

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

QUEEN'S BENCH DIVISION (JUDICIAL REVIEW)

AN APPLICATION BY JR50  
FOR LEAVE TO APPLY FOR JUDICIAL REVIEW

TREACY J

**Introduction**

[1] The applicant at the centre of this case is a 45 year old man who has a learning difficulty and is severely physically handicapped. He is fortunate in that he has a loving family who are actively involved in his care and do all in their power to maximize the quality of his life. He is also fortunate in having a committed team of professional carers and advisers around him who are appropriately concerned to secure his well being.

**Background**

[2] The background to the applicant's condition is as follows. At the age of 3 months he developed bronchial pneumonia and was taken to hospital for treatment. As a result of deficiencies in the medical treatment he received he developed cerebral palsy. I understand that a negligence action was taken in relation to his treatment at this time, that a finding in his favour was made, and that damages were paid to him. Other relevant background information includes the fact that when the applicant was 26 years old he was placed in "W" Residential Home while his mother underwent hip replacement surgery. While in this home he fell out of an unprotected bed breaking two vertebrae in his neck as a result of which the mobility in his arms is further restricted. This history is relevant because it unavoidably influences his family's attitudes towards, and trust in, the medical and caring personnel involved in the applicant's life.

[3] In addition to cerebral palsy the applicant suffers from low muscle tone as a result of which he has difficulty in swallowing. This presents a continuous risk of choking which is exacerbated if he is given inappropriate food. Also, he suffers from a learning difficulty. There is no medical consensus about the extent of his mental capacity/incapacity, other than that all experts agree that he cannot make decisions for himself about what foods he can safely eat. There is also evidence that the applicant may suffer from a mental disorder of a kind which may benefit from the use of anti-psychotic drugs. However, there is divergence in the medical evidence about the nature and extent of any such disorder, and there is a belief in the applicant's family that no such condition exists.

[4] At the time this case began the applicant was placed in "AC" Residential Nursing Home which had been his home for the previous 14 years. Until the events arose which gave rise to this case the applicant was a voluntary patient in that facility. Throughout his placement there his family consistently took him out on Sundays, sometimes keeping him out overnight at the family holiday home until the following day. The family also consistently ensured that he was included in family holidays at Christmas, Easter and during the summer time, and in addition they frequently visited the applicant in his placement during the week.

[5] Over a period of time a disagreement emerged between the family and some of the professional carers in relation to the applicant's treatment and care. This disagreement had two main features. First, some professional advisers suggested that the applicant suffers from a mental condition which would benefit from the use of anti-psychotic drugs. The family does not accept that he has such a condition and some family members vehemently object to the use of anti-psychotic drugs in his case. They fear that such drugs may be used only to make the patient easier for staff to deal with. They also fear that such drugs could have negative side effects that would reduce the quality of the applicant's life.

[6] The second area of dispute relates to the professional recommendation that the applicant should only receive food of a certain consistency. The family believes that eating is one of the few pleasures in the applicant's life and they had difficulty accepting the professional advice about the preparation of his food and, apparently, reliably giving effect to that advice.

[7] The conflict between the professional carers and the family has not been handled well by either side. On the one hand members of the family have become intransigent in their resistance to some professional advice. They have made excessive threats about their possible reaction to non-compliance with their wishes in relation to his treatment and care. This behaviour has raised concern within the Trust and caused it to seek methods to secure and protect the applicant's well-being.

[8] On the other side the care professionals have not handled the family's legitimate concerns in the most appropriate way. In particular, in an incident on 20<sup>th</sup> December 2009 the family were peremptorily refused permission to take their son on

an outing. The family were allegedly 'casually informed' that he might have a 'peg' tube inserted into his stomach for feeding purposes. The inappropriate handling of this sensitive information about a possible invasive medical procedure precipitated an emotional outburst from the applicant's mother. The incident culminated in the extraordinary spectacle of a 73 year old lady being handcuffed and forcibly removed by police from the side of her disabled son. This outcome cannot have been helpful for any of the parties involved, least of all for the applicant who, I understand, was present when the incident occurred.

[9] In view of the low ebb reached in relations between the family and the professional carers the Trust decided on 17 December 2009 to restrict the family's contact with the applicant. In anticipation of a negative reaction to this restriction from the family the Trust applied for guardianship of the applicant. The guardianship came into effect on 24 December 2009, was discharged on 9 January 2010 and was then renewed on 11 January 2010. As a result of this action by the Trust the applicant's visits to his family home, his overnight stays with his family and his holidays with the family all ceased or were severely reduced.

### **Relevant Legal Provisions**

[10] The principal statutory provision governing guardianship is the Mental Health (NI) Order 1986 ("the 1986 Order"). Art 18(2) sets out the grounds on which a guardianship application can be made:

**"(2) A guardianship application may be made in respect of a patient on the grounds that –**

**(a) he is suffering from mental illness or severe mental handicap of a nature or degree which warrants his reception into guardianship under this Article; and**

**(b) it is necessary in the interests of the welfare of the patient that he should be so received."**

[11] Art 22 sets out the effects of a guardianship application and so far as relevant these are to confer on the guardian:

**"22. ... to the exclusion of any other person -**

**(a) the power to require the patient to reside at a place specified by the ... person named as guardian;**

**(b) the power to require the patient to attend at places and times so specified for the purpose of medical treatment, occupation, education or training; ..."**

[12] Art 29(2) of the 1986 Order is also relevant to the present case. It provides:

**“(2) Where a patient who is for the time being subject to guardianship under this Part absents himself without the leave of his guardian from the place at which he is required by the guardian to reside, he may, subject to paragraph (3), be taken into custody and returned to that place by any constable or approved social worker or by any person authorised in writing by the guardian or by the responsible.”**

[13] As noted in para 9 above the Trust used these provisions to take guardianship powers over the applicant. It then purported to use its powers as guardian to refuse the applicant permission to leave the grounds of “AC” House unless supervised by Trust staff. This restriction is identified in the applicant’s skeleton argument as “the detention issue”. The applicant alleges that the Trust had no legal authority to restrict his liberty in the way that it did. The Trust argues that the guardianship gave it the requisite power to lawfully impose this restriction.

[14] The Trust also refused the applicant unsupervised contact with his family. This restriction was identified in the applicant’s skeleton argument as “the contact issue”. The applicant submitted that this restriction on family contact offends Art 8 of the European Convention which protects the right to family life. It submitted that guardianship did not constitute appropriate legal authority for abrogating family contact in this way. The Trust accepted that the restrictions it imposed did abrogate the applicant’s Art 8 rights, but submitted that this abrogation was necessary to protect the applicant’s Art 2 rights. The Trust submitted, and medical evidence confirmed, that there was always a significant risk of choking in this case which was exacerbated if the applicant was given inappropriate food. The evidence suggested that, for at least a window of time, the applicant’s family disputed what was and was not appropriate food for the applicant to eat and there are grounds to suggest that they may have given him food that could have exacerbated the choking risk with potentially fatal consequences. This then is the context within which the Trust took guardianship powers over this applicant.

[15] The Trust’s intention in applying for guardianship powers was to control, pre-empt and stymie steps which the Trust feared the patient’s family might take in response to its decision to supervise their access to their son. This intention is clear in p.2 of the statement of Aine Morrison where she states:

**“A decision was made on 17 December 2009 to restrict family contact to supervised contact only because of concern about the family’s lack of adherence to dietary recommendations ... The Trust anticipated that the reaction to supervised contact might be such that the family would seek to**

**remove [the applicant] from “AC” House and believed that this would place him at risk of significant harm. It was for these reasons that the Trust applied for guardianship to secure his placement in “AC” House.”**

[16] In other words the Trust applied for guardianship powers over a vulnerable voluntary patient in order to secure for itself the apparent legal power to enforce its decisions about the management of that patient over objections from his actively, arguably intrusively, concerned family. Much of the argument in this case centres on whether or not the guardianship mechanism did or did not confer the legal powers that the Trust then purported to use in its management of the patient.

### **Discussion**

[17] It is clear on every page of this case that what existed here was a fraught conflict between two sets of well motivated carers each of whom had different perspectives and different roles in the applicant’s life and each of whom had strong convictions about how the applicant’s needs could best be met. Both sets of carers had different but equally legitimate roles to play and each of those roles could and should have inured to the benefit of the applicant. Unfortunately, the two roles did not co-exist peacefully and productively in this case. Each side in its own way sought to have the dominant role in the patient’s care and to restrict or marginalise the input of the other. This drive for exclusive control is not appropriate and ultimately is not beneficial to the patient. The patient is the focus of this Court’s concern and the Court wishes to ensure that the patient is able to benefit from the accepted and respected input of everyone with a legitimate interest in his care.

[18] Ultimately the Trust sought to resolve this dispute by taking guardianship powers and using these to give itself an apparent legal “casting vote” in the dispute between itself and the patient’s family.

[19] I am entirely satisfied that whatever else guardianship may or may not permit, it certainly does not permit one party to a dispute about the management of a vulnerable person to assert a borrowed primacy over any other party’s legitimate but conflicting interest. The idea that guardianship might be used in such a way offends fundamental principles of law and common sense, for example, the principle that “no man shall be judge in his own cause”. In effect, in the circumstances of this case, the Trust took on guardianship powers to give itself a determinative role in a dispute with a private family and clothe itself with powers which it alleged vested it with sufficient authority to defeat the family’s interest. It is quite clear that this is not what guardianship is for and that the Trust was wrong in seeking to use guardianship for this purpose.

[20] It also appears to be accepted in both party’s skeleton arguments that other methods exist to resolve disputes of this nature. For example, both parties agree that the High Court has an inherent power to issue guidance on how such conflicts

should best be resolved. There was consensus between the parties that such an avenue for dispute resolution does exist and indeed has some legal pedigree as seen, for example, in the case of *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1 and in *Re PS (Incapacitated or Vulnerable Adult)* [2007] EWHC 623 (Fam), [2007] 2 FLR 1008. Where there is an entrenched dispute between parties about the management of a vulnerable person, and where this dispute cannot be resolved by appropriate information sharing and genuine participative decision making, or if necessary by mediation, then the matter should be referred to the court for its guidance. Such disputes should certainly not be decided by one of the parties to the conflict.

[21] Given this element of the decision I do not propose to go further and rule on the nature and extent of any aspect of guardianship powers. Much of the legal argument in this case has focussed on questions about the scope and extent of the guardian's right to specify a place of residence for a patient. In my view the use of guardianship in this case was entirely misconceived, although not badly motivated. Given that it was misconceived to assume guardianship powers for the purposes for which they were taken in this case I do not propose to go any further in elucidating the scope and/or the limits of those powers. What is important is to reiterate again the circumstances in which it is appropriate to consider guardianship for a voluntary patient.

[22] The appropriate context for guardianship is set out in para 3.3 of the Code of Practice on the Mental Health (NI) Order 1986 published by the then Department of Health and Social Services. I can do no better than to quote the most relevant components of this guidance. The first sentence of para 3.3 sets the context for all subsequent guidance in this Code. It states:

**"Where guardianship is used it should be part of an agreed comprehensive care plan drawn up by the professionals who are or who could be involved in the patient's care, and, ... the patient's nearest relative or other informal carer".**

[23] Para 3.4 sets out the components necessary for guardianship to be effective and it is also relevant in this case. The final component listed in this paragraph is particularly relevant in the present case namely:

**"Effective co-operation and communication between all persons concerned in implementing the care plan".**

[24] In this Court's view "effective co-operation and communication" means that all parties should be engaged as accepted and equal partners in the creation and delivery of the most appropriate care package for the vulnerable individual. It is clear, of course, that all parties do not have the same level of professional expertise to bring to the process. It should be equally clear that all parties do not have the same levels of personal experience and "contact hours" with the vulnerable

individual, and that this type of experience is plainly valuable to the process because it is relevant “on the job” experience. It is important that all forms of expertise and insight should be equally valued at the level and in the way appropriate to the issue under discussion in the care plan.

[25] The present case does contain excellent examples of practitioners displaying appropriately inclusive and accepting attitudes. The top paragraph of p. 3 of Dr Gleadhill’s report dated 18 May 2010 is a good example. He is commenting upon a dispute between the parties about the patient’s positioning for feeding purposes which could impact upon his swallowing ability. The patient’s mother had her own technique for positioning the patient and Dr Gleadhill comments: ‘I would support her wish to show the Speech and Language Therapist her techniques .... as obviously she looked after him for many years (prior to him going into care) and perhaps some helpful information could be learned by the staff and professionals....’. While the mother’s technique may or may not be capable of scientific proof that it assisted the swallowing process, it is recorded elsewhere in the papers that the patient found it more comfortable to eat while supported with pillows in the way his mother recommended. Scientifically significant or not, the higher comfort level of the patient is reason enough to adopt the mother’s technique. Moreover the reciprocal learning and shared decision making has a value beyond anything related to the specific swallowing issue. One value is that it may avoid the emergence of diametric conflict between carers and the need for applications such as this one to come before the courts.

[26] The two speech therapists adopted an equally inclusive and educative approach in their contact with the patient’s family, again in relation to the swallowing issue. In their affidavit they describe conducting a repeat videofluoroscopy of the patient’s swallow and arranging for the family to view this and have it explained to them while they watched the evidence. The therapists record that the patient’s mother ‘appeared to show understanding of what was explained to her and its implications for her son’s feeding’. They further recount receiving a phone call from the patient’s mother later that day in which she asked further questions about what she had seen. The therapists again answered her questions and record that the mother ‘was grateful at being allowed to participate in the assessment and for the detailed explanations given both during and after the assessment.’ I understand that the family benefitted from this experience and that it changed their attitude towards the feeding of the patient and helped them become more accepting of and compliant with the professional advice about the preparation of the applicant’s food.

[27] That educative inclusion, that delivery of the means of informed consent and co-operation, that is what promotes optimal care for vulnerable people. That form of progressive, inclusive practice may provide a backdrop against which guardianship powers may work effectively. It may also create a situation where guardianship powers may never be necessary to support a vulnerable voluntary patient. But using

guardianship to exclude, control or render ineffective an appropriately concerned interest is never the right way to proceed in cases such as this one.

[28] I have been invited by the applicant to make certain declarations and orders in this case. In considering this request I am acutely aware that there has been a significant change in circumstances in the case since the time of its inception and that it appears that peace has finally broken out between the interested parties. In these circumstances I am reluctant to grant any effective reliefs in the way in which they are currently framed in the Order 53 Statement. I invite the parties to come together to consider and propose an alternative formulation of the declaratory relief which is appropriate and which safeguards the new harmony that has emerged around this vulnerable adult.