Neutral Citation Number: [2022]EWCOP43

Case No: 1398600T

IN THE COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 30/09/2022

Before :

MRS JUSTICE MORGAN

- -

Between :

Newcastle Upon Tyne NHS Foundation Trust	**Applicant**
- and -	
MB	**Respondent**
(By his litigation friend the Official Solicitor)	

- -

- -

Mr Rhys Hadden (instructed by DAC Beachcroft LLP) for the **Applicant**
Ms Emma Sutton (instructed by the Official Solicitor) for the **Respondent**

Hearing dates: 27th & 28th September 2022

- -

Judgment Approved by the court

Mrs Justice Morgan:

1. This application brought by Newcastle upon Tyne NHS Foundation Trust ('the Trust') concerns MB and relates to urgent medical treatment. MB is an adult male in his 30's. He participates before me by his litigation friend the Official solicitor.

The Application

2. The Trust made a personal welfare application for serious medical treatment on 5th September 2022 which operates the hospital within which treatment is intended and is the acute provider of MB's care. MB is currently deprived of his liberty within the hospital following a standard authorisation first granted on 18 August 2022. The standard authorisation has been extended by the court until the conclusion of the final hearing.

3. The Trust seeks declarations and orders under section 15 and section 4A(3) and section 16 of the Mental Capacity Act 2005 ("MCA") that:

    (1) MB lacks capacity to conduct these proceedings and make decisions regarding treatment for suspected T-cell lymphoma, and

    (2) It is in MB's best interests to receive high dose methotrexate ("high dose MTX") under general anaesthetic over several days, for up to four cycles, and for the deprivation of MB's liberty arising from the use of chemical restraint and sedation to implement the treatment plan to be authorised by the court. At the commencement of the hearing the Trust indicated it now sought authorisation for up to two cycles.

Background

4. The situation which brings MB before this court is both sad and unusual. The way in which it has developed may be summarised in the following way.

5. MB is originally from Angola and is understood to be the youngest of 15 children. He moved to the UK in 2001 as an asylum seeker and was granted indefinite leave to remain. He has an 8-year-old daughter with his former partner. Within the documents I have seen it is reported that he also has two adult children from earlier relationships.

6. On the information available, MB was in gainful employment and living unremarkably in terms of his mental health until, in about 2021, he began to experience a deterioration in his mental health.

7. In February 2022 MB came to the attention of community mental health services. He was reported to be having auditory and visual hallucinations, suicidal thoughts and showing signs of self-neglect. From the history now provided by his family, he may have been experiencing neuropsychiatric symptoms during the 12 months preceding this.

8. He was prescribed anti-psychotic medication and provided with support in the community. There was improvement at first but then a further deterioration. He

presented as increasingly disorganised and chaotic, with increased drug and alcohol use, concerns regarding possible sexual and financial exploitation by neighbours, and frequent complaints by neighbours to the police.

9. On 16 March 2022 MB spent two weeks in supported accommodation where he appeared settled. He wanted to return home and did so on 31 March 2022. He was noted at this time to have difficulty packing a bag for his stay. There were concerns about physical symptoms of dizziness and falls as well as increasing confusion, poor judgment and deteriorating self-care. He was referred for physical investigations including blood tests and an MRI scan.

10. On 13 April 2022 an MRI scan found a number of features consistent with a degeneration of the brain and widespread neurological infection of the brain, but the cause was not clear. A medical admission was agreed for further assessment and management.

11. On 1 May 2022 MB was admitted to a neurology ward at a local infirmary under s.2 of the Mental Health Act 1983 ("MHA 1983") following further deterioration, diagnostic uncertainty and difficulties with engagement. He presented as very agitated and confused, consistently seeking to return home and he was violent to staff requiring sedation, and higher ratio nursing with support from security staff. His anti-psychotic medication was changed.

12. On 18 May 2022 MB underwent a brain biopsy. Mature looking abnormal T-cells were found in the peripheral blood, cerebrospinal fluid and in a skin biopsy. It was assessed that MB was likely to have T-cell cancer, a type of lymphoma, of the skin, brain and bone marrow; that the disease appeared to be affecting his central nervous system and was the likely cause of his psychosis and delirium. The diagnosis was a working diagnosis and there was agreement that his condition required clarification and treatment.

13. A review concluded that he had very little understanding of the reasons he was in hospital, the procedures undertaken or treatment planned. At about this time MB came to believe that he worked on the ward and was frustrated about being unable, when he perceived his working day to be complete, to leave. That delusional belief has persisted and is often the flashpoint for episodes of violent and dysregulated behaviour.

14. On 6 June 2022, his detention under s.2 MHA 1983 was rescinded. The psychiatric medication he was prescribed was to manage agitation and provide a degree of sedation rather than to treat any abnormal beliefs or hallucinations.

15. On 20 June 2022 MB was transferred to the current Hospital for further assessment and treatment by the haemato-oncology team. On arrival he tested positive for covid. The following day MB presented as highly agitated and seeking to leave, needing two support staff for safety, who have remained in place ever since.

16. In early July 2022 MB was treated with dexamethasone (a steroid), (a standard approach for nervous system lymphoma) to see if there was any clinical or radiological improvement, on an assumption of a central nervous system lymphoma diagnosis. An MRI scan was repeated which showed there had been no change within

the brain (except for a small subdural haematoma presumed secondary to biopsy). There was also no improvement to his presentation.

17. On 7 July 2022 a meeting was convened within the Trust. The diagnosis and cause of the presentations was still uncertain and the team needed to make sure that all possible underlying infectious causes of the presentation had been excluded. The view from the psychiatry discipline was that his psychiatric presentation had an organic cause and that it was not a primary psychiatric disorder.

18. Due to the complexity of this case, on 22 July 2022 the Trust sought a second opinion from Professor Graham Collins, consultant haematologist and Associate Professor of Haematology at Oxford University Hospitals NHS Foundation Trust and Clinical Lead for Lymphoma at Oxford University Hospitals. Professor Collins reported that although rare, the central nervous system is a recognised site for cutaneous T-cell lymphoma. He agreed that the demonstration of the abnormal T-cell clone in brain and skin tissue is highly suspicious, if not diagnostic of, T-cell lymphoma at both sites and he would agree with the proposal to give treatment for T-cell lymphoma affecting the central nervous system. He also thought it unlikely that further testing would help. He identified three potential treatment options, preferring High Dose MTX

19. MB's presentation declined following an unavoidable ward move on 11 August 2022. His agitation and aggression required an increase in sedative medication. He has been unable to tolerate continuous intravenous access. The evidence before me is that this deterioration may be multifactorial, including a change to his ward and adjustments in drug doses. It may also be attributable to progression of disease.

20. On 7 September 2022 Dr Brown, the consultant liaison psychiatrist, conducted a further assessment of MB and concluded that he lacks capacity to consent to treatment.

21. There remains accordingly no certain diagnosis. T cell lymphoma of the skin, brain and bone marrow is a working diagnosis, and it follows from that that it may be that MB is suffering from something else and the diagnosis – and therefore, importantly, that to which the proposed treatment is directed – is not correct. I bear that in mind as I hear the evidence of the medical professionals. The case has however had extensive consideration by specialist and eminent medical practitioners from all relevant clinical disciplines based on the clinical picture and presentation: haematology, neuroradiology, neurology, dermatology, immunology, microbiology and psychiatry. None of those who have contributed to that working diagnosis are able to suggest any, or even any possible differential diagnosis. Furthermore none propose any further or other test or investigation which should be conducted save and except that the point is made to me that confidence in the working diagnosis may be increased or diminished by the way in which he responds to the treatment I am invited to authorise.

22. The proposed treatment is to deliver two cycles of High Dose MTX. The treatment itself is not unusual and is, within the field of haematological oncology, a mainstream standard chemotherapy treatment. The intention to deliver two cycles and then review comes about because of the unusual circumstances in which treatment is being started on the basis of an uncertain diagnosis. The position of the Trust in seeking to administer it, is that whilst not curative, there is sufficient clinical reason to think it

will prolong life and may improve the quality of that life. It is, the Trust submits to me, at least life improving and arguably life sustaining.

23. The novel aspect of the treatment comes from the way in which that it is to be delivered. The common position is that none of those who are to administer treatment, should it be in his best interests, regard it as safe to do so unless MB is sedated intubated and ventilated at the time. It can only be delivered if MB is admitted to an intensive care unit and the treatment undertaken there.

The Legal Framework.

24. The legal framework within which this application falls to be determined is uncontentious. I have been greatly assisted by the agreed note of the relevant and applicable law which accompanied counsel's skeleton arguments and I adopt it here.

Overarching Principles

25. There is no obligation on a patient with decision-making capacity to accept life-saving treatment, and doctors are neither entitled nor obliged to give it. See Lord Brandon in *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1:

> "a doctor cannot lawfully operate on adult patients of sound mind, or give them any other treatment involving the application of physical force ... without their consent', and if he were to do so, he would commit the tort of trespass to the person"

26. As Lord Goff thereafter observed in *Airedale NHS Trust v Bland* [1993] AC 789 at p864:

> "... the principle of self-determination requires that respect must be given to the wishes of the patient, so that if an adult patient of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged, the doctors responsible for his care must give effect to his wishes, even though they do not consider it to be in his best interests to do so"

27. As Lord Browne-Wilkinson said in *Bland* (supra) at p877, the questions for the court are questions of law:

> "[b]ut behind the questions of law lie moral, ethical, medical and practical issues of fundamental importance to society"

28. The right to self-determination was expressed succinctly by Judge LJ (as he then was) in *St George's Healthcare NHS Trust v S* [1999] (Fam) 26:

> "Even when his or her own life depends on receiving medical treatment, an adult of sound mind is entitled to refuse it"

Capacity the Legal Principles Engaged

The Mental Capacity Act 2005 ('MCA')

29. A person must be assumed to have capacity unless it is established that they lack capacity (section 1(2) MCA). The burden of proof lies on the person asserting a lack of capacity and the standard of proof is the balance of probabilities (section 2(4) MCA, *KK v STC and Others* [2012] EWHC 2136 (COP) at §18).

30. Determination of capacity is always 'decision specific' having regard to the clear structure provided by sections 1 to 3 MCA. Capacity is required to be assessed in relation to the specific decision at the time the decision needs to be made and not to a person's capacity to make decisions generally.

31. 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 (section 1(3) MCA) and a person is not to be treated as unable to make a decision merely because they make a decision that is unwise (section 1(4) MCA and *Heart of England NHS Foundation Trust v JB* [2014] EWHC 342 (COP), Peter Jackson J at §7). As expressed by Hayden J in *Avon and Wiltshire Mental Health Partnership v WA & Anor* [2020] EWCOP 37 at §29:

> "the Act emphasises the right of the individual, in exercising his or her personal autonomy,
>
> to make bad decisions even extending to those with potentially catastrophic consequences
>
> …"

32. Pursuant to section 2(1) MCA, a person lacks capacity in relation to a matter if at the material time they are unable to make a decision for themselves in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain (the so called 'diagnostic test'). It does not matter whether the impairment or disturbance in the functioning of the mind or brain is permanent or temporary (section 2(2) MCA).

33. The question for the court is not whether the person's ability to take the decision is *impaired* by the impairment of, or disturbance in the functioning of, the mind or brain but rather whether the person is rendered *unable* to make the decision by reason thereof (*Re SB (A Patient: Capacity to Consent to Termination)* [2013] EWHC 1417 (COP) at §38).

34. Pursuant to section 3(1) MCA, a person is "unable to make a decision for himself" if he is unable (a) to understand the information relevant to decision, (b) to retain that information, (c) to use or weigh that information as part of the process of making the decision, or (d) to communicate his decision whether by talking, using sign language or any other means (the so called 'functional test'). An inability to undertake any one

of these 4 aspects of the decision-making process set out in section 3(1) MCA will be sufficient for a finding of incapacity provided the inability is *because* of an impairment of, or a disturbance in the functioning of, the mind or brain. There must be a causal connection.

35. It is a misunderstanding of section 3 MCA to read it as requiring the identification of a precise causal link when there are various, entirely viable causes. See Hayden J in *Pennine Acute Hospitals NHS Trust v TM (by his litigation friend, the Official Solicitor)* [2021] EWCOP 8 at §37:

> "insistence on identifying the precise pathology as necessary to establish the causal link is misconceived. Such an approach strikes me as inconsistent with the philosophy of the MCA 2005. What is clear, on the evidence, is that the Trust has established an impairment of mind or brain and that has, in light of the consequences I have identified, rebutted the presumption of capacity".

36. The information relevant to the decision includes information about the reasonably foreseeable consequences of deciding one way or another (section 3(4)(a) MCA). That is reflected in paragraph 4.16 of Chapter 4 of the Code of Practice, which provides that relevant information includes the nature of the decision, the reason why the decision is needed, and the likely effects of deciding one way or another or making no decision at all.

37. In *PCT v P, AH and The Local Authority* [2009] COPLR Con Vol 956 at §35, Hedley J described the ability to use and weigh information as:

> "the capacity actually to engage in the decision making process itself and to be able to see the various parts of the argument and to relate one to another".

38. Within the context of section 3(1)(c) MCA, it is not necessary for a person to use and weigh every detail of the respective options available to them in order to demonstrate capacity, merely the salient factors (*CC v KK and STCC* [2012] EWHC 2136 (COP) at §69). Even though a person may be unable to use and weigh some information relevant to the decision in question, they may nonetheless be able to use and weigh other elements sufficiently to be able to make a capacitous decision (*Re SB* [2013] EWHC 1417 (COP) at §44).

39. Whilst the evidence of psychiatrists is likely to be determinative of the issue of whether there is an impairment of the mind for the purposes of section 2(1) MCA, the decision as to capacity is a judgment for the court to make (*Re SB* [2013] EWHC 1417 (COP)). In *PH v A Local Authority* [2011] EWHC 1704 (COP) Baker J observed at §16(xiii) that:

> "in assessing the question of capacity, the court must consider all the relevant evidence. Clearly, the opinion of an independently instructed expert will be likely to be of very

considerable importance, but in many cases the evidence of other clinicians and professionals who have experience of treating and working with P will be just as important and in some cases more important. In assessing that evidence, the court must be aware of the difficulties which may arise as a result of the close professional relationship between the clinicians treating, and the key professionals working with, P …".

40. It was also held in *PH v A Local Authority* (supra) at §16(xi) that the court must always be careful not to discriminate against persons suffering from a mental disability by imposing too high a test of capacity.

Best Interests: The Legal Principles Engaged

41. The essential framework for the determination of best interests is to be found in Section 4 MCA 2005:

'(1) …

(2) The person making the determination must consider all the relevant circumstances and, in particular, take the following steps.

(3) He must consider—

(a) whether it is likely that the person will at some time have capacity in relation to the matter in question, and

(b) if it appears likely that he will, when that is likely to be.

(4) He must, so far as reasonably practicable, permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him.

(5) Where the determination relates to life-sustaining treatment he must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.

(6) He must consider, so far as is reasonably ascertainable—

(a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity),

(b) the beliefs and values that would be likely to influence his decision if he had capacity, and

(c) the other factors that he would be likely to consider if he were able to do so.

> (7) He must take into account, if it is practicable and appropriate to consult them, the views of—
>
> (a) anyone named by the person as someone to be consulted on the matter in question or on matters of that kind,
>
> (b) anyone engaged in caring for the person or interested in his welfare,
>
> (c) any donee of a lasting power of attorney granted by the person, and
>
> (d) any deputy appointed for the person by the court, as to what would be in the person's best interests and, in particular, as to the matters mentioned in subsection (6).
>
> (8-11) …'

42. Lady Hale, in *P v Cheshire West* [2014] UKSC 19, expressed the view at §45:

> "it is axiomatic that people with disabilities, both mental and physical, have the same human rights as the rest of the human race. It may be that those rights have sometimes to be limited or restricted because of their disabilities, but the starting point should be the same as that for everyone else. This flows inexorably from the universal character of human rights, founded on the inherent dignity of all human beings, and is confirmed in the United Nations Convention on the Rights of Persons with Disabilities"

43. Sanctity of life is a fundamental principle in a case of this nature. As Sir Thomas Bingham MR said in the Court of Appeal in *Bland* [1993] AC 789 (at §808):

> "A profound respect for the sanctity of human life is embedded in our law and our moral philosophy"

44. In *Briggs v Briggs* [2016] EWCOP 53 Charles J considered that where best interests in respect of life sustaining treatment is in issue the default position for incapacitous persons is founded on the sanctity of life and so the strong presumption that lives that have value should be continued by life-sustaining treatment (at §3). However, whilst there is a strong presumption in favour of the prolongation of life, it is not an absolute. As Charles J went on to say in Briggs (at §7):

> "In all the circumstances of this case I have concluded that the weightiest and so determinative factor in determining what is in Mr Briggs' best interests is what I am sure he would have

> wanted to do and would have concluded was in his best interests. And so, for him, his best interests are best served by giving effect to what he would have been able to dictate by exercising his right of self-determination rather than the very powerful counter arguments based on the preservation of his life"

45. Part 5 of the MCA Code of Practice provides assistance in assessing best interests at paragraphs 5.29-5.36. Paragraph 5.31 makes express reference to those very limited cases where it may not be in a person's best interests to prolong life:

> "All reasonable steps which are in the person's best interests should be taken to prolong their life. There will be a limited number of cases where treatment is futile, overly burdensome to the patient or where there is no prospect of recovery. In circumstances such as these, it may be that an assessment of best interests leads to the conclusion that it would be in the best interests of the patient to withdraw or withhold life-sustaining treatment, even if this may result in the person's death. The decision-maker must make a decision based on the best interests of the person who lacks capacity. They must not be motivated by a desire to bring about the person's death for whatever reason, even if this is from a sense of compassion. Healthcare and social care staff should also refer to relevant professional guidance when making decisions regarding life-sustaining treatment"

46. On the basis that MB lacks capacity, any decision as to whether giving lifesaving but forcible treatment is in his best interests must take into account his rights pursuant to Articles 2, 3 and, 5, 8 of the European Convention of Human Rights.

47. When contemplating "Best interests" those interests are not limited to his medical best interests, but are widely defined. In *Aintree v James* [2013] UKSC 67, Lady Hale stated at §39:

> "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 the nature of the medical treatment in question, what it involves and its prospects of success; 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 interested in his welfare, in particular for their view of what his attitude would be".

48. At §45, she added:

> "The purpose of the best interests test is to consider matters from the patient's point of view. That is not to say that his wishes must prevail, any more than those of a fully capable patient must prevail. We cannot always have what we want. Nor will it always be possible to ascertain what an incapable patient's wishes are. .... But insofar as it is possible to ascertain the patient's wishes and feelings, his beliefs and values or the things which were important to him, it is those which should be taken into account because they are a component in making the choice which is right for him as an individual human being".

49. The balance sheet approach to determining best interests, which is widely accepted as a useful tool, was set out by Thorpe LJ in *Re A* [2000] 1 FLR 549 at 560 – thus predating the MCA- as follows:

> "… there can be no doubt in my mind that the evaluation of best interests is akin to a welfare appraisal.… Pending the enactment of a checklist or other statutory direction it seems to me that the first instance judge with the responsibility to make an evaluation of the best interests of a claimant lacking capacity should draw up a balance sheet. The first entry should be of any factor or factors of actual benefit… Then on the other sheet the judge should write any counterbalancing dis-benefits to the applicant. An obvious instance in this case would be the apprehension, the risk and discomfort inherent in the operation. Then the judge should enter on each sheet the potential gains and losses in each instance making some estimate of the extent of the possibility that the gain or loss might accrue. At the end of that exercise the judge should be better placed to strike a balance between the sum of the certain and possible gains against the sum of certain and possible losses. Obviously, only if the account is in relatively significant credit will the judge conclude that the application is likely to advance the best interests of the claimant".

50. As Thorpe LJ said, this approach was advanced "*pending the enactment of a checklist or other statutory direction*". Within this context, whilst the balance sheet is a useful tool, having compiled the same, the court must still come to its decision as to best interests by reference to the principles set out above grounded in section 4 MCA.

51. McFarlane LJ observed in *Re F (A Child) (International Relocation Cases)* [2015] EWCA Civ 882 in the context of the assessment of competing welfare issues concerning children:

> *"Whilst I entirely agree that some form of balance sheet may be of assistance to judges, its use should be no more than an aide memoire of the key factors and how they match up against each other. If a balance sheet is used it should be a route to judgment and not a substitution for the judgment itself. A key step in any welfare evaluation is the attribution of weight, or lack of it, to each of the relevant considerations; one danger that may arise from setting out all the relevant factors in tabular format, is*

that the attribution of weight may be lost, with all elements of the table having equal value as in a map without contours".

The Weight To Be Attached To P's Wishes And Feelings

52. The weight to be attributed to P's wishes and feelings will differ depending on such factors as the clarity with which the wishes and feelings are evidenced, how frequently those wishes and feelings are (or were previously) expressed, how consistent they are (or have been), the complexity of the decision and how close to the borderline of capacity the person is (or was when they expressed their relevant views).

53. As stated by Munby J (as he then was) in *Re M, ITW v Z* [2009] EWHC 2525(COP) at §35:

> "I venture, however, to add the following observations:
>
> (i) First, P's wishes and feelings will always be a significant factor to which the court must pay close regard: see Re MM; Local Authority X v MM (by the Official Solicitor) and KM [2007] EWHC 2003 (Fam), [2009] 1 FLR 443, at paras [121]-[124].
>
> (ii) Secondly, the weight to be attached to P's wishes and feelings will always be case-specific and fact-specific. In some cases, in some situations, they may carry much, even, on occasions, preponderant, weight. In other cases, in other situations, and even where the circumstances may have some superficial similarity, they may carry very little weight. One cannot, as it were, attribute any particular a priori weight or importance to P's wishes and feelings; it all depends, it must depend, upon the individual circumstances of the particular case. And even if one is dealing with a particular individual, the weight to be attached to their wishes and feelings must depend upon the particular context; in relation to one topic P's wishes and feelings may carry great weight whilst at the same time carrying much less weight in relation to another topic. Just as the test of incapacity under the 2005 Act is, as under the common law, 'issue specific', so in a similar way the weight to be attached to P's wishes and feelings will likewise be issue specific.
>
> (iii) Thirdly, in considering the weight and importance to be attached to P's wishes and feelings the court must of course, and as required by section 4(2) of the 2005 Act, have regard to all the relevant circumstances. In this context the relevant circumstances will include, though I emphasise that they are by no means limited to, such matters as:
>
> a) the degree of P's incapacity, for the nearer to the borderline the more weight must in principle be attached to P's wishes and

> feelings: Re MM; Local Authority X v MM (by the Official Solicitor) and KM at para [124];
>
> b) the strength and consistency of the views being expressed by P;
>
> c) the possible impact on P of knowledge that her wishes and feelings are not being given effect to: see again Re MM; Local Authority X v MM (by the Official Solicitor) and KM, at para [124];
>
> d) the extent to which P's wishes and feelings are, or are not, rational, sensible, responsible and pragmatically capable of sensible implementation in the particular circumstances; and
>
> e) crucially, the extent to which P's wishes and feelings, if given effect to, can properly be accommodated within the court's overall assessment of what is in her best interests"

54. In *Re N* [2015] EWCOP 76 Hayden J said at §28:

> "…. where the wishes, views and feelings of P can be ascertained with reasonable confidence, they are always to be afforded great respect. That said, they will rarely, if ever, be determinative of P's 'best interests'. Respecting individual autonomy does not always require P's wishes to be afforded predominant weight. Sometimes it will be right to do so, sometimes it will not. The factors that fall to be considered in this intensely complex process are infinitely variable e.g. the nature of the contemplated treatment, how intrusive such treatment might be and crucially what the outcome of that treatment maybe for the individual patient. Into that complex matrix the appropriate weight to be given to P's wishes will vary. What must be stressed is the obligation imposed by statute to inquire into these matters and for the decision maker fully to consider them"

55. It is right to remember given MB's vulnerabilities in the light of his health and circumstance that the 'protection imperative' must be resisted. As set out by Baker J (as he then was) in *B v D (by his litigation friend, the Official Solicitor) et Ors* [2017] EWCOP 15 at §41:

> "In earlier cases, including PH v A Local Authority, Z Ltd and R [2011] EWHC 1704 (Fam) and CC v KK [2012] EWHC 2136 (COP), I have drawn attention to a potential risk, identified by Ryder J (as he then was) in Oldham MBC v GW and PW [2007] EWHC136 (Fam) [2007] 2 FLR 597, a case brought under Part IV of the Children Act 1989, that the professionals and the court may be unduly influenced by what

> Ryder J called the "child protection imperative", meaning "the need to protect a vulnerable child" that, for perfectly understandable reasons, may influence the thinking of professionals involved in caring for the child. Equally, in cases of vulnerable adults, there is a risk that all professionals involved with treating and helping that person – including, of course, a judge in the Court of Protection – may feel drawn towards an outcome that is more protective of the adult. This point was articulated most strikingly in the celebrated passage in the judgment of Munby J (as he then was) in Re MM (An Adult) [2007] EWHC 2003 (Fam)
>
> "A great judge once said, 'all life is an experiment', adding that 'every year if not every day we have to wager our salvation upon some prophecy based upon imperfect knowledge' (see Holmes J in Abrams v United States (1919) 250 US 616 at 630). The fact is that all life involves risk, and the young, the elderly and the vulnerable, are exposed to additional risks and to risks they are less well equipped than others to cope with. But just as wise parents resist the temptation to keep their children metaphorically wrapped up in cotton wool, so too we must avoid the temptation always to put the physical health and safety of the elderly and the vulnerable before everything else. Often it will be appropriate to do so, but not always. Physical health and safety can sometimes be brought at too high a price in happiness and emotional welfare. The emphasis must be on sensible risk appraisal, not striving to avoid all risk, whatever the price, but instead seeking a proper balance and being willing to tolerate manageable or acceptable risks as the price appropriately to be paid in order to achieve some other good – in particular to achieve the vital good of the elderly or vulnerable person's happiness. What good is it making someone safer if it merely makes them miserable?"

56. The MCA does not echo the Children Act 1989 with a specific provision as to the detrimental effect of delay on welfare. Nonetheless in a number of judgments in the Court of Protection, it has been emphasised (see, for example, *Sherwood Forest Hospitals NHS Foundation Trust, Nottingham University Hospitals NHS Trust v H* [2020] EWCOP 5, Hayden J at §13 and *London Borough of Southwark v NP & Ors* [2019] EWCOP 48, Hayden J at §31(i)), that delay is to be read into the MCA as a facet of Article 6 and Article 8 and delay is likely to be inimical to P's welfare.

Capacity

57. The oral evidence, and the greater part of the written evidence at this hearing has not been focussed on the issue of capacity since the parties are agreed on the issue. It is of course a matter which still falls to be determined and I am entirely satisfied on the evidence that the presumption that MB has capacity to conduct these proceedings and to make decisions about his proposed treatment has been rebutted

58. I accept the conclusions of the COP3 capacity assessment dated 5 September 2022 undertaken by Dr Amy Publicover (consultant haematologist) following interactions with MB between 18 – 25 August 2022. That MB was unable to understand, retain or use or weigh the relevant information (section 3(1)(a)-(b) MCA applied). The primary issue being that he did not accept he was unwell, a view he has repeated to me at this hearing, and was therefore unable to engage in the decision making process. MB thought he was working as a security guard within the hospital, which view persists. On other occasions he believed he was in hospital due to depression, but wanted to go home as felt better.

59. MB was assessed to be unable to make a capacitous decision regarding the proposed treatment plan due to organic brain damage (section 2(1) MCA applied) and Dr Publicover considered that "*even if he is given the proposed treatment, there is a good chance that it will not be successful and that he will never regain mental capacity*"

60. I further accept the assessment of Dr Sarah Brown (consultant liaison psychiatrist) dated three days before this hearing agreed with the haematology team's view that MB lacks capacity to make an informed decision regarding the treatment proposed due to his inability to understand or retain the information, which has been presented in several ways at different times by different people, with the support of an IMCA, and that he is therefore unable to use and weigh the information provided in order to make a decision.

61. Dr Rebecca O'Donovan (consultant forensic psychiatrist) concludes in her report dated 26th September 2022 that due to MB's presentation which is consistent with organic psychosis, he is unable to conduct these proceedings and make the relevant treatment decision since he is unable to understand, retain and use and weigh the information necessary to make such decisions (section 2(1) and section 3(1)(a)-(c) MCA applied) So far as the prospect of regaining capacity is concerned, Dr O'Donovan considers that treating the underlying cause of his organic psychosis is the only intervention that has the potential to enable MB to regain capacity. It follows that that aspect of her consideration factors into any best interests decision also but for present purposes I accept her evidence as to capacity.

62. I add to the medical evidence the wider view which I form from first my own conversation with MB at the outset of the hearing and second from the information given by his family members of their more recent experience of him which in combination is congruent with that medical evidence.

63. Accordingly I am satisfied that MB lacks capacity to conduct these proceeding and to make decisions regarding treatment for T-cell Lymphoma and will make sought pursuant to section 15 MCA accordingly.

Best Interests

64. I have had at this hearing the enormous benefit of medical and clinical evidence both written and oral of an exceptionally high quality. Some though by no means all of that it will be necessary for me to consider in this judgment. I do not intend to rehearse all that I have heard and read. I have heard oral evidence from

i) Dr Nicolas Martinez-Calle (consultant haematologist)

ii) Dr Ian Nesbitt (consultant anaesthetist)

iii) Dr Sarah Brown (consultant liaison psychiatrist)

iv) Dr Rebecca O'Donovan (consultant psychiatrist)

v) Dr Chris Danbury (consultant intensive care physician)

vi) Dr Gail Jones (consultant haematologist)

65. I have in addition read carefully the evidence from those doctors and clinicians, both treating and instructed contained within he trial bundle provided in advance of the hearing. Before I go on to consider some aspects of the medical evidence I will consider what I learned from MB's family members which provides a further dimension to MB's best interests and my decision about that and which also gives a context within which the medical evidence sits. Their views are relevant as I consider MCA s 4 (7) (b) , as they have an interest in MB's welfare.

Views Of Family Members

66. MB's family members – his uncle, aunt, sister and niece – visit him several times each week in hospital, his aunt, sister and niece attended by remote link parts of this hearing and listened to the evidence. From Dr Martinez-Calle's report of discussions with ward staff, I know that MB responds positively to their visits and has been seen talking and laughing with them during those visits. They have been consulted by the Trust and by the Official solicitor. Their views reflect the turmoil so often affecting those who are close to someone diagnosed with very serious conditions which require debilitating and gruelling treatment. They first gave a view that they would not wish him to be exposed to intensive and invasive treatment if the improvement to his condition for having endured it would be little or nothing. Yet also they expressed the view that his former partner and his younger – still very young – daughter are important parts of his life, and were he able to form and express a view he would want treatment that might give him more time with his daughter. Having listened to the evidence from the consultant haematologists, intensivist and psychiatric experts, and clinicians, I heard from his aunt and his niece -relayed via Ms Sutton- that they each thought he should be given the chance and that they believed that he would want treatment. I heard that that that was now their own view which was a shift in how they felt having listened to the way in which the medical witnesses explained their views. His aunt and his niece were though, very worried about what it might be like for him and were especially concerned about the prospect of delirium. Despite all of those misgivings they firmly felt the proposed treatment should happen and that it should take place all in one admission to ICU rather than in two separate episodes. A second aunt who is a woman of Faith particularly wanted it known that she would pray about the proposed treatment and her position was communicated through MB's niece. Those views are ones to which I have paid close attention. Likewise, to the fact that they are views that have developed and evolved over the course of hearing the oral evidence. I hold in my mind that these are people who have known MB as the boy he once was and the man he became before he was unwell and so bring another

perspective to those who know him only as a patient or as the person who is subject of this application.

67. What was also relayed to me was that MB's aunt said she had '*struggled with the decision*'; and that his niece said she felt the weight of it *'on her shoulders'* and did not want to feel responsible for deciding what to do. I have made it clear to them that whilst their views are a very important part of the process of reaching a decision, that decision is mine not theirs, and the weight of it not theirs to bear. Whatever the ultimate outcome for MB his family's contribution has been valuable. To him and to me.

68. MB strongly wished to speak to me at the outset of the hearing. He told me - in the presence only of his lawyers- firmly and repeatedly that he does not believe he has cancer or has ever had cancer. That he is very healthy and alive. He attended by link some but not all of the hearing having indicated that he wished to do so.

69. The evidence I have heard and read from all the doctors involved has been striking for the thread that runs through it of a real sense of anxiety to do what is best for MB; to try to reach a clinical view which encompasses an empathy for their patient's situation and to keep in their mind what might be the wishes MB would hold and express about his treatment were he to be capacitous to form and express them. MB has been a difficult patient to treat on the ward and his illness has caused him to present challenges, including challenges to the physical safety of those caring for him, but I did not detect the slightest sense that he had become a problem to be solved rather than a person whose best interests lay at the heart of the clinical debate. I was especially stuck by the way in which Dr Brown said that it was so difficult to decide what was in his best interests that she had found it helpful to step back and ask herself the question '*if this were me or if it were someone I cared about what would I want for them?'*

Discussion and Conclusions: Best Interests

70. MB's situation is extremely complex and has caused a range of highly specialised and highly eminent clinicians from a range of disciplines to have anxious discussion about what might be best for him. The salient features of the complexity of his medical position and the difficulties flowing from it seem to me on the basis of all that I have heard and read at this hearing to be capable of being distilled to the following

    i) There is, even now, a working diagnosis only in respect of MB.

    ii) That said, no one suggests either that there is any other differential diagnosis which can be offered or that there are further tests or investigations which should be carried out.

    iii) The working diagnosis is of a very rare type of lymphoma: B-cell lymphoma is rare T-cell far rarer such that those from the centres of excellence from which I have heard have told me that they might expect to see 1 case about every 2 years – Dr Martinez-Calle's evidence was that from a population of 4.5 million he sees typically 18 cases of B-cell lymphoma of the brain each year and 1 case every 2 years of the T-cell lymphoma affecting the brain, if that.

iv) As well as the rarity, the presentation in MB is atypical, affecting his brain skin and bone marrow. It seems to be atypical also in its rate of progress, there being reason to believe that it has probably affected him in some way for at least the last 12 months perhaps 18, whereas the more usual course of lymphoma affecting the brain and central nervous system would be so swift as to require, on diagnosis, what Dr Jones described to me as treatment on almost an emergency basis. Dr Martinez spoke of a prognosis in brain lymphoma of weeks only.

v) The psychiatric presentation, felt to be most likely the consequence of the damage to his brain is in part irreversible (that which relates to the atrophy and the infarction) and in part may be reversible (that which related to the infiltration) but it is not clear or predictable what will be the extent to which it can be reversed neither is it predictable what improvement there will be on MB's functioning as a result. Nor can one confidently identify which parts of the brain are causing the distortion in his functioning which had been seen to have so markedly deteriorated since May of this year.

vi) The proposed course of 2 cycles of treatment may assist with confirming diagnosis – in the sense that if it is demonstrably effective it would indicate that the working diagnosis is correct whereas if it has no effect at all it may indicate it is not the diagnosis (though there is always the possibility that as is sometimes the case the cancer may simply not respond to treatment).

vii) It is not suggested that the lymphoma (if that working diagnosis is right) can be cured by any treatment offered but there is agreement that treatment can prolong life expectancy and agreement that there is potential for it to improve his executive functioning and so the quality of his life.

viii) MB's presentation and behaviours consequent upon his illness along with his inability to understand or recognise the fact of his illness, the treatment plan, or the need for it are such that if he is to have the proposed treatment it can only be delivered to him whilst he is sedated intubated and ventilated in an intensive care unit ('ICU').

ix) That means of delivery is novel and outwith the experience of any of those from whom I have heard expert and clinical evidence at this hearing. save and except Dr Martinez told me that he had on 2 occasions had experience of administering chemotherapy to patients in ICU but not from the starting point of being admitted to ICU for the purpose of receiving treament without otherwise needing to be there.

x) If, but only if, following the delivery of the 2 cycles of high dose Methotrexate, there is what is judged clinically as success then it would be intended, if possible, to proceed to the next phase of treatment. However the range of treatment options that may be offered to MB in this second phase will require further consideration by the Trust and by the Official Solicitor on MB's behalf. All invite a return to court before that next phase of treatment commences to consider what is in his best interests and the range of possible options.

xi) There are risks attendant upon the novel means of delivery and the need for a prolonged period of elective admission to ICU, sedation, intubation and ventilation. The risks are not trivial or inconsequential. They include but are not limited to delirium, post ICU syndrome, PTSD, infection, and sepsis. The range and extent of the risks is, as with all else in this case hard to quantify but a measure of it is that the intensivist instructed by the Official Solicitor told me he would not be prepared to undertake the procedure in his ICU.

xii) If no treatment is administered, there will be an inevitable decline and deterioration in his functioning, and he will die. The prognosis in terms of life expectancy is hard to quantify because of the atypical presentation and progress of the disease but it has been expressed at this hearing as a conservative estimate of 4-6 months at one end of the scale and months to perhaps a small number of years at the other. The prognosis as to the quality of his life is more predictable: increased confusion, distress, agitation, dependence on others for basic living, an increasing need for care, and a diminution of such limited freedom as has been possible to make for him in his present circumstances in which he is deprived of his liberty.

71. Dr Martinez-Calle, instructed by the Official Solicitor and Dr Gail Jones who is a treating clinician are each consultant haematologists. I did not detect disagreement or real difference of view between them save perhaps as to the prognosis if untreated Dr Martinez-Calle was prepared only to contemplate 4 -6 months Dr Jones reasoned that the slow development to this stage led her to think it would be longer. What they were agreed about however was that the quality of MB's life during that period would be very much worse. Dr Martinez-Calle anticipated that absent treatment there would be an infiltration of sites of the brain stem which are exquisitely sensitive.

72. This infiltration he would expect to lead to a variety of manifestations: motor problems and mobility issues; decreased consciousness progressing ultimately to coma; seizures depending on where geographically the brain were affected; hydrocephalus and increased pressure with the cranium that causes confusion. This can then develop to brainstem complications for essential functions such as breathing and then can cause sudden deterioration of neurological condition. What is obvious from his evidence is that without treatment it is a bleak picture. It may yet be bleak with treatment but one of the few certainties in this uncertain situation is that is it bleak without it. That is, as I understood her evidence, why Dr Jones does not see a 'watch and wait' approach as having any place in the options.

73. Both were of the view that for this young otherwise relatively fit man it should be tried. Dr Martinez-Calle regards the therapy as sub-optimal for a T-cell lymphoma and puts the prospect of success at only 20 % with a high rate of relapse within 5 years. His view was that the diagnosis is more likely than not (in the sense of 51%) correct. The 2 cycles would be likely to confirm that. His view was that 2 would be needed before one could confidently know if it was working. Dr Jones took a similar view. Both told me that the circumstance in which they would stop after one cycle only would be if MRI scanning showed that the disease had continued greatly to progress despite the high dose MTX. Dr Martinez-Calle said that his view was that the proposed treatment is life sustaining and should be attempted. The T-cell lymphoma will be lethal and so, although the success rate predicted is low, it is, in the final analysis, in MB's best interests to have it. Dr Jones' view was similar.

74. Neither Dr Jones nor Dr Martinez-Calle gave their evidence with any sense of false optimism. They each held the view that whilst there was clear and structural damage on the brain scans the active infiltration is what one would hope to reverse and have some improvement in functioning. It is impossible to know in advance whether there will in fact be improvement, but the point made by Dr Martinez-Calle which I accept, is that it is the only prospect of improvement. In his evidence he told me that one of the things that makes unpredictable the outcome is that sometimes a patient with a scan that looks very bad makes a recovery and vice versa. When Dr Jones came to give her evidence she echoed this. She, as it happened, gave her evidence after having heard those from the psychiatric field and said that their evidence that the proposed treatment was the only prospect of some improvement in executive functioning was important to her thinking. As I see it and having in mind the balance sheet approach urged on me by the Official Solicitor some prospect of an improvement of MB's functioning is a significant positive.

75. There is before me a wealth of detailed evidence about the way in which an admission to ICU would be carried out in the circumstances of this case. Dr Nesbitt consultant anaesthetist and Dr Danbury consultant in intensive care, have each been asked to assist, if that is to be the manner of delivery, on which of two options would be preferable having regard to the risks involved. The first is to have one unbroken admission whereby MB is sedated, intubated and ventilated at the start of a period, the first cycle is delivered, the necessary recovery period between cycles occurs, and then the second cycle is delivered and only at the completion of the second will the process of awakening, extubation and a move out of ICU to be undertaken. The best estimate of the minimum time for such an admission is about 14 or 15 days. The second is to have 2 admissions where by MB is sedated intubated and ventilated at the start of a period, the first cycle is delivered, he is then awoken extubated and moved out of ICU for the necessary recovery period and then readmitted to repeat the process for the delivery of the second cycle. Dr Nesbitt's oral evidence was that he and Dr Danbury had discussed at the multi-disciplinary meeting the risks of a single admission as against two and that he felt that they had thought the risks were of a similar order of magnitude for each. Elaborating in what he meant he said '*effectively we are swapping one set of unquantifiable risks for another'*. His view, from the point of view of his own discipline was that his preference would be 2 admissions. Taken again to the comparative risks by Ms Sutton he did not move from that view, but he would agree that if the evidence from those in the field of psychiatry was that the benefits from the point of view of their field of a single admission outweighed the risks, he would accept a single admission provided there was a clear and coherent plan agreed that the risks could be assuaged. He volunteered to me that as he gave his view that others in his position might well take the opposite view.

76. Dr Nesbitt was prepared to go so far as to say that his view was that it would be in MB's best interests to have the treatment. Of MB he said '*I think he is in an extremely unfortunate position whatever happens if we don't offer him this treatment no better off and more likely to develop further problems and die'*. He observed that he is already in restricted environment and that there is an option to improve that – and thus his quality of life – which is offered by the treatment if it works. He went on to explain his thinking in coming to his view in discussion with his colleagues that MB's best interests are to have the treatment bearing in mind that MB is only now in his 30s: '*If we do offer chemotherapy the benefits are low but measurable. I think it's less*

than 20 % and his tumour may already have caused fixed deficit so I think that is his only chance. No one's eyes are closed and we recognise doing nothing is an option our majority view is we should offer him this treatment recognising less likely to benefit him than not but still worth trying it'.

77. Dr Danbury whose expertise as a consultant clinical intensivist has a significant degree of overlap with that of Dr Nesbitt in his oral evidence took, just as heralded by Dr Nesbitt, an opposite view. It remained his view, he said, that this is an incredibly finely balanced case which is proving very difficult for three different specialities where the expertise do not overlap. He would take at face value the views of those from haematological oncology and psychiatry if they thought there could be an improvement by undertaking the treatment but his own view remained that admitting him to intensive care would probably do more harm than good. Very prominently in his thinking featured the almost inevitable prospect of delirium for, he would think, at least a week perhaps substantially longer. The more so if the chemotherapy did not improve the functioning of his brain. He thought there was a strong risk of PTSD. In addition to these risks he felt that there were physical risks from intubation and ventilation leading to, for example, ventilator induced pneumonia; arterial and venous line infections and catheter urinary infections raising the prospect of sepsis. Were MB to become septic in the circumstances here, Dr Danbury pitched the mortality rate at just below 50 %. Given the very serious reservations he was expressing in his evidence and his view that admission to intensive care would probably do more damage, he was asked if it was his view that the treatment plan should not be embarked upon. He responded *'it is finely balanced from the perspective of all three disciplines. From my perspective if he were in my unit and oncologists were suggesting it then we would not be offering to do it'.* Reminded as I have been by the Official Solicitor of Dr Danbury's experience and expertise in serious medical treatment cases before this Court, that was a striking answer. Later in his evidence he observed '*I think if I were more certain of the benefit on his neurocognitive state I would be confident that it fell on the other side but my view is the structural changes are sufficient to explain his function changes and so I don't think it is worth doing'*

78. He did however readily acknowledge two things; first that others in his field might properly take a different view second that the views he was able to express came only from his own field and that if in the overall picture incorporating the views of other disciplines, those from for example psychiatry then a decision could well be different. For him key to that would be how certain are the oncologists that treatment would improve MB's life

79. Were there to be such treatment undertaken, then Dr Danbury ultimately differed from Dr Nesbitt on the question of how many admissions to intensive care there should be. Reflecting on all of the differing risks to be taken into account he ultimately favoured a single unbroken admission. From his detailed and helpful evidence it seemed to me that the tipping point for him was the avoidance of a second episode of intubation and extubation between the 2 sessions and the associated removal of lines. He also gave evidence that whilst a first admission to intensive care is a venture into the unknown, subsequent admissions even for those with poor memory carry with them anticipatory anxiety which disproportionately affects them and would be likely to lead to greater effort to achieve the admission especially were

there to be persisting delirium. I reflected on that part of his evidence when considering the views of those from the field of psychiatry and the weight they each gave to a diminution of the prospects of increased delirium as part of what inclined them to favour a single admission. As well as coming to the conclusion that one unbroken admission did not materially increase the risks flowing from the length of it as compared with two shorted admissions in quick succession Dr Danbury's clear view was that the question of one or two admissions should not be left as a matter of clinical judgment at the time but that for those carrying out the treatment it would be better for this decision to be made by the court

80. I was very greatly assisted by hearing as well as reading the evidence of these two doctors. Neither were dogmatic in their view. Each impressed on me the very great difficulty that they have had coming to a view in a case which time and again they described as very finely balanced. Each respected the contrary conclusion of the other.

81. Dr Brown is a consultant treating psychiatrist, Dr O'Donovan a consultant psychiatrist instructed by the Official Solicitor as an expert within these proceedings. As with Dr Martinez- Calle and Dr Jones, I did not detect much which might properly be regarded as difference between the views of Drs Brown and O'Donovan. As to what were described as the 'disbenefits' of undergoing the proposed treatment they both regarded delirium as an almost inevitable outcome. There was agreement too that for someone with MB's profile delerium would be difficult to treat or to manage and that one cannot predict how long it might endure. I found their evidence on this point both illuminating and disturbing. I can well see why it was an aspect of this case which so worried MB's family. It is a serious negative. I had the impression that Dr Brown was slightly more sanguine about whether PTSD was quite so inevitable. Her view was that so impaired is his memory that, since a component of PTSD is how memories are laid down, she thought it may not be that MB would progress to it. On this point Dr O'Donovan differed. Whilst she agreed that Dr Brown was right to say memory has a fundamental role in PTSD she said this: '*we know from individuals who had all manner of mental health difficulties and had also had PTSD that memory could be distorted but yet the trauma response is not dissimilar'* and she went on to give the example of offenders who commit offences when very unwell and with no apparent awareness but go on to develop perpetrator PTSD.

82. Dr O' Donovan took into account in reaching her views, aspects of the admission which might indeed be very negative yet not only did she agree with Dr Brown that it was in MB's best interests to have the treatment, she agreed that it was the only prospect of there being any chance of improving his executive functioning. Even though the benefit might be small since as she observed '*we don't know how much his functioning will change or improve if at all and already there is evidence of cerebral atrophy and cell death that is not going to change, and we don't know how much executive functioning is impaired by that and how much by T-cell lymphoma and we don't know his response yet and if functioning will be the same as it is now'* . Yet with all that in the negative side of the balance she still came to the view that the potential - and that the treatment was the only thing with that potential - was what tipped her to the view that it was in his interests to do it notwithstanding the negative aspects.

83. At the conclusion of Ms Sutton's questions Dr O'Donovan said this: '*If there is a potential is that not worth looking at? he is a young man who pre morbidly had*

functioned well with no history of mental illness [he is] *unlikely to return to that but if there is an option of improvement and no reason in terms of his physical health not to do it then I agree it is reasonable to give him that opportunity to try'* . That is, in my view a powerful point in favour of proceeding with the 2 cycles of treatment.

84. Dr O'Donovan was firmly of the view that from a mental health perspective, there would be advantage to a single uninterrupted admission to intensive care. One admission would be preferable as it was felt that there would be increased risk of delirium after intubation and extubating escalating the risk he would pose to himself and others. The view of Dr O'Donovan was that putting MB through that once was preferable to twice. Dr Brown though saying she would incline to defer to the ICU specialists on whether it should be one or two admissions, agreed that from a purely psychiatric point of view one was better. It is interesting to note that Dr Danbury to whom Dr Brown would properly defer on the number of admissions, himself comes down in favour of one over two (recognising of course that he says the treatment should not proceed at all) in part because of the anxiety effects that he describes as affecting those who are repeat admissions to intensive care.

85. In the light of all of the evidence and despite the presence of a number of countervailing factors, I conclude that it is in MB's best interests to undergo treatment to receive 2 cycles of high dose MTX under general anaesthetic over a period of days during one admission and for the deprivation of his liberty arising from the use of physical and chemical restraint as set out in the treatment plan to be authorised.

86. In reaching that conclusion I have formed the view that the medical evidence viewed in its totality, although finely balanced because of the exceptionally unusual circumstances and the very significant risks involved persuades me that it is in MB's best interests. I have given very careful thought indeed to Dr Danbury whose evidence to me seemed most strongly to be to the contrary. I do not regard him as being an outlier amongst those from whom I have heard since having re-read his evidence it has been noticeable to me that at each point where he expressed strongly his view that the treatment was not something he advocated and would indeed not be prepared to undertake he acknowledged both the scope for professional difference of view within his own specialism and that his own view came with the caveat that he would accept those of the other two disciplines involved. The haematologists nd the psychiatrists all recommend proceeding with the treatment. That is not to be taken as a crude approach on numbers but as one which places the view he expresses within the wider context of the case.

87. At the outset of the hearing the Official Solicitor took the position that the evidence of whether MB would actually derive any benefit from the treatment was profoundly lacking. This was within the context of drawing my attention to B v D (by his litigation friend, the Official Solicitor) and others [2017] EWCOP 15 at §41 which incorporates Munby J (as he then was) in Re MM (An Adult) [2007] EWHC 2003 emphasising the need to tolerate manageable risks as a price appropriately paid '*in order to achieve some other good'* . The Official Solicitor's position has changed in submissions following the exploration of the evidence. I agree that there is indeed now evidence of some benefit or potential benefit to MB from the treatment. Most especially there is the potential -it may only be potential but it is the only potential – for some improvement in his executive functioning. Without treatment there is the

prospect of a decline – perhaps a swift decline perhaps a slower one – to a level of functioning and a quality of life diminished yet further.

88. I accept that having the treatment may if successful prolong his life and that the starting presumption is protection of his life; that the right to life carries with it strong weight and that even and although the estimate of success is put at 20 % within the context of Article 2 EHCR that is not negligible. Even the most pessimistic of the evidence before me does not suggest the treatment is futile.

89. When I consider MB's beliefs and values (section 4(6)(b) MCA), I am satisfied that I can reasonably conclude - and I do - that MB would wish for treatment to be provided if such treatment afforded him the chance of spending more time with his daughter. Elsewhere in this judgment I have examined the way in which his family (whose views are relevant under section 4 (7) MCA) have contributed the view that he would want to have time with his daughter. That view has persisted throughout even when they themselves leaned towards perhaps the view that they might not want him to go through the treatment.

90. As I have already set out The views of MB's treating clinicians, whose commitment to MB and determination to provide him with the best possible clinical care has been outstanding, consider that on balance the proposed plan is in his best interests. So too does the second opinion doctor Professor Collins, whose written evidence I have considered carefully notwithstanding that there was no need for oral evidence from him.

91. The risks arising from the novel and highly invasive nature of the proposed treatment to which I have already made extensive reference are serious and have featured in the analysis of all those who have given evidence. I am satisfied however that they are outweighed by the potential benefits

92. Having received now the final treatment plan amended to take account of the evidence heard, I approve that plan and make the declarations and orders sought.