

JERSEY / JUDGMENT

AG -v- A [2018] JRC 012 (16 January 2018)

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judgment

the deputy bailiff: 1. The application before us relates to the question of the capacity of Ms A to make a decision to refuse medical treatment. We set out our decision in a brief ex tempore judgment on 29 th November, 2017, with more elaborate reasons to follow. These are those

reasons.

2. Ms A is a woman of 57 years of age who was stopped whilst entering Jersey and searched by officers of the Customs and Immigration Department. During the course of that search, cling film was found on her vagina which tested positive for cocaine. She was arrested and eventually taken to hospital where, at the time of application before us, she remained. 3. Because of the nature of her arrest and investigation it was thought that it was highly likely that she was concealing cocaine internally and that she was at serious risk to her health in the event that the packages were to leak and the cocaine thereby enter her bloodstream. 4. Whilst at hospital she did not want any form of physical examination but was found to have capacity by the doctors treating her and she was discharged into the custody of the Customs and Immigration Department. She was subsequently re-assessed because of increasing concerns relating to her physical condition and the fear that cocaine might have begun to leak into her system. Such leakage could cause serious consequences for her health and, possibly, if treatment did not take place, even her death. 5. At the time of the application before us the medical professionals were divided on whether she had capacity to withhold her consent to medical treatment. Her treating physician, Dr Caroline Jenkins, in consultation with other doctors at the General Hospital, formed the view that Ms A had capacity to consent or to refuse treatment. Because Dr Jenkins was not, however, a psychiatrist, it was thought advisable, in this case, to call upon specialists to assess her capacity. 6. The circumstances leading up to this assessment can be simply stated. Ms A began to exhibit the symptoms that could be associated with the leakage of cocaine into the system, specifically tachycardia and high blood pressure. If it proved to be the case that cocaine was leaking into her system then it was a matter of urgency that she be scanned to determine what and where the packages were and possibly undergo surgery to remove them in the event that it could not be done in any other way. 7. Ms A, however, indicated that she did not consent to take any medical investigation or treatment. She refused to be scanned

and have any investigation still less any intrusive surgery to help her. It was felt for the reasons set out below that she was motivated by deep concern for herself and her family (she apparently had some eleven children) and there were concerns expressed that she was so overcome by these concerns, (which originate in the possible consequences that may be visited upon her and her family from the people for whom she was carrying the drugs) that this was overriding her judgment in the matter. 8. She was subsequently examined by a consultant psychiatrist Dr Vijay James who together with Miss Kiran Sembhi, a social worker who is an expert in assessment of capacity, formed the view that Ms A lacked capacity to refuse medical treatment. Because of this clear distinction between the views of the treating physicians and the psychiatrist and social worker, the Attorney General has made an application to the Court to determine the issue of capacity. We accordingly sat at very short notice at 19:30pm on 29 th November with little or no documentation and we are grateful to both counsel for the care and thoroughness with which they presented the application before us. 9. We heard first from Dr Caroline Jenkins who is a consultant in intensive care and she had had care of Ms A since 5 o'clock that day. Before her, Ms A had been treated by Dr Roberts who had done a thorough handover to Dr Jenkins prior to going off duty. She gave evidence as to the circumstances in which Ms A had been admitted to hospital and the fact that a film on Ms A's vagina had tested positive for cocaine. Ms A had collapsed with tachycardia and hypertension which was consistent with cocaine in the blood system but also consistent with other potential conditions. If Ms A had consented to treatment then the first stage would have been a CT scan. That would have been a little invasive as a cannula would have needed to be inserted. Somewhat less invasive, but less clear, would have been an x-ray. Ms A permitted Dr Jenkins to feel her tummy. Ms A apparently did not know why she was in hospital and although Dr Jenkins explained the medical treatment to her, she refused to be further examined medically. Whenever asked whether or not she would consent to treatment she asked for her lawyer. 10. She refused even a general abdominal examination. If she had indeed ingested cocaine she could have suffered a cardiac arrest. Dr Jenkins indicated, however, that at the time she left the hospital there was no obvious urgency although if any container of cocaine had burst internally then it would have become extremely urgent. Ms A had confirmed to Dr Jenkins that she would want resuscitation in the event of cardiac arrest but she said she was not holding drugs internally. 11. Dr Jenkins assessed her capacity in the sense that she judged her understanding and ability to recall information over an appropriate time period. She was experienced, practically, in the assessment of capacity having to make such assessments on a daily basis. She had discussed the matter with other colleagues and the view that she had formed is that Ms A did not lack capacity. She understood what was being said to her and she understood the potential consequences and that even if Ms A were being coerced by some external force, Dr Jenkins did not think that capacity was lacking. Dr Jenkins advised us that this was the view of Dr Roberts as well. Ms A had not actually positively refused treatment but she simply had not agreed to it. 12. We then heard from Dr Vijay James who is as we have said a locum consultant psychiatrist who had been in Jersey since July. He had operated at consultant level since 2006 and was recognised by the Secretary of State for drugs experience and

management of mental disorders including assessment of capacity. He had spoken on the telephone with Dr Roberts that morning who had also discussed the matter with his colleagues and all were very concerned about Ms A. It was difficult for them to reach a firm decision concerning capacity. They thought that the complexities and seriousness of the situation warranted Dr James' opinion. At the time when Dr James was consulted, Dr Roberts thought there was a high potential risk of fatality in the event that any internally concealed cocaine had escaped. Dr Roberts had explained the context of Ms A's response to the prospect of medical treatment, namely that in his view she was fearful of the consequences for herself and her family and that thought had a huge bearing on her attitude. 13. The normal way of assessing capacity is by way of a four point assessment. The patient must demonstrate that they comprehend information given to them, that they retain it, that they can weigh up the pros and cons and reach a decision and that they can communicate that decision. However in Dr James's view that test is not appropriate in circumstances where the will of the patient is being overborne by undue influence or coercion such that the patient cannot form a proper judgement. In other words they can theoretically pass the four stage test but still not have capacity because of the level of coercion being placed upon them. 14. When Dr James had seen Ms A she was concerned of the effect of the treatment on her eleven children and grandchildren. She confirmed that they would want her to be around at Christmas time. Dr James asked her concerning the influence from others on her decisions and he said that he realised that she feared for the safety of herself and her family in the event that she allowed medical treatment. In response to this she nodded. 15. This was not a real conversation. She was largely silent and unresponsive but Dr James's unequivocal view was that her fear and lack of consent was linked to the consequences for herself and her family from outside individuals and not concerning her fear or concerns with the medical procedure itself. 16. In his professional opinion Dr James was clear that Ms A lacked capacity and he was concerned about any delay in investigation. Nothing he had heard in the evidence of Dr Jenkins had caused him to change his position. In cross-examination on behalf of Ms A, Dr James confirmed that the undue influence he was talking about is the fact that Ms A so fears the consequences from a drugs gang or the like on herself and her family that she could not consent to treatment. 17. We heard from Miss Kiran Sembhi, a social worker who is an expert in capacity assessments. As she told us she carries out capacity assessments day in and day out. When she saw Ms A, Ms A was lying in a hospital bed shivering and doubled over in apparent pain. There was no one there to support her. Her ability to engage in the process was in effect prohibited. 18. Ms A had on arrival spoken to Customs and Immigration officers who were present throughout and Miss Sembhi had been told that Ms A had said that she was a "drugs mule" and that she was very worried about the consequences. Miss Sembhi had difficulty communicating with Ms A. Although she tried to make eye contact, Ms A remained with her eyes closed for much of the time. Miss Sembhi asked Ms A about her family and Ms A responded she had seven grandchildren and said that maybe she would consent to treatment. She was however clearly ambivalent about the whole thing and did not give clear consent. It was Miss Sembhi's view that Ms A's inability to engage meant that she did not

have capacity. Miss Sembhi did not think that Ms A was simply making an unwise decision but rather that she simply could not engage with the decision making process at all. She could not gain any sense of Ms A's thought processes. When she had seen her, however, Ms A was clearly in pain and the degree of urgency was apparent. Miss Sembhi took the view that her ability to form any judgement was compromised. The Law 19. In the Attorney General-v-X

[2004] JRC 010 Birt, Deputy Bailiff, (as he then was) said this at paragraph 9:- " In Re MB (Medical Treatment)

[1997] 2 FLR 426 was concerned with an adult woman who, although she wanted her baby born, panicked at the last moment because of her needle phobia and refused to consent to the necessary caesarean section. The Court of Appeal summarised the general position as follows at 432:- "(1) Subject to (3) below, in general it is a criminal and tortious assault to perform physically invasive medical treatment, however minimal the invasion might be, without the patients consent....

- (2) A mentally competent patient has an absolute right to refuse the consent to medical treatment for any reason, rational or irrational, or for no reason at all, even where that decision may lead to his or her own death ...
- (3) Medical treatment can be undertaken in an emergency even if, through a lack of capacity, no consent has been competently given, provided the treatment was a necessity and did no more than was reasonable required in the interests of the patient. ...". 20. At paragraph 15 of that judgment the court said:- "We are in no doubt that we should adopt the principles described in the cases to which we have referred as accurately reflecting the law of Jersey. Accordingly a mentally competent adult with full capacity has an absolute right to refuse to consent to medical treatment or to take food and drink for any reason, or for no reason at all, even where that decision may lead to his or her death." And, at paragraph 17 et seq:- "We were referred to three English cases which are helpful in clarifying what is required in order for a person to have the necessary capacity to decide such matters. In Re T , Lord Donaldson MR said at 661:- "The right to decide one's own fate presupposes a capacity to do so. Every adult is presumed to have that capacity, but it is a presumption which can be rebutted. This is not a question of the degree of intelligence or education of the adult concerned. However a small minority of the population lack the necessary mental capacity due to mental illness or retarded development..... This is a permanent or a long-term state. Others who would normally have that capacity may be deprived of it or have it reduced by reason of temporary factors, such as unconsciousness or confusion or other effects of shock, severe fatigue, pain or druMs A being used in their treatment. Doctors faced with a refusal of consent have to give very careful and detailed consideration to the patient's capacity to decide at the time when the decision was made. It may not be the simple case of the patient having no capacity because, for example, at that time he had hallucinations. It may be the more difficult case of a temporarily reduced capacity at the time when his decision was made. What matters is that doctors should consider whether at that time he had a capacity which was

commensurate with the gravity of the decision which he purported to make. The more serious the decision, the greater the capacity required. If the person has the requisite capacity, they are bound by his decision. If not, they are free to treat him in what they believe to be his best interests."

18. The test for establishing the necessary capacity was elaborated by Thorpe J in *Re C (Adult: refusal of medical treatment)* (1994) 1 All ER 819 at 824:- "However, submissions divide over the definition of the capacity which enables an individual to refuse treatment. Mr Gordon argues for what he calls the minimal competence test, which he defines as the capacity to understand in broad terms the nature and effect of the proposed treatment. It is common ground that C has the legal capacity to initiate these proceedings without a next friend within the terms of RSC Ord 80. Mr Gordon contends that the capacity to refuse treatment is no higher and is equally no higher than the capacity to contract. I reject that submission. I think that the question to be decided is whether 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. I consider helpful Dr Eastman's analysis of the decision-making process into three stages: first, comprehending and retaining treatment information, secondly, believing it and, third, weighing it in the balance to arrive at choice."
19. Finally the Court of Appeal in *Re MB*, having referred with approval to the comments of Thorpe J in *Re C* and to the recommendation of the Law Commission in Law Com No 231 on Mental Incapacity, formulated the position as follows at 436:- "(1) Every person is presumed to have the capacity to consent to or to refuse medical treatment unless and until that presumption is rebutted. (2) A competent woman who has the capacity to decide may, for religious reasons, other reasons, for rational or irrational reasons or for no reason at all, choose not to have medical intervention, even though the consequence may be the death or serious handicap of the child she bears, or her own death. In that event the courts do not have the jurisdiction to declare medical intervention lawful and the question of her own best interests objectively considered, does not arise. (3) Irrationality is here used to connote a decision which is so outrageous in its defiance of logic or of accepted moral standards that no sensible person who had applied his mind to the question to be decided could have arrived at it. As Kennedy and Grubb *Medical Law* (Butterworths, 2nd edn, 1994) point out, it might be otherwise if a decision is based on a misperception of reality (e.g. the blood is poisoned because it is red). Such a misperception will be more readily accepted to be a disorder of the mind. Although it might be thought that irrationality sits uneasily with competence to decide, panic, indecisiveness and irrationality in themselves do not as such amount to incompetence, but they may be symptoms or evidence of incompetence. The graver the consequences of the decision, the commensurately greater the level of competence is required to take the decision: (4) A person lacks capacity if some impairment or disturbance of mental functioning renders the person unable to make a decision whether to consent to or to refuse treatment. That inability to make a decision will occur when: (a) the patient is unable to comprehend and retain the information which is material to the decision, especially as to the likely consequences of having or not having the

treatment in question; (b) the patient is unable to use the information and weigh it in the balance as part of the process of arriving at the decision. If, as Thorpe J observed in *Re C* (above), a compulsive disorder or phobia from which the patient suffers stifles belief in the information presented to her, then the decision may not be a true one. As Lord Cockburn put it in *Banks -v- Goodfellow*

- [1870] LR 5 QB 549 , 569: `..... one object may be so forced upon the attention of the invalid as to shut out all others that might require consideration.' (5) The `temporary factors' mentioned by Lord Donaldson MR in *Re T* (above) (confusion, shock, fatigue, pain or drugs) may completely erode capacity but those concerned must be satisfied that such factors are operating to such a degree that the ability to decide is absent. (6) Another such influence may be panic induced by fear. Again, careful scrutiny of the evidence is necessary because fear of an operation may be a rational reason for refusal to undergo it. Fear may also, however, paralyse the will and thus destroy the capacity to make a decision.'" 21. We were also referred to the case of a Local Authority-v-DL
- [2011] EWHC 1022 (Fam) where at paragraph 1 of the headnote it is stated:- "1. Set out in *Re SA* (Vulnerable Adult with Capacity: Marriage)
- [2005] EWHC 2942 (Fam) was a protective jurisdiction that extended beyond dealing with issues on mental incapacity; it had survived the coming into force of the Mental Capacity Act 2005 and the Code and was not confined to vulnerable adults, although they were more likely to fall into the category of cases in which the jurisdiction would be applicable. It followed that the inherent jurisdiction could still be invoked to make declarations and, if necessary, put protective measures in place in relation to individuals who did not fall within the Mental Capacity Act 2005, that it would reasonably be believed to be deprived of the capacity to make the relevant decisions, disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent by reason of such thin as constraint, coercion, undue influence or other vitiating factor. ...". 22. At paragraph 21 of that judgment the Court said this:- "21. I do not propose to set out all the cases referred to, but merely highlight a few. Munby J referred to what had been said by the Court of Appeal in *Re T* (Adult: Refusal of Treatment)
- [1993] Fam 95 , sub nom *Re T* (An Adult) (Consent to Medical Treatment)
- [1992] 2 FLR 458 : "[55] ... the Court of Appeal had made it clear in *Re T* (Adult: Refusal of Treatment)
- [1993] Fam 95 , that the court has jurisdiction to determine whether an apparent consent or refusal of consent is vitiated, for example, by the effects of shock, fatigue, pain or drugs, or because the will has been overborne by the undue influence of another, or by deception or misinformation of a significant kind. As Butler-Sloss LJ said at page 117: "Although the issues of capacity and genuine consent or rejection are separate, in reality they may well overlap, so that a patient in a weakened condition may be unduly influenced in circumstances in which if he had been fit, he would have resisted the influence sought to

be exercised over him." Slaughton LJ made a similar point at page 122 when he said: "at the time of apparent consent or refusal the patient may not, for the time being, be a competent adult. Her understanding and reasoning powers may be seriously reduced by drugs or other circumstances, although she is not actually unconscious."

- [56] Lord Donaldson of Lynton MR made some general comments at page 113 which are important in the present context: "When considering the effect of outside influences, two aspects can be of crucial importance. First, the strength of the will of the patient. One who is very tired, in pain or depressed will be much less able to resist having his will overborne than one who is rested, free from pain and cheerful. Second, the relationship of the 'persuader' to the patient may be of crucial importance. The influence of parents on their children or of one spouse on the other can be, but is by no means necessarily, much stronger than would be the case in other relationships. Persuasion based upon religious belief can also be much more compelling and the fact that arguments based upon religious beliefs are being deployed by someone in a very close relationship with the patient will give them added force and should alert the doctors to the possibility - no more - that the patient's capacity or will to decide has been overborne. In other words the patient may not mean what he says."
- [57] Butler-Sloss LJ made much the same point at page 120: "it has long recognised that an influence may be subtle, insidious, pervasive and where religious beliefs are involved especially powerful. It may also be powerful between close relatives where one may be in a dominant position vis-à-vis the other. In this case Miss T had been during her childhood subjected to the religious beliefs of her mother and in her weakened medical condition, in pain, and under the influence of the drugs administered to assist her, the pressure from her mother was likely to have a considerably enhanced effect. I find it difficult to reconcile the facts found by the judge with his conclusion that the influence of the mother did not sap her will or destroy her volition. The degree of pressure to turn persuasion or appeals to affection into undue influence may as Sir James Hannen P said in *Wingrove -v- Wingrove*
- (1885) 11 PD 81, 82-82, be very little." 23. We apply the above principles to the instant case. 24. It is clear that Dr Jenkins and the other treating physicians, applying the normal four stage test, had no reason to think that Ms A lacked capacity to refuse medical treatment. 25. Advocate Blackmore, for Ms A, urged upon the Court that there was no direct evidence that she was under the influence of fear of any drug gang or the like, such that her will had been overborne by her fear of the consequences that might fall upon her or her family. Dr Jenkins's evidence had been that there was no immediate risk and indeed there was no current confirmation that Ms A was in fact carrying packages internally. In the circumstances Advocate Blackmore urged upon us that we should not treat Ms A as lacking in capacity and should respect her decision not to undergo any investigation or treatment. She did not need to give reasons and she had clearly not expressed any desire to have treatment and had acted consistently in that regard. 26. It is clear that we should proceed on the basis that Ms A has capacity to agree to or refuse medical investigation or treatment

unless there is some sufficient basis for thinking that she does not. 27. We were somewhat concerned that we did not have any direct evidence from the Customs and Immigration officers nor indeed from Dr Roberts who had been her treating physician prior to Dr Jenkins coming on duty. 28. That being said, we have to proceed on the basis of the evidence that we have and Dr James, who is the expert psychiatrist who has examined Ms A, supported by Miss Sembhi, were entirely clear that their professional opinion was Ms A lacked capacity. She did so because her ability to make a proper judgement had been overborne by her fear of the consequences of permitting any form of investigation into her condition. Her fear was of the consequences that may be visited by others upon either her or upon her children or grandchildren. Dr James was clear that when he asked her during the course of his examination or expressed the fact that he was conscious that she was worried about the consequences for herself or for her family, she had nodded. 29. In our view there are extraordinary circumstances in this case, with an individual at perceived risk of catastrophic consequences should she be carrying cocaine internally and should that cocaine leak. The understanding from both the Customs and Immigration officers (although provided to this Court by means of hearsay evidence) that she was a drugs mule terrified of a drugs gang. These circumstances and the clear assessment by the consultant psychiatrist, gave us a reasonable basis to believe that Ms A lacks capacity. Accordingly we make a declaration that Ms A does not have capacity to make decisions relating to any investigation and treatment relating to the potential internal concealment of unlawful drugs. 30. We repeat our thanks to the medical professionals involved for their enormous assistance and for the submissions of counsel that have been of help to us in what has been a difficult balancing exercise. Postscript 31. We are informed that after making the decision that we did and on being informed of it, Ms A agreed to medical investigation. Authorities Attorney General-v-X

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