Neutral Citation Number: [2019] EWCOP 10

Case No: COP 13402860

IN THE COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 21/03/2019

Before :

MRS JUSTICE LIEVEN DBE

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Between :

East Lancashire Hospitals NHS Trust	**Claimant**
- and -	
PW	**Defendant**
(by his litigation friend the Official Solicitor)	

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Miss Twist (instructed by **Hempsons**) for the **Claimant**

Mr Lawson (instructed by the **Official Solicitors Office**) for the Defendant

Hearing dates: 13 & 14 March 2019

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Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

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MRS JUSTICE LIEVEN

This judgment was delivered in private. The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of the incapacitated person and members of their family must be strictly preserved. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

Mrs Justice Lieven DBE :

1. This is an application by East Lancashire NHS Trust for orders under the Mental Capacity Act 2005 that PW lacks capacity "to make a decision regarding whether to undergo the leg amputation surgery to address his high risk of sepsis"; and that it is lawful to carry out that surgery having regard to his best interests. Before dealing with the substantive issues in this case I will deal with the timing of the application.

2. The application came before me on an extremely urgent basis on Wednesday 13th March 2019. The application was only lodged with the Court late on the 12th and I understand that the Official Solicitor was only sent the draft application at around 4pm on the 12th. I am in the circumstances most grateful for the assistance that I received from the Official Solicitor's counsel, Mr Lawson and individual solicitor, Mr Beck. The application said that matter needed to be considered within one day and the witness statement of Dr L, and a letter from the Trust to the Court of Protection, said that the surgery was required within the next 48 hours.

3. However, it was entirely apparent from the papers that the application had been in the course of preparation for at least a month, and that the clinical team at the treating hospital had been contemplating the need for the surgery for 9-12 months. I will explain the medical background below. Although the matter had become extremely urgent because PW's foot had deteriorated when PW attended the Hospital on 12 March, this deterioration was entirely predictable and indeed had been why the application started to be prepared in mid-February.

4. In these circumstances this application could and should have been made some weeks ago, even if at that stage it was on a slightly more precautionary basis. The effect of the delay has been detrimental to PW's interests and to a fair process which could fully take into account his wishes. The timing of the application has meant that the Official Solicitor had no time to visit PW and discuss the operation and his views with him; it has meant that there has been no time for the Independent Mental Capacity Advocate (IMCA) to visit him before the hearing , the last visit was in July 2018; and the OS has had no time to instruct an independent doctor for another opinion if he had felt one was justified.

5. Although I spoke to PW over the phone, in order to try to understand his wishes and feelings, it would have been much better for the Court and PW if the OS had been able to visit him and prepare a report for the Court. The delay in making the application has therefore been contrary to PW's interests. I should make clear that it has been possible to achieve a fair process here, not least because as I explain below it is my view that ultimately the decisions I have to make on the evidence are fairly clear-cut. However, this application should have been made weeks ago.

6. In NHS Trust 1 v G 2015 1 WLR 1984 and A University Hospital v CA 2016 EWCOP 51, Keehan J and Baker J emphasised the need for timely applications. In G Keehan J gave guidance on the procedure that should be followed in order to avoid the kind of extreme urgency and rushed applications that I had to deal with in this case. He said in the Annex to his judgment at [18] to [21]:

> *"18. Where it is decided that P's case falls within one of the four categories set out in para 3 above or it is otherwise decided to*

> *make an application, an application should be made to the court at the earliest opportunity*
>
> *19. Save in case of genuine medical emergency, any application should be made no later than four weeks before the expected date of delivery. This time frame is required for the following reasons: (i) where P is assessed as lacking capacity to litigate, it will enable the Official Solicitor to undertake any necessary investigations; (ii) to ensure the final hearing is listed and heard at least a few days before the proposed interventions; and (iii) to enable a directions hearing to be held around two weeks before the final hearing. The court and the parties will then have the opportunity to ensure the court has all the relevant and necessary evidence at the final hearing.*
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> *20. In compliance with the timetable set out above, the trusts should in a timely manner, take the following steps: (i) issue the application'; (ii) notify the Official Solicitor of the application; (iii) disclose any evidence to the Official Solicitor which they consider appropriate; (iv) seek an urgent directions hearing, preferably around two weeks before the final hearing, at which disclosure and the scope of the evidence can be determined; (v) liaise with the clerk of the rules to list the substantive hearing at an early stage.*
>
> *21. It is important that the trusts should seek early advice and input from their legal advisers."*

7. This Guidance was reiterated by Baker J in A University Hospital, who said at [5]:

> *"I hope that those responsible for managing the case within the Trust will carry out a proper investigation as to the causes of this delay. Hereafter, all NHS Trusts must ensure that their clinicians, administrators and lawyers are fully aware of, and comply with, the important guidance given by Keehan J in respect of applications of this sort."*

8. Although both of these cases concerned orders allowing caesarean sections, the same principles must apply to medical interventions which are predictable and where there is a very strong likelihood, if not an inevitability that an application to the Court of Protection would be needed. There was no benefit to PW in waiting to make this application, and for the reasons above very strong disbenefits. The guidance given by Keehan J should have been followed in a case such as this.

9. As in *A University Hospital* the Trust is to carry out an investigation into the delay and provide the Court and Official Solicitor with the outcome.

The background

10. The background to this case is that PW is a 60-year-old man with a diagnosis of paranoid schizophrenia. PW has been living in a care home (described as a specialist psychiatric care facility) since at least 2016, initially subject to a Community Treatment Order under MHA 1983 and now a standard authorisation. PW also has diabetes. In April 2016 he was admitted to hospital as an emergency with sepsis related to a severe diabetic foot infection to his left foot. He had an emergency amputation to part of the foot. It seems that he was considered to have capacity at this time, although that is not entirely clear from the papers. That operation led to the loss of all but one of the toes on his left foot, and the partial removal of his ankle joint. This operation was only partially successful in as much as the immediate risk to PW receded, but the left foot continued to be highly problematic.

11. In July 2018 PW's clinical team considered four options – a below the knee amputation; a pin in PW's leg to secure the ankle; a continuation of treatment solely through the use of antibiotics and no treatment. Dr L, the consultant physician, completed a mental capacity assessment stating that PW lacked capacity to make a decision regarding the proposal for an amputation. At that stage an IMCA was instructed and visited PW at the care home on four occasions. Her report is dated 25 July 2018. Unfortunately, for the reasons I have given above, her report is the most recent written evidence of PW's wishes. What is set out in that record very much accords with what PW said over the phone to the Court.

12. The key parts of the IMCA report are as follows:

    i) PW said that he did not have diabetes;

    ii) He said that his leg was not infected;

    iii) He said he did not want the operation because he wanted to keep his foot and his leg and he felt he would not be able to walk properly and might need a wheelchair if he had the operation;

    iv) He thought his foot could continue to be treated by antibiotics and he referred to believing that his toes could grow back. He said to the IMCA that his GP surgery, the X Medical Centre, could fix his foot.;

    v) On the second visit he said "I don't want to die. I am only 60".

13. At all four visits PW remained adamant that he did not want the operation. The IMCA explained to him that if he did not have the operation there was a risk that the infection might spread and he would have to have a more serious operation. She reported that he accepted the better operation would be a below the knee operation, but did not think that this would be needed.

14. The IMCA's conclusion was "*P is consistent and unwavering in his view that he would not like a below the knee amputation and that if this was to go ahead against his wishes he would feel angry and deeply unhappy*".

15. There was a best interests meeting held on 31 July 2018, with Dr L, Mr B (orthopaedic surgeon) and Dr M (the consultant psychiatrist who subsequently provided a capacity assessment for the court). PW attended that meeting and reiterated that he did not want the operation and he believed that his foot could be grown back. No further action was taken at that stage, possibly because of PW's opposition to the operation although a decision was made to issue an application in the Court of Protection.

16. In February 2019, PW attended hospital and was seen by Dr L and Dr B. I have seen a letter from Dr B dated 19/2/19 explaining that PW's foot was slowly deteriorating and making clear that a further operation was highly likely but saying;

> *"at the moment P's quoted protection situation is unresolved. I do not feel that we would justify operating on his foot without his full consent which we do not have. Therefore, at the moment, I think we have to press on with supportive care. We have asked P again to think about the option of surgical treatment.*
>
> *The view of the multi-disciplinary team was that the only surgical option with any reasonable chance of success was a trans-tibial amputation would be the least restrictive and the most likely to restore P's good function at the lowest risk."*

17. In his witness statement Dr L explains how PW's foot had deteriorated since the best interests meeting in July 2018, the consideration in February 2019 and the options which had been considered. Since the operation in 2016, PW's foot has been managed by having a below the knee cast. However, the ankle has become increasingly unstable and this has led to skin ulceration and initially superficial infection. In mid-February the ulceration spread to the weight bearing part of the foot. At this point there was a multidisciplinary discussion and options were again discussed with PW. The existing treatment was agreed by the clinicians to be failing and no longer to be sustainable. If the team simply waited for an emergency admission there was an increased risk that the subsequent operation would have to be more extensive and could involve removal of the leg above the knee, because infection could spread rapidly through the bone and up the leg. This operation would be significantly more disabling for PW because it would be much more difficult to learn to walk with a prosthetic leg above the knee joint.

18. There is also a risk that leaving the operation would allow infection to spread into the bloodstream with potential effects on other organs, and thus a material (though hard to quantify) risk that PW could die. There was consideration of a different operation with the ankle being fixed with a pin. However, this option is very unlikely to stabilise the ankle, and would lead to further problems in the cast, which itself is extremely likely to create further infection. The pin itself was likely to lead to further infection. When Dr L gave oral evidence (on the phone), he was asked a number of questions about this option. It was apparent to me that it was not a realistic option to provide even a short-term solution to the problems with PW's left foot. The ankle would not be stable, and as such either catastrophic injury and/or further infection, would follow. All these options were discussed with PW and he continued to refuse to accept amputation.

19. At this point, mid-February 2019, preparations for an application to the Court were commenced. However, before the application was made PW was admitted to hospital as an emergency on 12 March at 12pm. There is now significant swelling and redness around the residual left ankle joint, and fluid is draining from the deeper tissues. Dr L said that this was consistent with deep infection possibly involving the bone. He is being treated with intravenous (IV) antibiotics however the most recent culture from the wound indicates that the bacteria is showing some resistance to the first antibiotic used. This increases the risk of the infection spreading and antibiotics being less able of controlling the spread.

20. This was the state of the evidence on 12 March. On 13 March Dr L gave oral evidence, and having done so I asked him to return to the hospital to check whether there was any further information, either in terms of cultures returned from the laboratory or in respect of PW's leg. The position however remained effectively the same as in the oral evidence given earlier, and the written evidence of the previous day.

21. The evidence on capacity also remained the same as in the documentation. PW spoke to the Court on the phone, and was asked some questions by Mr Lawson and myself. He was articulate and appeared to understand the information he had been given, in as much as he could to some extent repeat it. However, he was adamant that he did not want an amputation. He repeated to the Court at least twice that he believed his GPs (at the X surgery) could treat the infection with antibiotics). He did not accept the possibility, indeed probability, that if he did not have the amputation the operation would become more serious and disabling.

22. I have to consider two issues under the Mental Capacity Act 2005: firstly, does PW have capacity to make the decision in question; and secondly, is it in his best interests to have the operation. The principles to be applied were helpfully summarised by Peter Jackson J (as he then was) in *Wye Valley NHS Trust v* B 2015 COPLR 843 at [5] relying on the decision of the Supreme Court in *Aintree University Hospital NHS Trust v James* [2014] 1 AC 591:

> *"(1) Every adult capable of making decisions has an absolute right to accept or refuse medical treatment, regardless of the wisdom or consequences of the decision. The decision does not have to be justified to anyone. Without consent any invasion of the body, however well-meaning or therapeutic, will be a criminal assault.*
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> *(2) Where there is an issue about capacity:*
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> *• A person must be assumed to have capacity unless it is established that he lacks capacity: s.1(2) .*
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> *• 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: s.2(1)*
>
> *• The question of whether a person lacks capacity must be decided on the balance of probabilities: s.2(4) .*
>
> *• 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: s.1(3)*
>
> *• A person is not to be treated as unable to make a decision merely because he makes an unwise decision: s.1(4) .*

• A lack of capacity cannot be established merely by reference to—
(a) a person's age or appearance, or
(b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about his capacity: s.2(3) .
(3) A person is unable to make a decision for himself if he is unable to understand the information relevant to the decision, to retain, use and weigh that information, and to communicate his decision: s.3(1) .
(4) Where a person is unable to make a decision for himself, there is an obligation to act in his best interests: s. 1(5) .
(5) Where a decision relates to life-sustaining treatment, the person making the decision must not be motivated by a desire to bring about death: 4(5).
(6) When determining what is in a person's best interests, consideration must be given to all relevant circumstances, to the person's past and present wishes and feelings, to the beliefs and values that would be likely to influence his decision if he had capacity, and to the other factors that he would be likely to consider if he were able to do so: s.4(6) .
(7) So far as reasonably practicable, the person must be permitted and encouraged to participate as fully as possible in any decision affecting him: s.4(4) . "

23. A person does not have to be able to comprehend every detail of the decision to be decided, but just the salient points *LBL v RYJ* [2010] EWHC 2664.

24. In terms of the approach to best interests, Baroness Hale in *Aintree v James* at [35] said:

> *"The most that can be said, therefore, is that in considering the best interests of this particular patient at this particular time, decision makers must look at his welfare in the widest sense, not just medical but social and psychological; they must consider what the outcome of that treatment for the patient is likely to be; they must try and put themselves in the place of the individual patient and ask what his attitude to the treatment is or would be likely to be; and they must consult others who are looking after him or are interested in his welfare, in particular for their view of what his attitude would be."*

25. Where a patient lacks capacity it is of great importance to give proper weight to their wishes and feelings and to the patient's own beliefs and values. I have had close regard to *Wye Valley NHS Trust v* B, referred to above, because that case had some similarities with the present. B was a 73-year-old man with a severely infected leg, without an amputation the inevitable outcome would be that he would shortly die. B had schizoaffective disorder and strongly objected to undergoing the operation. Peter Jackson J found at [34] that B did not have capacity and said that he did not understand the reality of his injury and thought he would get better with proper care. B was having auditory hallucinations and he had said that the Lord did not want him to have his leg amputated.

26. Peter Jackson J found that B did not have capacity because he had a clear inability to weigh the relevant information as part of the process of reaching a decision. The Official Solicitor had argued that weight should be given to B's wishes and feelings, and value given to his religious beliefs. The Judge found that it would not be in B's best

interests to force him to have the operation against his wishes [45]. The reason for this conclusion was that B's religious beliefs were deeply meaningful to him, and that to force him to have the operation would be to take away his little independence and dignity to replace it with a future he had little appetite for [45]. B had said that he was not afraid of dying.

Capacity

27. The first issue I need to address is whether PW has capacity to make the decision about treatment decisions regarding his foot. I have reached the view on the evidence that he does not. I rely upon the assessment of Dr M and Dr L, as well as hearing PW's evidence to the Court. PW's diagnosis is of paranoid schizophrenia with treatment resistant delusional beliefs. He also has a cognitive impairment which means that his ability to understand and weigh up information is reduced. According to Dr M he has no insight that his beliefs are false. In Dr M's view PW is unable to understand the risks of not having the operation, despite having been given patient friendly information, and in particular he does not understand the danger to his life through sepsis. Dr M is also of the view that PW cannot use or weigh up the information as part of his decision making. Dr L's evidence entirely accords with this.

28. I accept Dr M's evidence. The evidence that PW gave over the phone entirely supported what Dr M said, that PW is delusional in his belief that his foot can be healed, and that he does not understand the risks in not having the operation. He has remained entirely fixed in this view over a prolonged period despite obvious deterioration in his foot. His references to the GP being able to heal his foot indicate a clear inability to process or comprehend the information he is being given and the universal medical advice he is receiving.

Best Interests

29. I turn then to PW's best interests. The medical evidence is overwhelming, that if PW does not have the below the knee amputation now then certain consequences will follow. Either the infection will spread and he will need a much more debilitating operation and in a worst case scenario die from sepsis which spreads before it can be controlled; or in a best case there will be a brief improvement from the IV antibiotics but his foot will inevitably become infected again.

30. I accept Dr L's evidence that if PW does have the operation there is a good prospect that he will be able to cope well with the prosthetic leg below the knee.

31. There is no benefit in the alternative operation of inserting a pin into the bone, as it is again inevitable that the infection will return and again there is a risk that the subsequent operation will be more serious or the infection will rapidly spread. Although investigating the option in questions to witnesses, Mr Lawson did not seek to persuade me the alternative operation was in PW's best interests, or was an appropriate alternative to the below the knee amputation.

32. I am very aware of the fact that PW is strongly opposed to having an amputation. This is based at least in part on having had the previous amputation and not wanting an operation. Those are perfectly understandable feelings that would be shared by many. However, the medical evidence shows that PW is either going to have to have an

amputation, or the infection will spread and he will die (though in an uncertain time frame). In my view, following Peter Jackson J in B, it is appropriate to give weight to PW's wishes and feelings, even though he does not have capacity, and given that those wishes are clearly expressed, strongly and consistently held, give them considerable weight. However, unlike B, PW does not want to die. He does not understand the choices he faces - he is labouring under a delusion that there is an alternative, namely IV antibiotics, which the medical evidence shows will not solve or materially alleviate the condition.

33. PW is a 60 year old man, so significantly younger than Mr B, and who if he has the below the knee amputation has a good prospect of regaining mobility, and indeed be in better physical health than he has been in the recent past. I also do not think, though I cannot be totally confident on this, that PW's opposition to the operation is as deep seated, or as fundamental to his dignity, as was Mr B's. I am therefore hopeful that the impact of him having the operation, albeit against his wishes will not fundamentally undermine his dignity and his independence.

34. For these reasons I have reached the clear view that it is in PW's best interests to have the operation. I also take into account the fact that there is a care plan in place to assist him, both before and after the operation, and that further work is to be done on the post-operative care plan. Having heard Dr L give evidence I have every confidence that PW will be given the best and most thoughtful care possible in coming to terms with the aftermath of the operation.