportunity* ***providers use the least restrictive methods possible in line with the MHA and MCA Codes of practice*** *(see Box 3). Any use of restriction must be proportionate to the risks involved and providers should refer to their ethics committees where required"* (page 11)
- *"the key human right that is at risk when considering the management of people, who will not self-isolate, is the Right to Liberty, which is a limited right, and* ***any restriction on this right has to be lawful, necessary and proportionate"*** *(page 13)*
- *"The Department recognised the additional pressure the pandemic will put in the DoLS system. Fundamentally, it is the Department's view that* ***as long as providers can demonstrate that they are providing good quality care and/ treatment for individuals, and they are following the principles of the MCA and Code of Practice, then they have done everything that can be reasonably expected in the circumstances to protect the person's human rights"*** (para. 21 DOLS Guidance)

Case Study – Ann

Ann is 44 years of age. She has a moderate learning disability and lives in a specialist care home. She tested positive for COVID-19 but is asymptomatic and feels perfectly healthy. Prior to COVID-19, she was extremely sociable with other residents and would always take a central lead in all communal activities. Many steps have been taken by the care home to support Ann to remain away from her friends (who have all tested negative). She has moved to a different area of the care home, a range of alternative activities have been offered to Ann in her room and 1:1 support is being offered as much as possible (with PPE). However, Ann remains extremely distressed; she does not understand the reasons for not seeing her friends this and thinks she is being punished. She often runs away into other areas of the home to find her friends and the care home have been using reasonable restraint to return her to her room. They now feel the only option is to intermittently lock her room door (particularly when staff are engaged with other residents and cannot provide 1:1 support for Ann). When this happens, Ann is extremely distressed. There is a standard authorisation in place but Ann's new arrangements are far more restrictive than when it was granted.

Case Study – Ann

Does the current standard authorisation provide legal basis for additional restrictions?

1) Schedule A1, MCA & DoLS Guidance: Arguably no – arrangements are a lot more restrictive and appear purely for the protection of others **(see paragraph 16, schedule A1 MCA and paragraphs 15 and 16 of DoLS Guidance)**

2) *Nb. Munjaz v United Kingdom* [2012] M.H.L.R. 351 - person who is lawfully detained may be subject to additional restrictions which amount to a deprivation of their liberty requiring additional authorisation (and *R. (on the application of Munjaz) v Mersey Care* [2005] UKHL 58)

3) If new restrictions are not authorised by current SA (or s.16 court order), should care home contact local health protection team? (i) how will isolation be legally enforced without PHO or constable present?; and (ii) importantly, public health powers are not the least restrictive measure

4) Solution? Referral for review of the current SA authorisation and/or urgent application to the CoP under section 21A or section 16 (nb. s.16 only option if Ann were living in supported living placement). The CoP provides a collaborative, solution based approach with fundamental expertise. Best interests analysis should ensure an Ann-centric approach and can consider all *'relevant circumstances'* including the possibility of more draconian public health measures being used against her. Nb also *Birmingham City Council v SR* [2019] EWCOP 28 (paras. 29-30).

Deprivation of Liberty

ALEX RUCK KEENE

Deprivation of Liberty (1)

- *Re X* procedure
  - Electronic applications acceptable
  - Highlight if awaiting discharge from hospital or has planned imminent move date
  - Stayed applications not being progressed
- Legal aid pitfalls:
  - Section 21A applications and the *UF* trap
  - The immoveable bar at one year

Deprivation of Liberty (2) Remote assessments

- Acceptable as per DHSC and the Court of Protection (*BP v Surrey County Council*)
- Swings and roundabouts:
  - The impact of greater preparation and triangulation
  - Some situations simply impossible – what to do then?

What does good care look like in a pandemic? A Statement of Principles for Residential Care Settings

DR MICHAEL DUNN

My focus

- The value of articulating a broader set of ethical principles to guide good practice for those working in care homes
  - Intersects broadly with MCA requirements
  - Fills in gaps where legal guidance might be lacking
  - Avoids the risk of ‘regulatory tunnel-vision’ in care home practice
  - Re-energises the moral core of care work during a pandemic

Context

- Responding ethically to a pandemic in care homes
  - Slow to start; limited in scope
  - Principled guidance from DHSC in March 2020: broad; limited practicality
  - Novel ethical challenges arising
  - Departure from ethical norms: reconfiguring person-centredness; changing relations of interdependency; the ‘extended’ care home as a unit of ethical attention
  - Extensive moral uncertainty and moral distress

Principle 1

- Harm reduction
  - From ‘quality of life’ considerations to a basic requirement to prevent harm and save lives
  - Shifting an ethical vision in the short term from ‘doing good’ to ‘preventing harm’ is likely to be jarring for care home staff
  - The scope of the obligation: reducing harms for residents and staff
  - Equipment, infection control, interface between hospitals and care homes, in-home management of serious illness and palliative care

Principle 2

- Non-abandonment
  - A directive from care ethics theory: not turning away from someone in need who is dependent on you
  - Reconfiguring compassionate care during a pandemic
  - Duties of support from managers to front-line staff
  - Maintaining existing relationships: flexible discharge policies, technological modes of contact, personalised interactions

Principle 3

- Caring fairly
  - The reality of communal living environments: challenges the viability of an ‘individual’s interests’ approach to configuring caregiving duties
  - Harm minimisation strategies provoke risks of inequities arising in care delivery
    - A justification for cohorting residents
    - Meeting needs of those self-isolating
    - Fairness in staffing considerations: role allocation, shift patterns, the ‘staff as resident’

Principle 4

- Maintaining agency and dignity
  - Pandemics place the public, or home-wide interest, front and centre in caregiving in residential settings
  - Person-centred approaches must survive this re-orientation, despite residents being legitimately denied full control over all decisions
  - Duties to respectfully engage and involve; preserving the unique value and dignity of each resident

Conclusions

- COVID-19 is leading to significant ethical upheavals in care homes
  - Important for managers and staff to re-think, and re-imagine in practical terms, their broad ethical obligations in providing care at this time, as well as clarifying narrower legal duties
  - Empowering staff to think constructively about how they can act in the right way towards residents, colleagues, and families at this time

Questions and resources

- www.cpba.org.uk
- www.mentalcapacitylawandpolicy.org.uk
- www.courtofprotectionhandbook.com