



On the borderline

Giles Eyre & Dr Linda Monaci
discuss vulnerable individuals &
the Mental Capacity Act 2005

The issue of the mental capacity of a claimant during or at the conclusion of injury litigation may arise from a condition pre-dating and independent of the accident or event that is the subject of the claim, or the condition may be the result of the accident or event; or, as in this paper, a combination of both.

Section 2 of the Mental Capacity Act 2005 (MCA 2005) provides that '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.' The burden of proving lack of capacity is on the person asserting such lack. Section 1 of MCA 2005 provides that '(3) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success (4) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.' These latter two provisions can be challenging to apply to the facts of a case.

Case study

Ms D suffered a preventable subarachnoid haemorrhage (SAH) at age 45, which left her with a degree of cognitive, physical and emotional symptoms. At the time of the index event she lived with her partner and their 17-year old daughter; she worked part-time in a warehouse. She brought a claim for negligence against the healthcare provider.

On discharge from hospital she was reported to be able to wash, dress and safely cook a meal with minimal physical restrictions. Subsequently she had some community neurorehabilitation and on numerous occasions was referred for psychological support due to mood disturbances and prescribed antidepressants.

Neuropsychological assessment
Eighteen months after the index event, Ms D reported that since the index event she had been unable to live independently, needing considerable help, for instance in order to organise and carry out shopping, cooking, and dressing. Her partner attended the appointment with her and he also (consistently with her self-report) indicated that she could not live independently and that he now supported her including in all financial matters. He reported that he had to give up his job as a building contractor to become her carer and had recently applied for Carer's Allowance. Ms D, now medically retired, received a small work pension and state benefits. All spare income was spent in funding the partner's online gambling which appeared to take up much of his time.

The assessment could not objectively establish the degree of cognitive decline because Ms D failed effort tests so she was likely to have underperformed on tests of cognitive functioning. Ms D also over-reported physical, cognitive and emotional symptoms on a questionnaire that included validity scales. Her underperformance and overreporting were considered to be consistent with malingering, factitious disorder or somatisation; in the first two the person has a conscious intent, but this is subconscious in the latter.

Ms D's medical history suggested a past tendency to somatise (ie experience physical symptoms in response to psychological stress). There was consistency between her reports, her partner's reports and the multitude of contacts with her GP, rehabilitation team and

services providing psychological support. As a teenager she had been involved in a relationship that featured physical, emotional and sexual abuse; she also had a long-standing history of recurrent depression.

During the relationship prior to her current one, which also featured physical and emotional abuse, she was charged with several counts of theft and handling stolen goods, which she reported committing to please her partner at that time in the hope that he would stay with her and they would get married. She had not reported any abuse by her current partner, but her history prior to the SAH indicated she was a vulnerable individual and she had a tendency to become emotionally dependent on the men with whom she formed romantic attachments and as a result she had made decisions that were not in her best interest (eg becoming involved

in criminal acts, remaining in abusive relationships) to maintain the relationship. It was significant therefore that she was now content that much of their meagre income went on the partner's gambling.

In order to try to establish her cognitive problems, the neuropsychologist considered data on the prevalence of cognitive problems following a SAH, cognitive test data, behavioural observations, interview, third party reports and information contained in the medical and occupational records. While the cognitive testing results could not be relied on (because of the failed effort tests), all other information consistently indicated that since the index event she had difficulty in maintaining goals and this was consistent with executive problems, also impacting on her social and interpersonal functioning.

When the neuropsychologist asked questions aimed at understanding her ability to manage finances, Ms D reported being completely independent and having no problems. However, when Ms D's partner was interviewed (separately), he reported that Ms D needed support with money management which he now took complete responsibility for, saying she would 'regularly lose her purse'.

Ms D reported seeing herself as physically and cognitively disabled. She did not enjoy going out or meeting others as social interactions created heightened anxiety for her. As a result, she and her partner were socially isolated and she had become even more emotionally vulnerable and dependant on him. Although the results of the cognitive testing were not conclusive, there was abundant behavioural evidence that, while even before the index event she was disorganised and struggled with completing a

training course, since the brain injury she was less socially aware (eg often making socially inappropriate comments), and she was considerably more anxious, vulnerable and dependant than she had been before the SAH.

The capacity test

Under Section 3 of MCA 2005 it is provided that 'a person is unable to make a decision for himself if he is unable:

- to understand the information relevant to the decision
- to retain that information
- to use or weigh that information as part of the process of making the decision
- to communicate his decision (whether by talking, using sign language or any other means).'

'The information relevant to a decision includes information about the reasonably foreseeable consequences of:

- deciding one way or another, or
- failing to make the decision.'

Financial capacity issues

Upon direct questioning, although Ms D's responses suggested that she had capacity, the key issue was her ability to weigh up information and her ability to do so in face of possible influence by those close to her, as indicated by her pre-morbid history and more recent events. There was a mismatch, typically observed in individuals with executive problems (the likely consequence of the SAH) between what she said she would do and what she actually did in reality. In addition, there was her pre-existing emotional vulnerability and tendency to undertake actions that were not in her best interests in order to preserve a romantic relationship.

- ▶ Ms D reported managing finances without help but needing help with more basic activities such as self-care, which was inconsistent with the cognitive abilities required by these tasks.
- ▶ The records showed that before the index

event, on several occasions, she agreed to do something but then failed to go through with her stated intent.

- ▶ Given her history of somatisation, her underperformance on cognitive tests and over-reported symptoms were highly likely to be the result of somatisation rather than malingering or factitious disorder; however, intent cannot be excluded due to the presence of secondary gains, both in terms of financial rewards but also care (eg her partner had applied for Carer's Allowance and there was a clinical negligence claim).
- ▶ Multiple sources of information indicated Ms D appeared to experience significant executive problems since the index event.

Conclusion

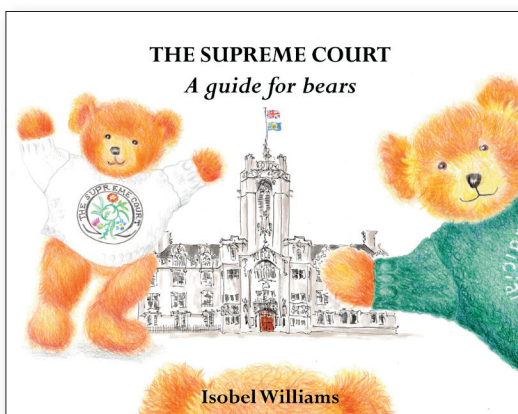
The neuropsychologist, contrary to the opinions of the psychiatrist and neurologist instructed, raised the issue of vulnerability and that due to pre-existing emotional vulnerability, together with her perceived disability, social isolation and problems in executive functioning since the SAH, Ms D was even more vulnerable to being exploited and manipulated by others and at high risk that she would allow the substantial damages she was to receive to be gambled away by her partner in order to appease and placate him. In these circumstances she was not just likely to make a bad financial decision (as she was entitled to do under the mental capacity test) if she felt this was necessary to maintain a romantic relationship, but because of those factors she was unable properly 'to use or weigh that information as part of the process of making the decision'.

While MCA 2005 presents us with a two-stage test that needs to be applied to establish whether an individual lacks capacity, 'borderline' capacity cases raise difficult, and at times almost philosophical issues, as to what is meant by the proper weighing of information, and how judges approach such cases.

Each case is unique and among experts a range of opinions can often be found. It is ultimately a matter for the judge to apply the law in each individual case, but it would be helpful for both members of the legal profession and expert alike to be able to access court decisions in such difficult cases, including in the County Court and Court of Protection, to be able to enrich their understanding of the application of MCA 2005 in practice.

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