

# Water Rescue within UKSAR: consent, capacity and necessity

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## Abstract

For Search & Rescue Operators providing pre-hospital care and rescue within an aquatic environment, difficulties arise not only from the logistics of performing these interventions, but also obtaining consent from casualties. A great proportion of UKSAR operatives are volunteers, nevertheless, the law expects them to provide the same standard of care as a professional. Consequently, this high standard, combined with the proliferation of operations concerning mental health and the supposed “litigation culture”, leaves these volunteers in a uniquely difficult position. This paper aims to provide a guide, for those operating in and around water, on law regarding consent, capacity and necessity in England & Wales.

**KEY WORDS:** *Mental Capacity, Water Rescue, Mental health*

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## Introduction

For a UK Search and Rescue Operator (“SAR Operator”), water environments are perhaps one of the most challenging places to work. Not only are Operators subjected to the multitude of natural hazards that accompany an aquatic environment, but also to the behaviour of those they report to rescue. In recent years, a “*mental health crisis*” has arisen within the United Kingdom (“UK”), and SAR Teams, including those operating in water environments, spend a great deal of operational time handling mental health related incidents (Prothero & Cooke, 2016). Consequently, SAR Operators providing pre-hospital care to patients with mental disorders are inevitably placed in a position where they are required to make judgments as to whether a patient has mental capacity to consent to intervention.

SAR within the UK is facilitated by the United Kingdom Search and Rescue (“UKSAR”) framework and this provides land, maritime and aeronautical cover across 2 million square miles (United Kingdom Search & Rescue, 2017). The ultimate operational authority in SAR incidents lies with statutory bodies, however, these government agencies rely heavily on volunteers who make up a considerable proportion of SAR Operators (See Figure 1).

Figure 1- UKSAR Operational Framework



\*For more information see United Kingdom Search & Rescue, 2017 (as above)

\*\*Note that the Fire & Rescue Service’s involvement will depend on the type of incident and resources of the particular Service. Some Services are fully equipped to deal with water related incidents and may operate without the assistance of voluntary SAR assets, while others have very limited resources in regard to flood or water rescue (Department for Environment, Food & Rural Affairs, 2019). It should also be noted that in some areas, the Fire & Rescue Service play lead role in co-ordinating flood and water rescue operations (Chief Fire & Rescue Adviser, 2010)

Despite the status of “volunteers” these individuals are held to the same standards as professionals working in the same position (Nichols, Goel, Nichols & Jones, 2014). Consequently, a SAR Operator, volunteer or not, found to have treated or rescued a patient without consent, absent of a legal defence, faces civil liability or, in extreme cases, even criminal culpability. The *supposed* growth of “litigation culture” within the UK, combined with the challenging environment water presents, leaves volunteers in a uniquely difficult position not encountered by other elements of UKSAR (Hand, 2010).

With this in mind, it is the purpose of this paper to attempt to give legal and medical clarity to SAR Operators, particularly non-medical professionals, on obtaining consent and determining mental capacity of patients within a water rescue environment. The first part focuses on the legal position within England & Wales (“E&W”), and explores the law surrounding patient consent and the rescuing team making a mental capacity assessment. It also seeks to outline circumstances where obtaining consent or assessing mental capacity is not necessary. The latter half of this paper addresses common medical conditions encountered in water related operations, and how they may affect a casualties’ ability to consent to treatment or rescue.

It should be noted that this article focuses only on those subject to the Mental Capacity Act 2005 (“MCA”) being those 16 years of age and over. The law surrounding consent and capacity of children is beyond the scope of this paper.

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## Consent, legal liability, mental capacity and necessity

### Consent (the “general rule”)

The idea of “consent”, within a medical context in its legal form, is complex and fluid, subject to frequent judicial and statutory modification (McGuire & Beskow, 2010). Legal questions regarding consent are predominately dealt with by the Court of Protection- a specialist court created by the MCA, dealing with the rights of people considered “vulnerable”. This includes patients within the National Health Service (“NHS”) or within the care of another state-run body (Lush, 2005). However, in the context of SAR Operations, the legal minutiae of consent and *best interests* has little impact on the care provided by Operators, as these legal decisions mainly apply to hospital settings (Clough, 2016). On this basis, “consent”, in the context of SAR Operations, is perhaps better understood as a rule that:

*“An Operator must seek permission from a casualty before he/she performs any medical or rescue intervention”*

While at face value this rule seems simple, it has various exceptions, as we shall explore below. As the law places a particularly high value on the need for consent, it is worth examining the underlying *principle of autonomy*.

### Principle of autonomy

At the heart of consent, both legally and ethically, is the right to bodily integrity, and to ultimately decide whether to consent to treatment- this is known as the *principle of autonomy* (Entwistle, Carter, Cribb, McCaffery, 2010). This is considered to be a fundamental right and is enshrined in both the law of the European Union (see Article 3.2(a) Charter of Fundamental Rights of the European Union) and the European Convention of Human Rights (“ECHR”) (See the European Court of Human Right’s (“ECtHR”) decision in *Glass v United Kingdom* [2011] ECHR 1664 in interpreting Article 8(1) ECHR)), both of which are binding on the UK. At national level, Lord Donaldson sitting in the Court of Appeal of E&W in *Re T (Adult)* [1992] 4 All ER 649 defined it as:

*“An adult patient[’s]...absolute right to choose whether to consent to medical treatment.”*

The extent and importance of this right is far reaching, as illustrated in *St George's Healthcare NHS Trust v S* [1998] 3 All E.R. 673. Here, a patient known as “S” was 36 weeks pregnant and had developed life-threatening pre-eclampsia, requiring an urgent caesarean section to save the life of both herself and her unborn child. “S” continually refused to consent and, while the lower courts (namely the High Court) initially approved the treatment contrary to her wishes, on judicial review, the Court of Appeal held, irrespective of the risk to her own life and that of her unborn child, “S” had the right to refuse treatment. Lord Donaldson continued in *Re T (Adult)* (as above) to state:

*“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.”*

It is seen here that the law regards a person’s right to choose what happens to them, in the context of medical treatment, as fundamental. Any breach of this attracts potentially both criminal and civil liability.

### Obtaining Consent

Legally, to obtain “consent” from a casualty, the following 3 elements must be present (Grubb, 2004):

- (i) The casualty must have mental capacity; and
- (ii) The consent must be “informed”; and
- (iii) The consent must be voluntary and made without duress or influence of another.

Determining mental capacity is dealt with in detail below, but for the purposes of consent, unless one of the “3 triggers of capacity” (below) is present, capacity may be assumed, because S.1(2) MCA states:

*“A person must be assumed to have capacity unless it is established that he/she lacks capacity.”*

The concept of “informed consent” under (ii) simply requires a patient be informed of the material risks of any treatment they receive and if possible, have alternatives presented to them (*Montgomery v Lanarkshire Health Board* [2015] UKSC 11). A typical example arises in a hospital, where a patient requires major surgery which inevitably entails risk. In such circumstances, a medical professional would need to disclose the risks involved in the procedure and outline any alternatives. Case law suggests the “material risks” should not be limited to what is considered a risk by the medical professional, but should also include factors which may be viewed as a risk by a reasonable patient and those which would affect their decision making (see *Mrs A v East Kent Hospitals University NHS Foundation Trust* [2015] EWHC 1038).

The law on what should be disclosed is extensive, fluid and subject to both legal and ethical debate (Gold, 2004 and see discussion in *Chatterton v Gerson* [1981] QB 432); however, in its simplest form: the riskier the procedure, the greater the need for disclosure (see *Pearce v United Bristol Healthcare NHS Trust* [1998] EWCA Civ 865). For most SAR Operators, the treatment provided in an aquatic environment will likely be limited to basic care, due to the safety, logistical and practical limitations on performing advanced medical interventions. Consequently, disclosure may be satisfied by simply asking the casualties’ permission to perform specific actions, for example an Operator may say “*I just want to put a bandage on that wound, if that’s okay?*”. Following this, a simple rule can be formed:

*A SAR Operator must tell the Casualty what they are going to do for each intervention (whether it be performing a rescue manoeuvre (e.g. a hoist) or medical procedure)*

From this, the Operator can judge whether the casualty consents to treatment or rescue. It is important to stress that this should be done for *each* intervention/manoeuvre, as consent is a continuing process and consenting to one treatment does not guarantee consent to another. For example, a patient may consent to having a wound bandaged, but refuse the insertion of an Intra-venous (IV) cannula, thus, continuing this treatment without gaining consent could result in liability. Following this rule not only discharges the legal burden of obtaining informed consent but is also good clinical practice in helping the patient to remain at ease.

Under requirement (iii), the consent must be voluntary. In simple terms, this means the decision must not be obtained through improper influence or coercion from a 3<sup>rd</sup> party, or through deception of the medical professional seeking consent (Pattinson, 2017). For example, in *Re T (Adult)* (as above) the Court of Appeal held that pressure exerted by a mother, a Jehovah’s Witness, on her daughter, a patient at a hospital, over a blood transfusion invalidated the daughter’s ability to consent, as it would not be “voluntary”. This is unlikely in a water environment, but if suspected, steps should be taken to limit the effect of suspected improper influence.

## Liability

In the words of Lord Scarman in *Sidaway v Board of Governors of the Bethlem Royal Hospital Governors* [1985] AC 871:

"[He who treats] *without the consent of his patient, save in cases of emergency or mental disability, is guilty of the civil wrong of trespass to the person; he is also guilty of the criminal offence of assault.*"

A casualty's right to decide their treatment is fundamental, and breaching this could potentially attract both criminal and civil liability.

### Criminal Liability

Criminal prosecution resulting from medical treatment is rare, and most reported criminal cases involve *not whether* the patient consented, but rather *what* a patient can consent to as a matter of public policy (see *R v Brown* [1994] 1 AC 212). However, providing training is followed, no treatment rendered by a SAR Operator will fall outside the scope of what a person can consent to, as it will fall within generally recognised medical practice (see *Airedale NHS Trust v Bland* [1993] AC 789).

However, treating a patient without consent technically could amount to a criminal offence, carrying the potential for a criminal record and other criminal sanctions. If such a complaint was made, the matter would be investigated by the Police, and the ultimate decision on charging would lie with the Crown Prosecution Service ("CPS") (see S.29(1) Criminal Justice Act 2003). Before the CPS makes a decision to charge an individual(s), under the Code for Crown Prosecutors ("the Code"), a 2 stage test must be applied:

- i. Is there sufficient evidence to provide a realistic prospect of conviction of each suspect on each charge (4.6-4.8 of the Code)
- ii. Is it in the public interest to bring a prosecution (4.9-4.13 of the Code)

Whether this test is satisfied depends on the facts of the case. However, criminal law is often described as "a law of last resort" and requires that any criminal charge be proven beyond all reasonable doubt (see *Woolmington v DPP* [1935] 1 AC 462 and Husak, 2014). For the CPS to bring a charge against a SAR Operator for breaching consent would take an exceptionally rare case, requiring extensive fault or gross-negligence (Husak, 2014). Consequently, even if they are found to have treated a patient in violation of consent, providing an Operator follows their training, the likelihood of criminal charges is very small. If an Operator was charged with a criminal offence during the course of an operation, specialist advice from an accredited criminal law practitioner should be sought.

### Civil liability

Conversely, a SAR Operator facing a claim for a civil wrong (known as a "tort") is much more likely. The supposed rise of the "compensation culture", is subject to considerable discourse in the media, the

judiciary and the Law Society (Dyson, 2013); however, regardless of this debate, civil liability remains a sobering possibility (Hyde, 2018).

The types of torts that could be brought against a SAR Operator can generally be split into 2 types:

- i. Claims based on trespass to the person; and
- ii. Claims based on negligence.

Trespass to the person (or intentional torts) claims are similar to their criminal counterparts, but they impose an obligation to pay monetary compensation (known as “damages”), rather than criminal sanctions (Resuscitation Council, 2018). Relevant intentional torts are summarized in Figure 2. Damages for intentional torts are recoverable, even if no actual injury occurs (known as “nominal damages”) or is proved. However, modern legal practice seemingly indicates claimants are more likely to rely on a claim based on negligence than trespass to the person (Patterson, 2014)

Unlike criminal claims, the burden of proof is “on the balance of probabilities”, which in simple terms requires the claimant to prove it was more likely than not that the defendant committed the tort (*In re H and others (Minors)* [1998] AC 72).

The law of negligence liability is one of the most extensive areas of law, and its intricate detail is beyond the scope of this article, but to establish a *prima facie* negligence claim a claimant must prove:

- i. That the defendant owed the claimant a duty of care
- ii. That duty was breached by the defendant
- iii. The defendant’s negligence caused *actual* injury to the claimant

Negligence liability in regard to consent normally arises from failure to inform a patient of the risks of the treatment, invalidating the consent as it was not informed (*Montgomery v Lanarkshire Health Board* (as above)). Most of these cases arise from a complication from surgery that the patient was not aware was a risk (Dawson-Bowling, 2011). Given the acute nature of pre-hospital care, and practical limitations on what medical interventions may be performed in an aquatic environment, providing the guidance above on obtaining consent is followed (or an exception applies), the possibility of a SAR Operator facing a negligence claim based on lack of informed consent is extremely unlikely. Negligence liability, however, may still arise from negligent actions, which is examined below.

All applicable steps should be taken to obtain consent or establish that an exception exists. However, inevitably, things go wrong, and it is strongly advised that all SAR Operators participating in live operations are covered by an appropriate insurance policy indemnifying against prospective litigation.

Figure 2- Intentional Torts

<b>Tort</b>	<b>Legal Provision</b>	<b>Requirements for a <i>prima facie</i> case</b>	<b>Defences</b>	<b>Practical example</b>
<b>Assault</b>	<i>Stephens v Myers</i> (1840) 4 C&P 349	<ul style="list-style-type: none"> <li>- An act by the defendant;</li> <li>- Intended;</li> <li>- To cause the immediate apprehension of;</li> <li>- Harmful or offensive contact.</li> </ul>	<ul style="list-style-type: none"> <li>- MCA</li> <li>- Necessity</li> <li>- Privilege (self-defence/defence of another/legal authority)</li> </ul>	Threatening to use physical force with an uncompliant patient.
<b>Battery</b>	<i>Collins v Wilcock</i> [1984] 1 WLR 1172	<ul style="list-style-type: none"> <li>- An act by the defendant;</li> <li>- Intended to cause harmful or offensive contact;</li> <li>- Actual harmful or offensive contact.</li> </ul>	<ul style="list-style-type: none"> <li>- MCA</li> <li>- Necessity</li> <li>- Privilege (self-defence/defence of another/legal authority)</li> </ul>	Physically treating a patient without consent.
<b>False Imprisonment</b>	<i>Bird v Jones</i> (1845) 7 QB 742	<ul style="list-style-type: none"> <li>- a complete restriction on the claimant's freedom of movement; and</li> <li>- the absence of legal authorisation.</li> </ul>	<ul style="list-style-type: none"> <li>- MCA</li> <li>- Necessity</li> <li>- Privilege (self-defence/defence of another/legal authority)</li> </ul>	Physically restraining a patient.
<b>Negligence</b>	<i>Donoghue v Stevenson</i> [1932] UKHL 100)	<ul style="list-style-type: none"> <li>- The defendant owed the claimant a duty of care;</li> <li>- That duty was breached by the defendant;</li> <li>- The defendant's negligence caused <i>actual</i> injury to the claimant.</li> </ul>	<ul style="list-style-type: none"> <li>- Contributory Negligence</li> </ul>	Failing to properly secure patient to a stretcher which results in injury.

## Mental Capacity (Exception 1)

The law recognises there are situations where a person is either unable to make a decision (e.g. through loss of consciousness) or incapable of making a decision for themselves (e.g. suffering from a mental health illness). The ability to make a decision is referred to as *mental capacity* and is required for a patient to be able to consent to treatment. As mental capacity is generally presumed, a SAR Operator need only make an assessment if one of the “3 triggers of capacity” are present:

- a) A casualty rejects help (i.e. does not consent); or
- b) A casualty does not give an answer to an offer to help; or
- c) The casualty makes a decision which the SAR Operator believes is adverse to their interests:

The law governing mental capacity in E&W is predominantly contained in the MCA, which lists a set of principles to be applied when considering capacity (S.1), and criteria required for establishing if a person has capacity (ss 2&3). Where the criteria are not met, a person does not have mental capacity (and thus is unable to give valid consent), and the law allows those coming to their aid to commence treatment in the casualty’s *best interests* (S.4) while they lack capacity. Thus the following rule may be formulated:

*If one of the “3 triggers of capacity” is present, then a SAR Operator must take all reasonable steps to carry out a mental capacity assessment.*

Again, whether this is possible wholly depends on the situation, and if there is no time to carry out such an assessment then the necessity exception may apply (see below).

### Making a mental capacity assessment

When making a mental capacity assessment, a SAR Operator needs to consider 2 stages (The Department of Constitutional Affairs, 2007):

- 1) Does the casualty have an impairment of, or a disturbance in the functioning of, their mind or brain (S.2(1))?

For most SAR Operators undertaking aquatic operations, detailed analysis of the impairment of mental function is of little use, given the practicalities and safety of handling patients in and around water. Instead, it is perhaps more beneficial that SAR Operators are familiar with frequently encountered conditions which have the potential to inhibit mental capacity, prompting the second stage of the mental capacity assessment. The latter half of this paper addresses common conditions encountered on operations which may lead to a SAR Operator questioning a patient’s capacity.

2) Does the disturbance in mental function mean that the casualty is unable to make a specific decision in regard to rescue or treatment? (S.3(1)(a)-(d))

Having ascertained that a casualty's mental function is potentially impaired, an Operator must assess whether this prevents them from making a decision. To assess this the Operator, when seeking consent to a specific course of treatment or rescue, must decide if the casualty satisfies the following 4 criteria. Regarding information about a course of treatment or rescue, can the casualty:

**i. Understand** the information?

Their ability to understand the information given to them regarding treatment. This includes understanding reasonably foreseeable consequences of making (or not making) that decision about the treatment or rescue.

**ii. Retain** the Information?

Can the casualty retain the information long enough to make a decision?

**iii. Weigh up** the information?

Their ability to consider the information given and weigh up the consequences, both benefits and risks, of their decision.

**iv. Communicate** the information?

The ability to relay the information given and communicate their decision.

It is imperative that these criteria are applied to *each* course of treatment for two reasons. Firstly, it is possible a patient is able to consent to one course of treatment but not another, as the greater the gravity of the decision, the more capacity is required (See *Re T* (as above)). A course of treatment with little risk requires a lower standard of capacity (e.g. dressing a wound or warming up a casualty) than a course of treatment/rescue where the risks are potentially life-changing (e.g. deciding between a high risk extraction, likely resulting in permanent damage to a limb; or a delay, potentially preserving the limb but increasing the threat to life). Secondly, capacity is *transient*, in the sense it may fluctuate over time (e.g. a patient's level of consciousness may increase and decrease throughout the rescue), making it necessary to reassess capacity to obtain consent for further treatment.

#### The Principles of *mental capacity*

In assessing a casualty's mental capacity under the MCA, it is also necessary to:

- 1) assume a casualty has capacity until it is established they have not (S.1(2));
- 2) take all steps, as is reasonably practical, to help the casualty make a decision (S.1(3)); and
- 3) acknowledge that, just because an unwise decision is made, does not mean a person lacks capacity (S.1(4)).

The presumption of capacity under S.1(2) is dealt with above. Regarding the requirement under S.2(3), situations may arise where it initially appears the patient lacks capacity, however, after some assistance in satisfying the 4 criteria, valid capacity may become apparent (Zuscak, S.J., Peisah C., and Ferguson, A. (2016)). For example, a patient apparently suffering from the effects of drugs or alcohol (which brings

capacity into question), as well as aphonia (a condition causing a bilateral disruption of the recurrent laryngeal nerve leading to an inability to produce vocal sounds), *prima facie* may appear to lack capacity (e.g. through an inability to communicate); however, a SAR Operator may find it is possible to communicate using alternative methods (e.g. sign language or non-verbal communication). In this case the patient may in fact possess capacity. Given the nature of operating in and around a water environment, the extent to which an Operator can assist the casualty in regard to consent may be limited, but as a general rule:

*A SAR Operator must consider if there is anything he/she can practicably do in the circumstances which would assist a casualty in meeting the mental capacity criteria.*

Finally, as mentioned above, if a casualty makes a decision seemingly averse to their interests, it may call into question their mental capacity. However, if a casualty is found to possess capacity then, applying the principle of autonomy, regardless of how the decision appears to the Operator it must be respected.

#### Best Interest

In the event a casualty does not possess capacity, under S.1(5) a SAR Operator may treat them in what they *reasonably believe* to be in that casualties' *best interest*. In exercising its *parens patriae* jurisdiction, the Court of Protection has produced a plethora of jurisprudence defining what constitutes "best interests" in a range of circumstances (Cough, 2016). For SAR Operators, these decisions are of little relevance, given the acute nature of the care they provide, but what is well established is that actions "*must be such as a reasonable person would [take] in all the circumstances*" (per Lord Goff in *F v. West Berkshire HA* [1989] 2 W.L.R. 1025. and S.4(2) MCA).

Consistently, the courts have held that following a *responsible and competent body of relevant professional opinion* satisfies the *reasonable person* test (*Re A (Male Sterilisation)* [2000] 1 F.L.R. 549 at 78). Thus, for a SAR Operator, following established rescue/pre-hospital care guidelines, proliferated by competent bodies (e.g. Resuscitation Council (UK), The Royal College of Surgeons Faculty of Pre-hospital Care, guidance on flooding protocols by the Department for Environment Food & Rural Affairs, Royal Life Saving Society, British Canoe Lifeguards, Royal National Lifeboat Institute and operational guidance provided by Fire & Rescue Services), will nearly always constitute the best interests of a patient. It should be noted that this treatment should be limited only to preserving life or mitigating serious injury. The law also requires under S.4(4), even if a person does not have capacity, the patient should be involved as much as possible, thus, as a general rule:

*When treating a casualty without mental capacity, SAR Operators should follow their medical/rescue training to the extent of preserving life, making every effort to involve the casualty insofar as possible in his/her treatment (e.g. telling the casualty what is happening and accommodating reasonable requests)*

Involving the casualty (regardless of capacity) is important for ensuring patient co-operation, which will consequently reduce risk to Operators. Furthermore, studies show that even comatose patients can detect auditory stimuli (Sission, 1990 and Asanini, 2009). Given the positive relationship between continual communication with a patient and improved outcome, communicating, even with seemingly unresponsive patients, is recommended (Sission, 1990 and Asanini, 2009).

## **Necessity (Exception 2)**

Under the Doctrine of Necessity (sometimes called the Doctrine of Emergency), the common law recognises that situations may arise where, given the imminent threat of death or serious injury, an individual may essentially dispense with the need to obtain consent, in order to prevent immediate harm (see *A (Children)* [2000] EWCA Civ 254).

### Treatment without consent

At common law, treatment or rescue may be administered without consent if (*F v. West Berkshire HA* (as above)):

- a) there is a necessity to act when it is not practicable to communicate with the assisted person; and
- b) the action is such as a reasonable person would in all the circumstances take, acting in the best interests of the assisted person.

Unfortunately, there is a dearth of jurisprudence as to what might constitute a *necessity to act*, but Lord Goff suggested (at para 35.6) in *West Berkshire* (as above) that:

*“a man who seizes another and forcibly drags him from the path of an incoming vehicle, thereby saving him from injury or even death, commits no wrong”*

Drawing on this, it is suggested that SAR Operators adopt a common sense approach, only considering it necessary to act when (Scannell, 2007):

- i) there is an immediate threat of death or serious injury to a casualty; and
- ii) the time critical nature of the threat means it is impossible to communicate or obtain consent before the harm occurs.

It is imperative to note that the intervention must be limited to preserving life or mitigating serious injury and, as soon as the casualty is out of imminent danger, the MCA will apply and the SAR Operator must obtain consent or carry out a mental capacity assessment as soon as possible and treat accordingly (The Royal College of Emergency Medicine, 2017). Thus, the following rule may be formulated:

*A SAR Operator may treat a casualty without consent and dispense with a capacity assessment if there is an immediate threat of death or serious injury, and it is impractical to communicate or obtain consent prior to the harm occurring. The Operator must limit the interventions to the extent needed to preserve*

*life or mitigate serious injury and must attempt to obtain consent or make a capacity assessment as soon as the crisis has passed.*

Finally, it must be stressed, from the little case law available, the courts have generally taken a narrow approach to the Doctrine of Necessity, only allowing intervention without consent in truly dire and time-critical circumstances (see *ZH v The Commissioner of Police for the Metropolis* [2012] EWHC 604 (QB))

#### Use of restraint

Situations may arise where SAR Operators are faced with a combative patient, and while most of these circumstances can be defused verbally, some patients may become physically aggressive or hostile.

Here, the safety of the Operators must take priority, even at the expense of the casualty's care. If it is suspected the casualty may become combative, it is highly recommended that Police support is sought, as they are trained to de-escalate conflict and possess explicit powers of restraint and detention (if necessary) under the Police and Criminal Evidence Act 1986 and Mental Health Act 1983.

While the authors strongly advocate that SAR Operators avoid situations where physical aggression becomes an issue, given the unique operational capabilities and remit of Water Teams within UKSAR, facing a physically aggressive patient with no immediate Police support is not beyond comprehension. For this reason, the authors make the following three recommendations:

- 1) SAR Teams likely to encounter physically aggressive patients have robust operational and management procedures in place. These protocols should be evidence-based and follow best practice guidelines. Their objective should be to reduce the risk of being forced to use physical restraint, but also include contingency plans if such an incident were to occur.
- 2) These operational procedures should be supported by appropriate risk assessments, insurance, incident report mechanisms and policies. It is recommended that appropriate specialist advice is sought here.
- 3) Where possible, SAR Operators should be trained in the management of aggression. This needs to include guidance on relevant medical complications which can arise when from the use of restraint, particularly given that there is a plethora of evidence to suggest use of improper or inappropriate physical restraint techniques may cause serious injury or, in some circumstances, even death (Berzlanovich, Schöpfer & Keil, 2012). Finally, while a simple outline of the law regarding physical restraint is outlined below, *it is vital that SAR Operators and Managers seek up to date specialist legal advice on this.*

Regarding non-police personnel lawfully using physical restraint, such powers either derive from the MCA or the common law (encompassing the Doctrine of Necessity and Self-defence).

In regard to the MCA, under ss.5 and.6 MCA, the law provides legal protection for those who restrain (including both verbal threats constituting an assault, and physical restraint constituting a battery or false imprisonment) a patient in the course of treatment/rescue, when it is deemed that the patient lacks capacity and restraint is in their best interests (Owino, 2008). All force used under the MCA must be proportionate to the likely harm to the patient and only used for as long as is necessary for that person's protection (S.6 MCA). Any restraint, verbal or physical, exceeding a proportionate and necessary response is considered unlawful and may attract civil or even criminal liability. For example, in *ZH v The Commissioner of Police for the Metropolis* (as above), Police Officers were found to have acted unlawfully after removing and restraining a 16 year old patient with severe autism, after he jumped into a swimming pool when transfixed by the water.

At common law, while there is some uncertainty as to the extent of the Doctrine of Necessity, it is suggested that using force to prevent a patient from committing a serious act of self-harm will likely fall within its ambit, providing the above-mentioned requirements are met (Hale, 2017). Additionally, it is also suggested, under the Doctrine of Self-Defence, encompassing the defence of others, force may be used against a physically combative patient if they pose an immediate physical threat to a SAR Operator, his/her colleagues and other members of the public (see College of Paramedics, 2013 and *R. v Owino* (1996) 2 Cr App R 128). Like the MCA, only "proportionate" or "reasonable" force is permitted, whether under the Doctrine of Necessity or Self-Defence, and such force should be limited to the extent needed to prevent harm (Elliot, 2015).

### **Treatment, rescue and negligence**

A detailed analysis of the law surrounding negligence is beyond the scope of this article, but it is important that SAR Operators understand that any treatment or help rendered to a casualty must be performed with care, or the risk of a negligence claim arises.

When assessing the standard of care required by a SAR Operator, the courts apply the "*reasonable person test*", which for our purposes asks "*what would a reasonable SAR Operator have done in the circumstances?* (*Bolam v Friern Hospital Management Committee* [1957] 2 All E.R. 118)". The "*reasonable SAR Operator*" is ultimately a person with the same qualifications and training as the one being sued for negligence. Controversially, no account is taken of the SAR Operator's personal lack of experience or knowledge, thus even during an Operator's first ever live deployment, he or she is still capable of acting negligently (*Nettleship v Weston* [1971] 3 WLR 370).

In terms of legal protection for SAR Operators, the common law has offered a degree of protection to those engaged in socially desirable activities (Goudcamp, 2018). However, in recent years Parliament have enacted two statutes designed to provide some clear and explicit protection for those engaging in "good Samaritan acts", including acts of voluntary rescue (Partington, 2016). Firstly, S.1 Compensation Act 2006 stipulates that the court *may* consider when assessing a breach of duty, whether imposing such a standard may deter or prevent others from engaging in socially desirable activities. For example

the court is unlikely to find negligence liability in a situation where it would deter others from joining or forming SAR Teams. Secondly, S.2 and S.4 Social Action, Responsibility and Heroism Act 2015, states that when assessing whether there is a breach of duty, the court *must* consider whether the act was for the benefit of society or was performed in an emergency to assist an individual in danger.

These statutes have yet to be fully judicially tested and academic opinion has been mixed, as many feel in practice these acts do little more than restate the common law and more comprehensive protection is required (for discussion see Goudcamp, 2018 and Mulheron, 2017). Despite this academic discourse, there is a clear Parliamentary intention to provide legal reassurances to those who do act for the good of society. SAR Operators can work in the knowledge that the Courts will consider the altruistic context of rescue operations when assessing a claim (Goudcamp, 2018).

However, as with any affliction, prevention is better than cure, and thus 2 rules are suggested. Firstly:

*SAR Operators should take care to ensure they are up to date with and follow, insofar as possible, clinical and practice guidelines within their competencies when providing medical or performing rescue interventions.*

Following these guidelines will, in the vast majority of cases, defeat any negligence claim, although in rare circumstances the courts have chosen to ignore established guidelines and impose negligence liability on the basis that there is no logical basis for the guidance, but this is rare in practice (see *Bolitho v City & Hackney Health Authority* [1997] 3 WLR 1151). Secondly:

*SAR Water Teams should ensure their personnel are adequately trained to recognised standards and ensure that they only perform operations which are within their competence. Furthermore, they should wherever possible, make provisions for inexperienced Operators to be adequately supervised.*

Ensuring adequate training and supervision is vital, not only for protection against liability, but also for the safety of the SAR Operators themselves.

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## **Water related conditions & capacity**

### **Introduction**

As explored above, anything with the potential to impair any aspect of the outlined decision-making process will result in a person lacking capacity to consent. It is imperative that casualties are assessed holistically on their ability to make decisions, by applying the four-stage test outlined above. Nevertheless, a knowledge of conditions likely to be encountered and their effects on capacity may prompt a SAR Operator to question the casualty's ability to consent, and whether capacity needs to be assessed.

## **Mental Health Conditions**

Between 2003 and 2013, in the UK, 18,220 people ended their own lives (University of Manchester, 2015). Furthermore, in 2017 there were 5,821 completed suicides registered by the office for national statistics; of these, 249 people completed suicide by drowning (Suicides in the UK - Office for National Statistics, 2019).

### Depression

Depression remains the predominant mental health problem worldwide, closely followed by anxiety, schizophrenia and bipolar disorder. It is impossible within the remit of this article to consider every specific mental health illness affecting capacity, however, it is important to recognise, just like physical illness, seemingly stable mental health illnesses can quickly become unstable and decision-making ability can therefore become impaired. For example, someone who is actively depressed may not be able to weigh information in a way that would give them a positive outcome for the future, leading them to refuse life-saving treatment – or indeed they may, due to their psychopathology, wish for a negative outcome, leading to undue weight on this in the decision-making process.

### Bipolar disorder

Bipolar disorder is '*a brain disorder that causes unusual shifts in mood, energy and activity levels...*' (National Institute of Mental Health, 2016). As a result, people can experience a very low mood or 'depressive episode', similar to that mentioned above, or they can experience a 'manic episode' i.e. elation or euphoria associated with disconnected thoughts and/or poor judgement. Consequently, people experiencing manic episodes may put more weight on positive aspects of treatment, which may be unrealistic.

### Schizophrenia

Schizophrenic disorders involve the distortion of thought and perception. For example, a few characteristics include (a) 'delusions of control', i.e. they may feel they are being controlled by '*a higher power*' for example, which makes them perform certain activities; (b) 'thought withdrawal' or 'insertion', i.e. thoughts being placed into or withdrawn from their heads; and (c) auditory hallucinations, i.e. voices commenting on the patient (often derogatory) in the third person. As a consequence of disordered thought and/or perception, people can struggle to understand and retain information, as concentration is often impaired, as well as weighing the information, due to delusions of the 'higher power' over-ruling any decision.

### Dementia

Dementia is a progressive disease of the brain, leading to disturbed higher functioning in areas such as memory, comprehension, judgement, thinking, orientation and language. SAR Operators may encounter dementia patients with memory impairment and disorientation. It is important to recognise that, despite a person having a known dementia diagnosis, capacity must still be assessed. All 4 domains of capacity are likely to become affected in moderate to severe forms of dementia, as

comprehension, memory, thinking and language impairment all contribute to aspects of understanding, retention, weighing and communicating information.

### **Physical Health Conditions**

Mental capacity can also be affected by other more physical issues sustained for example by an accidental fall into water. Immersion is the 3<sup>rd</sup> leading cause of unintentional death worldwide (World Health Organisation, 2014). Common medical problems related to immersion encountered by water rescue teams are cold shock response, hypo and hyperthermia, head injuries and drug overdose/intoxication, to name a few.

#### Cold water Injuries

Cold shock response (CSR), caused by cold water immersion (CWI), has psychophysiological components. The physiological components are important, as CSR peaks within the first minute of CWI and hyperventilation occurs, leading to aspiration (i.e. breathing in the water) and ultimately death; however, this can partially be controlled psychologically. Anxiety can have a massive predictor on CSR and survival. Barwood *et al* (2018) noted that anxiety levels predicted respiratory response and, as a result, hyperventilation was less likely with lower anxiety levels. The psychological aspect of CSR is often paired with acute stress reaction or 'psychological shock'. It is important to recognise, that elements of psychological stress can include 'dissociative symptoms', such as dissociative amnesia. Here, patients may struggle to concentrate and remember information. Therefore, during a capacity assessment, they could fail in areas of understanding and retention.

#### Hypothermia

Bierens *et al* (Bierens, Lunetta, Tipton & Warner, 2016) note that hypothermia '*affects cellular metabolism, blood flow and neural function*'. The severity of symptoms usually correlates with temperature. Mild hypothermia at 35°C can cause some confusion, affecting a person's understanding during the capacity assessment, however, as the temperature drops further to 34°C, the person may experience amnesia which can affect their ability to retain information. Loss of consciousness can occur at temperatures around 30°C. At this point, patients should be treated in their best interests until capacity can be properly assessed when they regain consciousness.

#### Hyperthermia and dehydration

Hyperthermia is classified as a temperature greater than 38.5°C. Like hypothermia, it ranges from heat stress, which is relatively mild, to severe heat stroke, depending on the degree the temperature deviates from the normal range. With hyperthermia comes a spectrum of symptoms. As a result of slight increases in temperature, the body adapts in several ways, including sweat production as a means of evaporative cooling, however, the complication of this is dehydration. From early stages in hyperthermia, both physiological and psychophysical effects are noted. Akerman *et al* (Akerman, Tipton, Minson & Cotter, 2016) note the synergistic effects of dehydration and hyperthermia (particularly core hyperthermia) on reduced cerebral perfusion. This can cause confusion, irritability or loss of

consciousness. As above, at this point the Operator should treat the patient in their best interests until capacity can be formally assessed.

### Head Injuries

Head injuries are another potential injury encountered by SAR Teams, particularly those involved in Swift Water Rescue. Head injuries can cause concussion, which is defined by the American Academy of Neurology as “a clinical syndrome of biomechanically induced alteration of brain function, typically affecting memory and orientation, which may involve loss of consciousness” (Giza *et al*, 2013). Based on this, it can be assumed there is a high possibility, although often transient, that any of the 4 elements of capacity could be affected. As this is often temporary, it is particularly important to carry out a continuous capacity assessment.

### Drug or alcohol intoxication

The last common scenario for SAR Teams is drug or alcohol intoxication. Again, these effects are often temporary and so the rescuer must be aware of potentially rapid changes in capacity. Intoxication, i.e. administration of a psychoactive substance, can have many psychophysiological responses, including alteration of a person’s cognition, perception or judgement, which may lead them to endeavour in risk taking behaviour, such as that involving water bodies.

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## Conclusion

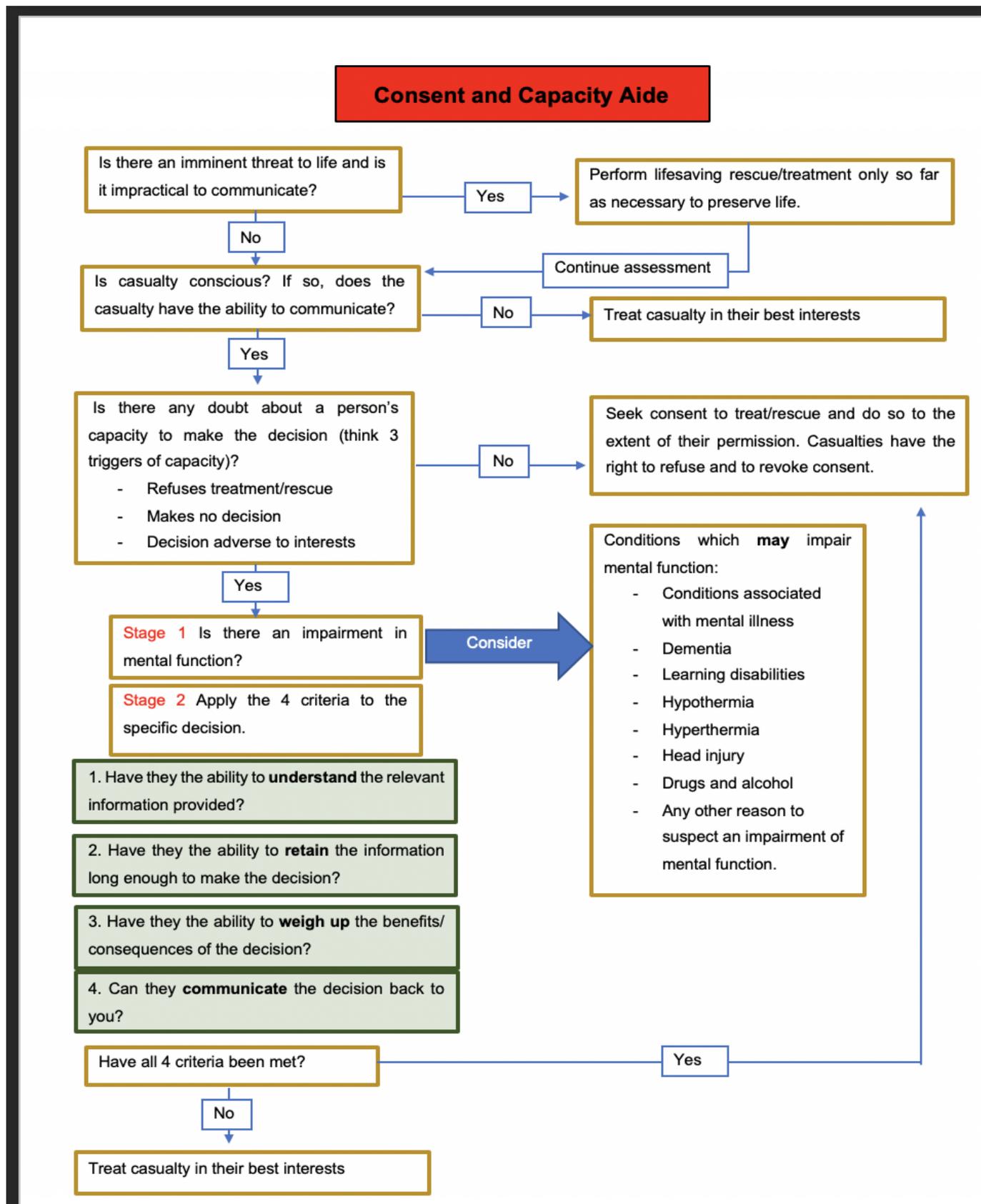
From this article, what is perhaps apparent is that the law surrounding consent, capacity and necessity is complex and sometimes unclear. Professionals often grapple with definitions of the aforementioned concepts, furthering confusion amongst those with no formal training in applying these principles. Throughout this article, the authors have attempted a balance, giving the reader a technical insight into the law, while also trying to provide some practical advice on its application by formulating a series of rules, which are summarized as follows:

- 1) *An Operator must seek permission from a casualty before he/she performs any medical or rescue intervention*
- 2) *“A person must be assumed to have capacity unless it is established that he/she lacks capacity.”*
- 3) *A SAR Operator must tell the Casualty what they are going to do for each intervention (whether it be performing a rescue manoeuvre (e.g. a hoist) or medical procedure)*
- 4) *If one of the “3 triggers of capacity” is present, then a SAR Operator must take all reasonable steps to carry out a mental capacity assessment*
- 5) *A SAR Operator must consider if there is anything he/she can practicably do in the circumstances which would assist a casualty in meeting the mental capacity criteria.*
- 6) *When treating a casualty without mental capacity, SAR Operators should follow their medical/rescue training to the extent of preserving life, making every effort to involve the casualty insofar as possible in his/her treatment (e.g. telling the casualty what is happening and accommodating reasonable requests)*

- 7) *A SAR Operator may treat a casualty without consent and dispense with a capacity assessment if there is an immediate threat of death or serious injury, and it is impractical to communicate or obtain consent prior to the harm occurring. The Operator must limit the interventions to the extent needed to preserve life or mitigate serious injury and must attempt to obtain consent or make a capacity assessment as soon as the crisis has passed.*
- 8) *SAR Operators shall always place the safety of themselves, their colleagues and members of the public above the safety of the casualty.*
- 9) *SAR Operators should take care to ensure they are up to date with and follow, insofar as possible, clinical and practice guidelines within their competencies when providing medical or performing rescue interventions.*
- 10) *SAR Water Teams should ensure their personnel are adequately trained to recognised standards and ensure that they only perform operations which are within their competence. Furthermore, they should wherever possible, make provisions for inexperienced Operators to be adequately supervised.*

We have also included a simple flowchart (see Figure 3) which may be used on operations as a simple prompt to the *10 Golden Rules for consent capacity and necessity*.

Figure 3- Consent and Capacity Aid mem



REMEMBER:-

Capacity is both

- ◇ **DECISION** dependent, and
- ◇ **TIME** dependent

It can also be TRANSIENT therefore must be continuously assessed throughout patient contact.

Disclaimer: While every effort has been made to ensure that the information in this article is correct at the date of publication, both the law and medical guidelines change. This article does not constitute proper legal or medical advice and it is for academic purposes only.

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## Abbreviations

- E&W “England & Wales”
  - ECtHR “European Court of Human Rights”
  - ECHR “European Convention on Human Rights”
  - CSR “Cold Water Response”
  - CWI “Cold Water Immersion”
  - MCA “Mental Capacity Act 2005”
  - SAR “Search & Rescue”
  - UKSAR “United Kingdom Search & Rescue”
  - NHS “National Health Service”
  - The Code “The Code of Crown Prosecutors”
  - IV “Intra-venous”
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