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IN THE HIGH COURT OF JUSTICE

FAMILY DIVISION
COURT OF PROTECTION
[2020] EWCOP 27

Royal Courts of Justice
Strand
London, WC2A 2LL

Thursday, 21 May 2020

IN THE MATTER OF **THE MENTAL CAPACITY ACT 2005**

Before:

THE HONOURABLE MRS JUSTICE GWYNNETH KNOWLES

(Sitting as a Judge of the Court of Protection)

(In Private)

B E T W E E N :

UNITED LINCOLNSHIRE HOSPITALS NHS FOUNDATION TRUST — Applicant

- and -

(By her litigation friend, the Official Solicitor) — Respondent

Q

REPORTING RESTRICTIONS APPLY: Court of Protection Rules 2007

MS N. KOHN appeared on behalf of the Applicant.

MS C. WATSON appeared on behalf of the Respondent.

J U D G M E N T

MRS JUSTICE KNOWLES:

1. This is an application by a hospital trust for, firstly, a declaration as to the capacity of Q, a 57-year-old woman, first to conduct these proceedings and, second, to make decisions about her dental treatment, and secondly, for a best interests decision and order as to whether (i) she should undergo full dental clearance under general anaesthetic, and (ii) whether she should receive intramuscular sedation to facilitate her transfer to hospital to undergo this dental surgery. I have case managed this application since its issue on 11 March 2020. The matter is listed for final hearing today.

2. Q's interests in the proceedings are represented by the Official Solicitor. Following the receipt of further witness evidence and an advocates' meeting on 14 May, both the applicant and the Official Solicitor are agreed as to the orders they invite me to make. I note also that Q's sister has filed a witness statement and is, I record, in agreement with the orders sought by the applicant and now endorsed by the Official Solicitor.

3. The agreement of the parties and of Q's sister is welcome but does not absolve this court from coming to its own conclusions as to whether what is proposed is in Q's best interests. I am very grateful to Ms Kohn on behalf of the applicant Trust and to Ms Watson on behalf of the Official Solicitor for their position statements, for the production of a useful electronic bundle, and for their participation in what was clearly a very productive advocates' meeting on 14 May. I have read all that material before the court in coming to my decision today.

4. First, I set out a little of the background. Q is now 57 years old. She has profound and lifelong learning disabilities together with epilepsy. Sadly, she also has impaired eyesight and is registered blind. She has mobility difficulties which necessitate the use of a wheelchair. Those who care for her believe her to suffer from some form of autistic spectrum disorder and it is clear that, from time to time, she displays extremely challenging behaviour to her carers. Q lives in a supported living placement with two other residents and has 24-hour care and supervision. She has lived there for about 14 years. She is highly resistant to changes in the very rigid structure of her daily life and she can reject attempts to provide her with personal care. For many years, she has resisted any proper or thorough dental hygiene.

5. In March 2018, the Special Care Dental Service was asked to see Q due to concerns raised by her carers that she was experiencing dental pain. She was seen to be frequently rubbing or touching the left side of her mouth, was refusing food, and when she did eat, she was mainly chewing on the right side,

6. On 29 May 2018, a domiciliary visit was carried out by a dentist from the community dental service. Ongoing concerns about Q refusing food, rubbing her tongue against her teeth, and sucking on her teeth were all reported. Her carers reported that her gums bled all the time and there was limited cooperation from Q with toothbrushing. The dentist who attended Q on that occasion noted that it was difficult to examine her but, on a simple visual look at her upper anterior teeth, her gums were red and swollen with visible recession and bone loss.

7. On 9 November 2018, Q was referred to the maxillo-facial surgeons at the local hospital for a full dental clearance under general anaesthetic. The referral was acknowledged in March 2019 and the surgery was scheduled to take place on 18 September 2019. However, it was cancelled on the day of the operation as Q had a prolonged seizure of around six minutes whilst getting ready to come to the hospital.

8. Best interests meetings were held on 20 November 2019 and 11 February 2020 and it was agreed by everyone present that it would be in Q's best interests to undergo the proposed dental surgery

and to receive intramuscular sedation to facilitate her transfer to and from hospital. Accordingly, the applicant NHS Trust made an application to this court for an order and declarations that Q lacked the capacity to make decisions about her dental treatment, in particular, whether she should undergo a full dental clearance under general anaesthetic. It was submitted that it was in her best interests to undergo full dental clearance under general anaesthetic to relieve the pain and discomfort caused by periodontal disease and to receive sedation to facilitate her transfer to hospital to undergo such surgery. I note that the applicant is particularly concerned that the deterioration in Q's oral health is compromising her health generally, causing her pain, and complicating her enjoyment of food which is one of her great pleasures in life.

9. I turn to the legal framework which is well known and is helpfully summarised in paragraphs 11-15 of Ms Kohn's position statement.

10. The principles to be applied under Part 1 of the Mental Capacity Act 2005 ["MCA"] are familiar and are summarised in outline form below. Sections 1 to 3 of the MCA set out the principles by reference to which the capacity of those over the age of 16 is to be determined. Insofar as they are relevant to this application, the MCA provides that:

    a) A person must be assumed to have capacity unless it is established that she lacks capacity: s.1(2) MCA. The burden is on the party asserting a lack of capacity to establish it on the balance of probabilities: CC v KK & STC [2012] EWHC 2136 (COP) per Baker J at paragraph 18.

    b) A person is not to be treated as unable to make a decision unless all practicable steps to help her do so have been taken without success: s.1(3).

    c) The determination of capacity under Part 1 of the MCA is always "decision specific".

    d) Any lack of capacity must result from an impairment of, or a disturbance in, the functioning of a person's mind or brain: s.2(1).

    e) It does not matter whether the impairment or disturbance in the functioning of the mind or brain is permanent or temporary: s.2(2).

    f) A lack of capacity cannot be established merely by reference to an aspect of her behaviour, which might lead others to make unjustified assumptions about her capacity: s.2(3).

    g) A person is to be treated as unable to make the decision on the matter in issue for herself if she is unable to (i) understand the information relevant to the decision; (ii) retain that information; (iii) use or weigh that information as part of the process of making the decision; or (iv) communicate that decision: s.3(1).

    h) The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent her from being regarded as able to make the decision: s.3(3).

    i) The "information relevant to the decision" includes information about the reasonably foreseeable consequences of deciding one way or another: s.3(4)(a).

    j) The court should guard against overcomplicating what is "the information relevant to the decision" for the purposes of s.3. As Baker J stated in paragraph 69 of CC v KK & STCC [2012] EWHC 2136 (COP), it is not necessary for a person to demonstrate a capacity to understand and weigh up every detail of the respective options, but merely the salient factors.

11. In determining the question of best interests, the MCA provides that:

a) Any act done or taken in respect of a person who lacks capacity must be in her best interests: s.1(5).

b) The decision-maker must consider whether the purpose for which the act or decision is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action: s.1(6)

c) The person making a best interests determination must consider all the relevant circumstances (s.4(2)), including:

(i) A person's past and present wishes and feelings, so far as is reasonably ascertainable (s.4(6)(a));

(ii) The beliefs and values that would be likely to influence the person's decision if she had capacity (s.4(6)(b));

(iii) The other factors that she would be likely to consider if she had capacity (s.4(6)(c));

(iv) The views of family members and other engaged in caring for the person or interested in her welfare (s.4(7)).

d) The person making a best interest determination must, so far as is reasonably practicable, permit and encourage the person to participate, or improve her ability to participate, as fully as possible in any act done for her and any decision making affecting her: s.4(4).

In assessing best interests, the court is not limited to consideration of best medical interests: best interests encompasses medical, emotional, psychological and social issues (Re MB (An Adult: Medical Treatment) [1997] 8 Med LR 217 at 225; Aintree University Hospitals NHS Foundation Trust v James and Others [2013] UKSC 67 at paragraphs 39-40).

12. Turning to the question of capacity, there is, if I may say so, a wealth of evidence before the court that Q lacks the capacity to conduct these proceedings and to make decisions about her dental treatment. I do not propose in this judgment to identify each statement dealing with that issue, but I summarise the position as follows.

13. Firstly, Dr A, the associate specialist in oral surgery, carried out an assessment of Q's capacity to consent to full dental extraction under general anaesthetic on 5 March 2019. Dr A was assisted by Q's carers and used language that Q was used to hearing to explain to her that her teeth were wobbly and causing her pain and that this was why they needed to be removed. Q was unable to respond in a way which suggested that she understood either what Dr A was saying or indeed what was happening. She did not respond verbally at all and according to Dr A, lacked an understanding that the dental examination Dr A tried to carry out during the course of that assessment was part of a process which would have a positive impact on the amount of pain in her mouth that she was experiencing.

14. Secondly, Q's carers are of the view that she has always lacked capacity regarding her dental treatment, and this has been unchanged for many years. The manager of the home where Q lives and who has known her for the last three years is clear in her evidence to the court that Q has no understanding or awareness that she is attending medical or dental appointments even when told so by her carers. Q does, however, understand she is going out from her home and this triggers

anxiety and distress which is often accompanied by challenging behaviours where she is assaultive of staff.

15. Finally, Q's sister, Z, confirms that Q's ability to communicate is very limited and sometimes unreliable. She cannot convey what she understands verbally and instead communicates by shouting, grabbing, hugging, or using single words to convey her needs.

16. Looking at the variety of material from those who know Q very well, and from those involved in her care, I am satisfied, on the balance of probabilities, that Q lacks capacity both to conduct these proceedings and to make decisions about her dental treatment. It is plainly evident that Q has no ability to understand the most basic of discussions about oral hygiene or dental treatment. She cannot, in my determination, understand, retain, use, or weigh any of the information relevant to the decision whether or not to have such treatment, specifically full dental clearance, or the sedation and transport necessary to carry out such treatment.

17. I turn now to best interests. The applicant Trust has served detailed evidence which sets out the background to the application and the available options for the treatment of Q's periodontal disease and a detailed statement has also been served from Dr A, the associate specialist in oral surgery, in which she describes the available treatment options for Q's dental condition, including the risks and benefits associated with each of them. That evidence establishes, firstly, that Q has been seen by the community dental service and has been diagnosed with severe periodontal disease in November 2018. Secondly, Q will not tolerate basic mouth care and her carers have encountered increasing difficulties brushing her teeth. Thirdly, there is a belief that Q is experiencing pain and discomfort in consequence of her untreated periodontal disease. For example, she has developed increased salivation and refused food, leading to significant weight loss of around 6 kgs by February 2020. The records disclosed by the home indicate that she has lost 10.5 kgs of weight between March 2019 and March 2020. Since March 2019, Q has also shown an increased reluctance to leave her home which may be linked to her periodontal disease.

18. It is clear that, if Q does not receive dental treatment, there is a risk that her disease and tooth decay will get worse. Untreated, this is likely to increase her dental pain, her salivation, and the refusal of food which would in turn put Q at risk of malnutrition, dehydration, and increased seizures since her epilepsy medication is administered with her food. If left untreated, Q's periodontal disease may be a source of infection and she would be at risk of developing sepsis. The risks of surgery are low, and Q's medical records indicate that she has previously undergone surgery under general anaesthetic on at least five occasions without any complications. There have been unsuccessful attempts to bring Q to hospital for assessment and surgery. She was too unsettled and distressed to leave her home in May 2019 and she suffered a prolonged seizure when carers were getting her ready to go to the hospital in September 2019. To minimise her distress, intramuscular sedation with ketamine is recommended. This is considered a safe drug which can be administered in a manner consistent with Q's morning routine.

19. The applicant trust has served evidence from a consultant neurologist who has addressed the management of Q's epilepsy during the proposed dental treatment and confirms that Q's epilepsy can be effectively managed on the day of surgery and that there is, in his opinion, no increased risk to her in taking a dose of her epilepsy medication prior to surgery or in taking that medication alongside the administration of ketamine.

20. There is also evidence from a consultant anaesthetist who indicates his support for the proposed plan and says that Q can be safely sedated with ketamine to transfer her to hospital, that this drug will reduce the risk of seizures, and minimise her awareness of the lead up to general anaesthesia. In his opinion, the risks associated with general anaesthetic are no greater for Q than any other

patient and are outweighed by the benefit of undergoing dental treatment to relieve her current pain and discomfort.

21. Best interests meetings were held in November 2019 and February 2020, attended by clinicians from the Trust, representatives from the learning disability liaison team, representatives from the home where Q lives, and Q's sister, Z. At the first meeting, the option of full dental clearance was discussed, and further discussion took place in February 2020 regarding the use of oral or intramuscular sedation to facilitate Q's transfer to hospital for the surgery. All those present agreed that it would be in Q's best interests to undergo the proposed surgery and to receive intramuscular sedation to facilitate her transfer to hospital for that surgery.

22. The Official Solicitor, quite properly, explored whether Q was still experiencing dental pain. The manager of the home, Ms B, clarified that Q salivates constantly and continues to refuse some meals and oral care. She will only eat on the right side of her mouth and seems more anxious at mealtimes. She has been seen to have small amounts of blood in her saliva when she puts her thumb in the left side of her mouth and whenever a toothbrush touches her gums, blood is present. It is reasonable, in my view, to infer that Q continues to experience dental pain.

23. Additionally, the Official Solicitor was anxious to ascertain whether alternative and less invasive treatment options had been considered by the Trust. On receipt of answers to her questions from Dr A, the Official Solicitor is reassured that a comprehensive assessment of Q's dental health will be carried out once she has been conveyed to hospital and, if there are any teeth which are sound and firm and likely to remain so for a reasonable period, that Dr A will exercise her clinical judgment to decide whether these teeth should be retained rather than extracted. Though as a result of the COVID-19 crisis the Official Solicitor has been unable to instruct an independent expert in special care dentistry, it is accepted by her that the evidence filed in support of Q's dental care plan is comprehensive and thoughtful. Again, by reason of the COVID-19 crisis, the Official Solicitor has been unable to visit Q to ascertain her wishes and feelings. She does however accept, having read the minutes of the meeting undertaken by Ms B with Q on 30 April 2020, that Q's ability to communicate is very limited indeed due to her severe learning disability. It is thus difficult to ascertain with any certainty what Q's wishes and feelings are about the proposed dental treatment. I agree.

24. I have reviewed the care plan and the plan to transfer Q to hospital in order that she might receive dental treatment. That plan requires the covert administration of ketamine at Q's home as part of her breakfast routine. The necessity for the covert administration of ketamine is because, when anxious, Q becomes extremely aggressive, damaging her wheelchair and injuring staff and she is likely to become anxious and distressed if any attempt is made to take her to hospital voluntarily. The administration of ketamine covertly before departure allows for Q to be sedated when travelling to and fro from hospital by ambulance. Two previous occasions, as I have already indicated, to bring Q to hospital have been unsuccessful as no chemical restraint was used. Q became upset and had a prolonged fit. I accept that Q needs to be sedated to be safely transferred to and from the hospital. The use of a sedative administered covertly and safely, as happens with her annual flu injection, is proportionate and the least restrictive measure in the circumstances of this case.

25. Standing back and looking at matters in the round, I am satisfied that the proposed plan for medical and dental treatment is in Q's best interests. The plan is supported by all those who know Q well including her own sister. Though there is, of course, inherent risk in the administration of a general anaesthetic, the evidence of a consultant neurologist with a special interest in epilepsy indicates that the risk to Q is small and can be appropriately managed.

26. I have also considered that after surgery, Q's recovery is likely to be both painful and upsetting for her because she lacks the understanding to recognise what has happened to her and why it has happened. However, this will be transient discomfort after which she should be able to enjoy her food and derive pleasure from eating without pain. That transient discomfort has also to be balanced against the significant risk of, if untreated, Q experiencing worsening pain where she refuses food, becomes malnourished, and is at risk of developing sepsis. In my view, the course of action proposed by the applicant trust is necessary and the least restrictive possible course in order to carry out the dental treatment that Q urgently needs and has needed for some time on the evidence before me. I am satisfied that it is in her best interests to make the order sought in respect of dental treatment and I approve the contents of the draft order which has been placed before me.

27. Finally, and in conclusion, I very much hope that it will be possible for Q to have the proposed dental treatment as soon as possible. She should be able to eat without pain and enjoy her food. That outcome will vastly improve her quality and enjoyment of life. I also want to thank all of those who are involved with Q's care. It is obvious to me that they have had her best interests to the fore at all times.

28. That is my decision.

CERTIFICATE

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This transcript has been approved by the Judge