Neutral Citation Number: [2024] EWCOP 49 (T3)

Case No: COP 20001409

IN THE COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 29/08/2024

Before :

THE HONOURABLE MR JUSTICE COBB

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Between :

1. LEWISHAM AND GREENWICH NHS TRUST **2. SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST**	**Applicants**
- and -	
PG **(By the Official Solicitor as her Litigation Friend)**	**Respondent**

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Vikram Sachdeva KC (instructed by **DAC Beachcroft** and **Bevan Brittan LLP**) for the First and Second Applicants
Fiona Paterson KC (instructed by **The Official Solicitor & Public Trustee**) for the Respondent

Hearing dates: 28 and 29 August 2024

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Approved Judgment

This judgment was handed down on the afternoon of 29 August by circulation to the parties and their representatives by e-mail.

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THE HONOURABLE MR JUSTICE COBB

This judgment was delivered in public.
A transparency order is in place

The Honourable Mr Justice Cobb :

Introduction

1. The application before the court gives rise to complex and challenging clinical issues surrounding the investigation and treatment of potentially serious pathology, which includes different forms of cancer. The subject of the application is PG, a 57 year old woman; she is represented in the proceedings by the Official Solicitor as her litigation friend and appears by Ms Fiona Paterson KC.

2. The application dated 9 August 2024, is brought by the Lewisham and Greenwich NHS Trust (the treating hospital for the gynaecological issues) and the South London and Maudsley NHS Foundation Trust (the treating mental health trust); they are represented by Mr Vikram Sachdeva KC.

3. By their application, the Applicants seek the Court's determination of issues of capacity and best interests in respect of PG. For the purposes of determining the application, I have heard the oral evidence of Mr. M, a consultant gynaecologist, Dr. Y, a psychiatrist who has known PG for over twelve years, and Dr I, her current treating psychiatrist. I was due to hear briefly from Dr Ty Glover, instructed by the Official Solicitor, but in the event he was not required to attend for the purposes of cross-examination.

4. I have read other reports and statements from members of the multi-disciplinary team supporting the care and treatment of PG contained within a sizeable bundle of documents; I have received the able written and oral submissions of leading counsel for the parties.

5. On an assessment of the early filed evidence, this case looked unusually finely balanced and complex. As the evidence has developed, and in particular as it has been tested at a hearing over the last two days, the issues have clarified significantly.

Background

6. PG has experienced severe and disabling mental illness from an early age; she has a history of trauma, having witnessed a violently abusive relationship between her parents. During PG's childhood, her mother was said to have been suffering from chronic alcohol dependence. It is possible that PG was raped, or experienced a serious sexual assault, as a young person; she makes repeated reference to this and I comment on this again below.

7. PG has a brother, who visits her infrequently; I saw no evidence of any other family member with whom she has any current relationship.

8. PG first presented to mental health services in 1986, at the age of 18, and was at that time diagnosed with schizophrenia, with paranoid and persecutory delusional beliefs. In the intervening years she has had multiple admissions to psychiatric hospitals under the Mental Health Act 1983 ('MHA 1983'), and has not enjoyed any extended periods of stability while living in the community.

9. PG is currently living in South London in a small, single-sex, supported living placement, York House (not its real name), which she shares with two other residents;

her care is provided by a third party provider. She has been subject to section 3 MHA 1983 since the end of 2022 and has been on section 17 MHA 1983 'leave of absence' since mid-June 2024; ideally, she would like to return to live at her previous flat which is in a different borough in South London.

10. Her psychotic illness is treatment-resistant, and she remains symptomatic despite general compliance with medication. She has suffered relentless mental health difficulties, and her day-to-day activity has been profoundly affected by her illness. She suffers ongoing paranoid delusions, irritability and aggression; she is periodically fixated on her history of an alleged previous rape, to which I have already referred (§6 above). It is not known whether this is an accurately remembered trauma, or a delusion. She believes that that she has been controlled by a TV celebrity. She suffers from occasional auditory hallucinations.

11. In 1989, she was admitted to hospital under section 2 of the MHA 1983 and remained there for over a year receiving electro-convulsive therapy. She has been in and out of hospital ever since, sometimes spending months on end on acute psychiatric wards. She has limited insight into her mental illness and her care needs, and this has historically led her to engage in only a limited way with mental health services.

12. The professionals believe that if PG was indeed the subject of a serious sexual assault, and/or rape (as she describes), this may account at least in part for her firm resistance to even mildly invasive obstetric and gynaecological investigation. PG believes that any kind of vaginal examination is associated with abuse, and has raised delusional beliefs that the clinicians who are concerned about her at present are trying to effect an abortion or to rape her. She speaks of having had a child five years ago, although she has never been pregnant; this indeed is a delusional belief.

13. In 2022, PG was struggling to manage living in her flat even with support; she disconnected the boiler as she believed it was dangerous. She became resistant to taking her medication, and reduced her dosage against advice. She fell acutely ill in July 2022 and was admitted to hospital. While there, the possibility of supported accommodation was discussed with PG, but she declined it. She was discharged back to her flat in September 2022. Shortly after her discharge, she became unwell again and in December 2022 she was detained under Section 3 MHA 1983; she remains under this section to date.

14. In May 2023, PG was transferred to Lancaster Close (not its real name) a mixed sex rehabilitation unit in South London; she had been there many times before. In June 2024 she was transferred to York House. The placement at York House has been successful to date; PG appears to have sufficient confidence in staff to talk to them. An interesting insight into her life was provided to the Court from a discussion between the Official Solicitor's representative and the Operations Manager at York House:

> "… [PG] can be very friendly and pleasant. She's very up to date with current affairs because she watches a lot of TV. She also likes beauty products and manicures. She likes to talk about shopping…. She also likes to talk about how she wants her life to be – she would like to have a boyfriend and get married one day. Yes, she's quite pleasant to talk to and

> you can talk to her about anything, you could have a good conversation with her. She talks about politics, food prices and how expensive everything is. Today she was talking about US politics and Kamala Harris – she really keeps up to date with current affairs because she watches a lot of TV".

15. However, there is no doubt that discussions about her health, or meetings / appointments with doctors, trigger extremely agitated behaviours; she is "very suspicious of doctors because she feels that they want to control her life". She is reported to be capable of considerable aggression when roused in this regard, and while she is not physically abusive to others, she often slams doors, throws chairs, and "will rage" often "for hours". The Operations Manager was asked how PG would respond if told that she was to undergo any kind of medical procedure:

> "Oh my God… she would go ballistic I cannot imagine what would happen. Just the mere mention of antibiotics can make her hysterical… She would say you want to take her womb or make her have an abortion – this is what she says when you ask her to take antibiotics so I cannot imagine how bad it would be for anything more".

16. An attempt was made at a gynaecological appointment in June 2024; it took twelve members of staff to persuade her to get into the taxi. The events at the hospital are recorded as follows:

> "She began to run around the ward and into the garden, vocally resisting the appointment. When staff attempted to give her a jacket, she lay on the floor, kicking and screaming for staff to leave her alone, fearing they were taking her for an abortion".

The appointment was not kept. Dr Z and Dr I both told me that this was a "very typical" response from PG to engagement with medical issues; they independently reported similar direct experiences of PG's reactions to meeting with them: "she would run away or leave the room if I try to do any assessment of her … quite dramatic… I could hear her in the garden for an hour afterwards": (Dr I).

17. PG has a poor appreciation of good hygiene care, as described again by the Operations Manager:

> "… she stains the sofas, so we use cover sheets. We suggest that she uses a pad, but she refuses. There is an issue with her personal hygiene as well. Sometimes it will take a week of continuous prompting and encouragement for her to change her clothes. For example, we have to tell her when her trousers are stained and she will change them, but she rarely showers".

Psychiatric history and current state

18. PG suffers from very significant abnormalities of thought secondary to a severe and enduring psychotic illness. She has little or no insight into her poor mental health and has been unable to engage with psychological support. Her presentation appears to be dominated by persecutory beliefs, and a persistent fear of any form of medical investigations. She has only been able to live independently for relatively short periods of time. She has periodically rejected medication, and shows no understanding of the seriousness of either her physical or mental disorders. The experts appear to agree that PG has a very poor psychiatric prognosis.

19. As Dr Glover observed:

> "[although her] condition has settled to some degree with careful management of her antipsychotic medication, her mental state has remained disturbed with ongoing psychotic symptoms never far from the surface. [She] makes frequent statements relating to having been raped, being pregnant or having an abortion with these psychotic symptoms often emerging during discussions of a medical nature, seemingly of any sort…" (emphasis by underlining added).

Pathology: investigation and treatment

20. *The presenting symptoms*: In July 2023, carers noted dark blood staining to PG's underwear. In the following month, she was referred to her General Practitioner. She was diagnosed with post-menopausal bleeding, and was referred to the gynaecological services of the First Applicant; PG was non-compliant with medical appointments, and she was discharged from the clinic. Her refusal to attend hospital for gynaecological investigations are part of the chronic and persistent refusal to engage with doctors. When she was finally examined by her general practitioner in December 2023, she was noted to have a vulval lesion on her right labia which was assessed then to be 'fungating'; PG complained of it being painful. She was referred on for investigation into vulval cancer; PG refused various follow-up appointments.

21. In February 2024, PG tolerated a brief examination of her vagina by a specialist registrar; her labial lesion was noted to be about 3cms and assessed not to be 'fungating' but instead to be wart-like. There was found to be, and there remains, a strongly malodorous discharge from PG's vagina.

22. Over the course of the last twelve months or so, PG has lost approximately 30kgs in weight. In July 2024, PG suffered an episode of faecal incontinence.

23. *The issues*: When the Applicants first presented their application before the Court in early August 2024, there was considerably more uncertainty than there is now about the probable cause of PG's presenting pathology. The clinically instinctive wish to investigate that pathology was met with a strong body of psychiatric opinion by those who know PG well that any investigation into the cause of the presenting symptoms was likely to cause PG significant and enduring distress, and substantially impact on her fragile mental health.

24. This presented the clinicians, and then the Court, with a huge dilemma, encapsulated perhaps by these questions:

i) Is it in PG's best interests for a clinical *investigation* to be undertaken in relation to her post-menopausal bleeding and possible gynaecological malignancy, knowing that any such investigation will be likely to cause PG significant psychological distress, which in itself may have serious deleterious implications for her long-term mental health and thus for her community placement?

ii) If investigations do take place, and if they reveal cancer or other condition requiring *treatment*, will it be in PG's best interests to undertake that treatment, and if so how could this be achieved, given her resistance to medical intervention?

25. It was agreed at the Pre-Trial Review hearing (at which these issues were discussed) that it would be important for me to consider the second question when endeavouring to answer the first. For if the answer to that second question is that PG would not tolerate any treatment of any kind (i.e., surgery, chemotherapy, and/or radiotherapy), then it calls into question whether it would be in her best interests to subject her to investigations which are themselves likely to cause her profound psychological distress.

26. *Usual investigation*: Ordinarily, for a patient presenting with the range of physical symptoms displayed by PG, the treating gynaecologists would wish to undertake a surgical examination under general anaesthetic, to include a biopsy of the vulval lesion and any suspicious tissue, and a histological diagnosis of any cancer; alternatively, or additionally, I was advised that it would be usual for a localised MRI scan to be undertaken (with the patient under sedation) to check for cancer in the pelvic region; further or alternatively a full body CT scan would be commissioned to assess whether there are any signs of cancer elsewhere in PG's body.

27. *Investigation for PG*: The evidence from psychiatrists and others who know PG well is that she would be utterly resistant to any form of investigation; the evidence is equally clear that any form of medical intervention would be harmful to her in many ways. The evidence before the Court now reveals that PG would oppose any kind of restraint; that it would be impossible to effect any kind of sedation or anaesthesia even covertly without causing her high levels of disturbance; she would be deeply upset by any kind of engagement with medical health services about whom she is deeply suspicious. A deterioration in her mental health would be likely to lead to a breakdown in her much-valued and sought-after placement at York House. A deterioration in her mental health would be likely to lead to a return to months of in-patient treatment on an acute psychiatric ward; the loss of her place at York House would be "devastating to her psychiatrically" (Dr. H).

28. Prior to the hearing, the Official Solicitor helpfully explored whether there would be any scope for sedating PG sufficiently at York House so as to be able to convey her to hospital, perform an MRI examination under continuing sedation, and return her to York House, while she remains effectively unaware of what had happened. This proposal was considered conscientiously by the medical professionals, but dismissed as unrealistic, and indeed unsafe for PG.

29. *Would PG cope with treatment?* It was made extremely clear from the evidence that even if it were possible to *investigate* the cause of PG's presenting symptoms, any

form of *treatment* would present further significant challenges to the treating doctors and carers. If, as appeared likely on the written evidence, PG has a form of cancer, the evidence was clearly to the effect that she would not be able to tolerate any kind of surgery, chemotherapy and/or radiotherapy at least in part because these forms of treatment require the patient to surrender willingly (and in the case of radiotherapy and chemotherapy, repeatedly) to the administration of treatment.

30. *Diagnosis on the current information?* As the final evidence was filed on the eve and on the first morning of this hearing, and as the oral evidence emerged during the course of the hearing itself (specifically from Mr. M), it became apparent that a reasonably secure diagnosis could in fact be made of PG's presenting condition. Taking in combination: (i) the extraordinary weight loss (30kgs over 12 months), (ii) the sizeable vulval wart-like lesion, (iii) the chronic (12 months) of post-menopausal bleeding, (iv) the malodorous vaginal discharge, (v) the recent report of faecal incontinence, and (vi) that PG was, until relatively recently, an habitual smoker (twenty cigarettes per day), Mr N considered that it was "probable" that PG is suffering from a form of vulval cancer, and that this is likely to be stage 4. Stage 4 cancer is an advanced cancer, also known as metastatic cancer. Mr N expressed the view that, on the evidence, the cancer is likely to have spread to the nearby lymph nodes and/or urethra and/or anal canal.

31. Mr N told me that fewer than 15% of patients survive stage 4 vulval cancer; that survival figure represents those who have surgery, chemotherapy, and/or radiotherapy treatment. In PG's case, if she were effectively untreated (given that treatment would be virtually impossible), the prognosis for her would be correspondingly poorer.

Capacity: the law

32. There is no dispute in this case as to the relevant law, and its application. I have of course focussed on the statutory foundations laid by Part 1 of the Mental Capacity Act 2005, particularly sections 1-3; these statutory provisions have of course been interpreted, discussed and applied in multiple cases since the implementation of the 2005 Act. It is hard to find a better exposition of those fundamental principles than in the judgment of Lord Stephens in *A Local Authority v JB* [2021] UKSC 52, [47]-[84], to which I have had regard. I have applied those principles to the issues before me.

Capacity: the evidence

33. Capacity evidence is provided from a number of sources. There is no dispute between the Applicants and the Official Solicitor that PG has an impairment of, or a disturbance in the functioning of, the mind or brain, caused by her longstanding diagnosis of paranoid schizophrenia. She is experiencing delusions about the nature of her health issues and professionals' motives believing that investigations or treatment are attempts to rape her or perform an abortion. The unambiguous evidence is that she cannot:

    i) Understand the relevant information, claiming that she has already been "cured" by antibiotics and does not have any other health issues despite explanation to the contrary and does not accept that her recent weight loss could be attributed to physical health issues; due to delusions about the

treatment in reality involving rape, abortion and hysterectomy she rejects any information about the rationale behind any investigations or treatment;

ii) Retain the relevant information: she has not on any occasion demonstrated ability to recall details of the proposed investigations and refers to them consistently as forced abortion;

iii) Use or weigh the relevant information. Her ability to weigh up any information regarding the risks or benefits of investigation or treatment is substantially impaired by her chronic delusional beliefs regarding rape and abortion. She exhibits high levels of distress and agitation at any mention of gynaecological or physical health issues, frequently leaving or shouting over professionals. She is not able to engage in any meaningful discussion about the concerns relating to her symptoms and their possible seriousness.

34. The parties agree that on the evidence it is amply demonstrated that PG lacks capacity to:

i) Conduct this litigation;

ii) Consent to medical treatment, in particular to the investigation and treatment of suspected gynaecological malignancy.

Best interests: the law

35. The law relevant to best interests is, as with capacity questions, similarly underpinned by the provisions of Part 1 of the Mental Capacity Act 2005. Section 4 of the MCA 2005 defines the process for determining best interests. It is incumbent on me to consider whether it is likely that PG will at some time have capacity in relation to the matter in question, and if so, when that is likely to be. I should, so far as reasonably practicable, permit and encourage PG to participate as fully as possible in any act done for her, and any decision affecting her. It is necessary for me to consider, so far as is reasonably ascertainable, her past and present wishes and feelings, her beliefs and values and other matters which would be likely to influence her decision if she had capacity.

36. In this particular case, I have been much assisted by revisiting Baroness Hale's comments in *Aintree v James* [2013] UKSC 67 [2014] AC 591, and in particular:

> "18. …[The court's] role is to decide whether a particular treatment is in the best interests of a patient who is incapable of making the decision for himself.
>
> …
>
> 19. … Generally it is the patient's consent which makes invasive medical treatment lawful. It is not lawful to treat a patient who has capacity and refuses that treatment…
>
> …

> 22. [T]he focus is on whether it in in the patient's best interests to give the treatment, rather than whether it is in his best interests to withhold or withdraw it. If the treatment is not in his best interests, the court will not be able to give its consent on his behalf and it will follow that it will be lawful to withhold or withdraw it. Indeed, it will follow that it will not be lawful to give it…" (emphasis by underlining added)

> "35. The authorities are all agreed that the starting point is a strong presumption that it is in a person's best interests to stay alive. As Sir Thomas Bingham MR said in the Court of Appeal in *Bland*, at p 808, "A profound respect for the sanctity of human life is embedded in our law and our moral philosophy". Nevertheless, they are also all agreed that this is not an absolute. There are cases where it will not be in a patient's best interests to receive life-sustaining treatment.
>
> 36. The courts have been most reluctant to lay down general principles which might guide the decision. Every patient, and every case, is different and must be decided on its own facts**.** As Hedley J wisely put it at first instance in *Portsmouth Hospitals NHS Trust v Wyatt* [2005] 1 FLR 21, "The infinite variety of the human condition never ceases to surprise and it is that fact that defeats any attempt to be more precise in a definition of best interests" (para 23). There are cases, such as *Bland*, where there is no balancing exercise to be conducted. There are cases, where death is in any event imminent, where the factors weighing in the balance will be different from those where life may continue for some time." (emphasis by underlining added)

37. It is a ""best interests" rather than a "substituted judgment" test, but one which accepts that the preferences of the person concerned are an important component in deciding where his best interests lie…" (Baroness Hale in *Aintree* (above) at [24]).

38. Relevant to this case is the further observation of Baroness Hale in *Aintree* that "best interests" are not just medical best interests, but are widely defined:

> "[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." (emphasis by underlining added).

39. In this regard, it is appropriate that I should have regard to the quality of life which this patient (PG) would regard as worthwhile; it is clear from the *Aintree* case that the purpose of the best interests' test is to consider matters from the patient's point of view. As Baroness Hale went on to say in that case, it is not that the wishes of the patient will prevail (assuming that it is possible to determine what those views were and/or are), but insofar as it is possible to ascertain the patient's wishes, her beliefs and values, they should be taken into account in the best interests evaluation (see *Aintree* at [45])

Best interests: the evidence

40. *Optimal outcome?* All other things being equal, I am satisfied that it would be in PG's best interests to have her pathology *investigated* and then effectively *treated* in order to give her: (a) relief from her current and future symptoms, and (b) the chance of a longer and healthier life. However, focused treatment for her pathology cannot be undertaken without an investigation into its causes, and even investigation would come at a terrible cost to PG.

41. *What would she want?*: Insofar as they can be discerned, it is reasonable to conclude that PG would wish a normal life expectancy, provided that she were able to maintain a reasonable quality of life. She would wish to be pain-free, and relieved of the discomfort of persistent bleeding. She would not want to be psychiatrically unwell; she would not want to be returned to an acute hospital ward as a psychiatric in-patient, possibly for months on end. I believe that she would want to remain living at York House or, optimally, be returned to live at her flat.

42. It is abundantly clear that PG is deeply suspicious of doctors, is resistant to medical interventions generally (even taking antibiotics for her vaginal discharge, which she suspected was part of a plan to 'take away her womb'), and is fiercely opposed to any form of medical investigation for her condition. It is equally clear that she would be opposed to treatment of any kind in relation to her malignancy. I am satisfied that she would be yet more resistant to treatment which is either futile, or overly burdensome, or where there is no prospect of recovery. Dr Z told me that there would be "difficulties in even *discussing* any of this with her, let alone her actually having any investigation or treatment." PG's consistent and vociferous opposition to medical investigations carry significant weight in this case.

43. *Could PG be assisted to cope with investigations and/or treatment?*: Dr I advised me that she could conceive of no steps which could be taken to mitigate the predicted psychological fall-out of investigation and/or treatment of the gynaecological pathology. Due to PG's chronic mental ill-health, it is not viable for her to have prolonged interventions of the type which are ordinarily associated with cancer treatment, such as chemotherapy or radiotherapy. Nor would PG tolerate surgery; there is a very low expectation from the multi-disciplinary team that she could or would comply with post-operative wound care, with the insertion of a catheter for up

to 6 weeks (per Mr N), and/or the maintenance of significantly higher levels of hygiene than PG currently achieves.

44. *Is it in her best interests to be subject to investigation if she would never be compliant with treatment?* The view of the medical professionals was that if an investigation is likely be academic, in the sense of having no effect on treatment, it is unlikely to be in PG's best interests (or indeed of any clinical benefit to a capacitated patient).

45. *To what extent, if at all, would the use of force, or restraint, or the administration of sedation, be in best interests if this were to achieve investigation and/or treatment?*: It will be clear from the range of observations which I have already made above that it takes very little to cause PG distress; she is inherently suspicious and wary of medical professionals, and will not easily engage with them. It is Dr I's clear view that compelling PG to have gynaecological investigations against her wishes will have a significant detrimental impact on her acute and possibly long term mental health, lasting weeks to months, or possibly years. She would be likely to lose what limited trust she has in mental health and physical health professionals (she has already refused to attend chiropody appointments due to fears she will be forced to have an abortion), with long term implications for her care.

46. *Is it in her best interests to do nothing?* Dr I is of the view that any amount of medical investigation would cause a "near certain significant negative impact on her mental state", and this is powerful reason for doing nothing in her best interests. Her willingness and capacity to consent to further investigations could be reassessed in the event that her physical condition changed materially. I would add that if PG is only to receive palliative care, this would be more sympathetically and comfortably achieved for PG if she were continuing to reside at York House, than if (following a failed attempt at investigation and a consequential deterioration of her mental health) she were readmitted as a hospital in-patient under section 3 MHA 1983.

47. The Official Solicitor has rightly pointed out that 'doing nothing' to treat the pathology, and providing only palliative care, may itself place PG's psychological as well as her physical health at risk, if (as appears likely) she is in fact suffering from a gynaecological cancer. Her physical deterioration may not only be distressing for her but also heighten her deluded beliefs, causing a deterioration in her psychological state. This point was well made by Dr Glover:

> "This progression [of the suspected gynaecological cancer] is likely to occur whatever course of action is taken by the clinicians including no further active interventions of any sort. As well as the physical complications described above, it is more than probable that there will be psychological sequelae also; not just the stress and anxiety associated with what PG might well suspect is a malignancy, but also the potential for the sensations which accompany the malignant progression to become incorporated into PG's delusional network".

48. *The wider picture*: In accordance with the comments in *Aintree*, I must of course consider her best interests on a wider perspective. As I have said above, PG benefits immensely from her care at York House, which offers her comfortable, well-

appointed, 24-hour supported living. If PG were to suffer such a deterioration in her mental health that she required further inpatient treatment, the probability is that she would lose her place at York House. This had taken a great deal of time to arrange, and if lost, it would be difficult to replicate the arrangements in the future. All of this would be extremely damaging to her.

The position of the parties

49. When the application was issued in this complex and delicately balanced case, the Applicants were of the view that it was likely to be is in PG's best interests to investigate the cause of the bleeding and the lesion, given that the consequences of leaving a potential cancer untreated are likely to be terminal. The Official Solicitor was initially more circumspect about this, and plainly wished to explore all possibilities; in that regard she was encouraged by Dr Glover to submit that:

> "… further very sensitive and relatively non-intrusive options are tried in the first instance in order to elucidate a little further the exact nature of PG's vulval lesion, its pathology and its spread. That might allow for a more informed care plan to be constructed with the early involvement of other clinicians- palliative care specialist, pain management team- helping PG's psychiatric care team ensure they are best able to meet PG's ongoing needs whilst maintaining some stability in her mental state."

50. Ms Paterson made the powerful point at the outset of the hearing (a point which survives well the forensic enquiry) that:

> "… it seems unlikely that her current placement and care package, could be improved upon. The Official Solicitor suggests that anything which jeopardises this hard-won, recent and fragile stability, should be approached with the utmost caution as it could wipe away whatever quality of life [PG] maybe able to enjoy."

51. By the end of the oral evidence, the parties had reached a common position which corresponds with the conclusions which I find myself endorsing and which are set out at §59 below.

52. Ms Paterson emphasised in conclusion that if I were to find that it would not be in PG's best interests to undergo *investigations* (against her will), let alone *treatment*, a bespoke palliative care plan should now be devised jointly by her treating psychiatric, gynaecological (and where appropriate palliative / anaesthetic / psycho-pharmacological) treating teams, to anticipate and treat her probable physical and psychiatric demise, as a consequence of an untreated gynaecological cancer.

Conclusion

53. I am delivering this judgment *ex tempore* at the end of the second day of this two-day listed hearing. It is not in PG's best interests to defer a decision in relation to her treatment (if any) any longer, and I am concerned that those with responsibility for

caring for PG, clinically, psychiatrically, and otherwise, should have clarity about the way forward as soon as possible.

54. Regrettably, and for reasons which have not been entirely adequately explained, there was a significant delay in the issuing of these proceedings from the moment when investigations into possible cancer were first flagged in August 2023; this has been, at least potentially, to PG's detriment.

55. It may well be that the delay in the making of the application has arisen from a lack of communication between the two Applicants; this was hinted at by Dr. H. It may be that it flowed from an understandable concern by the Applicants that it would be inappropriate to trouble the court with an inchoate application in the absence of an agreed "fully-worked up" care plan, in respect of the investigations. If so, I would wish to encourage these Applicants and/or any other applicant in such circumstances with such a case, to be less concerned about ensuring that every 'i' is dotted and every 't' crossed before making the application where speed of decision-making may be of the essence: perfect in this instance may well be the enemy of the good. Once it became apparent that NHS Guidance regarding the investigation and/or treatment of PG's condition could not be complied with timeously, and/or where it was clear that PG's treating/receiving clinicians could not agree upon a care plan to facilitate the investigations and/or treatment, the application could or should have been issued. The Court could then have ensured with the assistance of counsel and solicitors that evidence was filed from the necessary factual and expert witnesses to enable the detail of the care plan to be completed, and a decision to be reached promptly in respect of PG's best interests.

56. I am informed that the Official Solicitor has (through counsel) offered to meet with the First Applicant's in-house legal team, to see what, if any collaborative reflections can be drawn from the present application. It is hoped that at least some of the anxiety surrounding PG's care and these proceedings may be avoided in the future. I welcome this initiative.

57. The case nonetheless causes me to emphasise for future reference that where cancer is a suspected pathology in respect of a person who lacks or may lack capacity to make treatment decisions, the Hospital Trusts should not hesitate one moment before bringing the matter before the court. I hardly need to underline here that cancer which is diagnosed at an early stage, when it is not too large and has not spread, is more likely to be treated successfully; where investigation and/or treatment is in respect of someone who lacks capacity like PG, court approval should be urgently sought.

58. Against that, I acknowledge that even if the case had been heard last year, PG's resistance to investigation and/or treatment, and the long-term outcome for her, would not have been different, or materially so.

59. PG's psychiatric and gynaecological conditions are plainly complex and severe; the intersection between the two is fraught with difficulty, and identifying PG's best interests has been particularly complex. However, for the reasons set out above, and in the final analysis supported by the unanimous views of the professionals, I have however reached the following clear conclusions:

i) PG lacks capacity to conduct the proceedings; I shall make the appropriate final declaration under section 15 MCA 2005 in this regard;

ii) PG lacks the capacity to consent to medical treatment in particular to investigation and treatment of suspected gynaecological malignancy; I shall make the appropriate final declaration under section 15 MCA 2005 in this regard;

iii) It is not in PG's best interests to undergo any of the following *investigations* of her gynaecological symptoms, examination under general anaesthetic and biopsy, local MRI, CT scan of her whole body;

iv) It is not in PG's best interests to undergo the following *treatment* of her gynaecological symptoms, either by way of surgery, radiotherapy, or chemotherapy;

v) It is in PG's best interests to receive such palliative care as her clinicians considered to be in her best interests at the time.

60. Based on Mr N's evidence, it appears that PG's demise could be imminent, that is to say, within weeks rather than months. The health and social care professionals looking after her, need to know how to manage all aspects of her demise, both physical and psychological. I shall therefore list this application for further hearing in a few weeks' time to consider the revised care plan which will have as its focus the palliative care arrangements for PG.

61. In the meantime, and on the recently issued application of the relevant local authority, I propose to make a community deprivation of liberty order, so that PG's section 3 MHA 1983 order can be discharged, so that her bed in hospital can be released, and so that her placement can be maintained at York House. In this regard my order shall include the following:

> "To the extent that the arrangements of PG's placement and care plan dated 22 August 2024 amount to a deprivation of liberty and interfere with her rights, such interferences are lawful and are hereby authorised by the court in the interim as being necessary and proportionate and in PG's best interests, provided that such measures are implemented in a way that is calculated to cause PG the least distress and that only such force as is reasonably necessary is used to prevent harm to her, and proportionate to the likelihood of her suffering harm and the seriousness of that harm."

62. That is my judgment.