Case No: COP13172091

IN THE COURT OF PROTECTION
[2018] EWCOP 28

The Royal Courts of Justice
Strand
London WC2A 2LL

Friday, 24 August 2018

BEFORE:

MR JUSTICE MOOR

BETWEEN:

Re: SJ

MS FIONA PATERSON (instructed by Clyde & Co LLP) appeared on behalf of the Applicant

MS NAGEENA KHALIQUE QC (instructed by The Official Solicitor) appeared on behalf of the First Respondent

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JUDGMENT

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(Official Shorthand Writers to the Court)

1. MR JUSTICE MOOR: This is an application made in the Court of Protection for the approval of medical treatment. The first matter that I have to deal with is an application to adjourn that has been made by the second respondent who is the sister of the patient with whom I am concerned, SJ.

2. These proceedings have, in fact, been in train since November 2017, but it is right that nothing substantively happened from 27 December 2017, when Cohen J made his second order and gave a short judgment, until this application was made on 18 June 2018.

3. The sister has filed a significant number of statements. They basically all say very similar things in relation to the treatment of her brother.

4. Williams J dealt with the case on 18 July 2018, but I think he did so on paper. His order was that Dr P should assess SJ's capacity and, indeed, Dr P has done so.

5. I now have two doctors who are able to assist me with capacity and I also have the various witnesses, clinicians and experts from the Local Authority as to the proposed medical treatment.

6. It was not until 22 August 2018 that the sister applied to vacate this hearing. She did so by paper application. I declined to make the order without having heard from the NHS Foundation Trust and the Official Solicitor as to their views on the matter. It was made quite clear to the sister that the matter was proceeding this morning albeit that she could apply at this hearing to adjourn.

7. She has not, in fact, attended, but both counsel tell me that there have been discussions with her and emails sent by her to their respective instructing solicitors, including to the Official Solicitor at 2.00 am and 7.00 am this morning. It is equally clear from these emails and other communications that the sister was equivocal as to whether or not she intended to come to court. "May or may not attend" were the words used to me by Ms Khalique QC on behalf of the Official Solicitor.

8. I do not understand why she is not here. She clearly has taken a significant interest in this case and it is surprising that she is not here. Although I recognise that all High Court

and Court of Protection proceedings are difficult and stressful for litigants-in-person, the simple fact of the matter is that she has had proper notice of this application and has deliberately absented herself, notwithstanding her knowledge that I have not agreed to adjourn the case and that I intended to hear any adjournment application and, if refused, the main application. It follows that her lack of presence at court cannot be a reason for adjourning.

9. She gives two further reasons in her application for seeking an adjournment. The first is that she says her brother is improving. Ms Paterson, who appears on behalf of the Trust, tells me that the evidence she will be calling will be that the treatment remains urgent and that SJ continues to need this operation. I will hear that evidence in due course, but a factual dispute such as that can be cleared up with the treating clinicians in their oral evidence. So that of itself is not a reason to adjourn. Her second reason is that she says that she thinks there is insufficient medical evidence. There is, of course, significant medical evidence, but she has not proposed an alternative expert. She has not indicated which expertise she wants further evidence about. She has not undertaken any communication with either of the other two parties in relation to this aspect.

10. I am therefore clear that it is not in the interests of SJ for me to adjourn this case today. The second respondent has decided, for whatever reason, not to attend court and I reject her application to adjourn. I make it clear that the order that comes out of this hearing must indicate that I considered the application fully and gave a judgment on the matter.

(**Proceedings continued**)

MR JUSTICE MOOR:

11. This is an application made by the X NHS Trust for the authorisation of medical treatment in relation to a patient, SJ, who is an inpatient in X's hospital.

12. The second respondent is his sister, MJ, who has not attended court for reasons that I do not understand, even though it is clear from her many statements, emails and the like that she has been very concerned about this matter and is opposed, strongly, to the application that is made.

13. SJ was born on 21 January 1975 and is therefore 43 years of age. His home is at N. He was, unfortunately, morbidly obese. He is diabetic and doubly incontinent. He has had a history of psychotic episodes and is currently detained in hospital under section 3 of the Mental Health Act. I am told that he had a psychosis in 2011 and there were concerns at that time as to cognitive decline.

14. He was admitted to X on 13 November 2017 with sepsis, secondary to a large necrotic infected Grade 4 sacral pressure sore. Indeed, the evidence I heard was that, at the time, it was some 15cm by 12cm and was 3cm deep, going down to the bone. At one point I found it difficult to understand how it could be that he could have put up with the pain from this very seriously infected pressure sore given that I was told that he does not tolerate pain at all well. During the course of the expert evidence that I have heard orally, I was told that one of the side-effects of his diabetes is to damage nerve ends and reduce the pain. In any event, he was in a sorry state when he was admitted to the hospital and he has been there ever since.

15. The matter came before the Court of Protection late last year as a result of his lack of capacity and disagreements between the NHS Trust and the family as to the appropriate treatment. On 28 November 2017, Cohen J made a provisional declaration in relation to lack of capacity as to medical treatment for the pressure ulcer and made a number of declarations. He declared that it was lawful to insert a bowel management system using the least restrictive means possible; to insert a urinary catheter and to carry out an X-ray. He authorised a deprivation of liberty and appointed the Official Solicitor to act as litigation friend for SJ. There was also to be a psychiatric report and the matter was set down for a final hearing. Indeed, the Official Solicitor instructed Dr P. Dr M was the consultant psychiatrist for the NHS Trust. Both were satisfied at that point that SJ lacked the necessary capacity.

16. The matter came back on 27 December 2017 before Cohen J. At the time it was considered that the risks to SJ of a general anaesthetic were too high to undertake a colostomy. There was a final declaration of lack of capacity and a further order that permitted drainage of collection. There was to be a surgical debridement of the wound if necessary and a CT scan. I am told that both of these were undertaken. In his judgment Cohen J said that the NHS Trust wished to carry out further procedures under general

anaesthetic, but the risk, at the time, of SJ dying during a general anaesthetic was in excess of 34 per cent. Perhaps inevitably, as a result of that statistic, the judge felt that he could not authorise the colostomy there and then. The judge also made the point that SJ was improving and stable at the time, but the Trust believed he would deteriorate again and that any such operation should be done whilst he was stable. The hospital had agreed to wait to see if improvement was maintained, but Cohen J did authorise medical treatments if there was a material deterioration in his health.

17. The matter came back before the court by an application dated 18 June 2018 for authorisation of a surgical procedure under general anaesthetic to form a colostomy and to authorise subsequent care, including intensive care unit if necessary. A number of expert reports had been obtained.

18. On 15 June 2018, Dr M, a consultant psychiatrist, reported that, in her view, SJ had no insight. He was unable to understand or believe information given to him. He was unable to weigh up the pros and cons of treatment. In her view, he lacked capacity to make decisions regarding his health. She thought that he probably suffered with an autistic spectrum disorder. There had been an improvement in his psychotic symptoms. His abusive and antagonistic behaviour had subsided. She thought it likely he would tolerate a colostomy bag, given that he has cooperated with medical procedures and interventions recently.

19. On 16 June Mr V, a consultant general surgeon at the hospital, reported in a statement that he considered that SJ needed a de-functioning colostomy. The operation would bring the colon to the skin, form an artificial opening (a stoma) and the faeces would then pass into the stoma bag, not down into the rectum. Initially, when SJ had come into the hospital, defecation had been regulated by a tube inserted in his anal passage. That had worked well for about a month, but it then kept falling out as a result of its presence weakening the anal muscles. As a result, it was removed in December 2017. Since then, it has been impossible to keep faeces out of the wound. This has been the most likely cause of repeated episodes of sepsis that SJ has suffered. Indeed, I have been referred to a list of the occurrences of sepsis during the course of this year. The first commenced on 1 May 2018 and was treated with antibiotics until 14 May 2018. Sepsis then recurred as quickly as 17 May 2018. Antibiotics were again given until 7 June 2018. He was put

on a dose of Amikacin on 13 June 2018 for a multi-resistant Klebsiella. On 3 July 2018, there was a recurrence of sepsis and he was given Meropenem, Teicoplanin and Amikacin. The doctor's evidence is that this is an almost monthly cycle of sepsis.

20. Obviously, the doctor and the surgeon have both been very concerned about this. Mr V says in his statement that he considered that there would be a higher chance of the wound healing if the colostomy bag was in place, although it was unlikely to heal completely if the patient refused to turn over or, when he was turned over, he immediately turned back onto this back. It was alleged that this was what he was doing at least at one point.

21. It was thought that by inserting a colostomy bag, it would significantly reduce the risk of infection and sepsis. If not, the doctor thought it was very likely that the situation would rapidly deteriorate to a position where the patient would get septic shock and would die. His estimate was that SJ would be unlikely to live for more than another six months. This estimate was given on 16 June 2018, in other words two months ago. The doctor considered that the benefits of the colostomy greatly outweighed the risks and he made the very fair point that the patient's BMI has reduced considerably since he was first admitted to hospital. Indeed, I was told during the oral evidence that he has lost seven stone in weight and is now down to approximately 16 stone from a previous weight of 23 stone. As a result, the risk of him not surviving a general anaesthetic was down to only 2.3 per cent. Indeed, the point was made that he did survive a previous general anaesthetic following Cohen J's last order.

22. On 18 June 2018, a consultant anaesthetist, Dr C, produced a report in which she confirmed that SJ's risk of mortality as a result of the general anaesthetic would be 2.3 per cent. His risk of morbidity was 35.9 per cent. When I read that I was not completely clear what she meant, but it has been explained to me in evidence that "morbidity" means complications that are likely to be non-fatal complications and that can be managed. So, although it is a fairly high percentage, it relates to complications that the doctors are confident they can deal with. The anaesthetist said that the reason why the risk was so much lower was due to the reduction in SJ's BMI and the drugs he has been taking to combat his various ailments.

23. Williams J dealt with the case on 18 July 2018. The Official Solicitor wished to instruct Dr P again to assess capacity. Williams J made such an order, as a paper exercise. Dr P reported on 14 August 2018. He visited and assessed SJ. The patient said he did not want the operation as there would be pain. He was also concerned about the anaesthetic, saying it was highly likely, in his view, that he would not wake up. Dr P considered that SJ had responded well to antipsychotic medication. The doctor could not rule out autistic spectrum disorder. He said that, although the patient understands the relevant issues and can retain information, he is unable to weigh that information and those issues or use the information properly due to deficits in his cognitive functioning and thinking pattern. As a result, Dr P took the clear view that the patient lacked capacity to make decisions. In addition, he was of the view that SJ lacks capacity to litigate as he is unable to weigh in the balance the issues involved in this application.

24. The sister has filed a significant number of statements. They are all very much of the same character. In her first statement, she says that her brother knows the risks that he might die, but he does not want the operation. She says that she believes that he has the capacity to decide, but that is not, of course, the view of the two psychiatrists. She says he needs to be taught to say he is going to open his bowels and, if he can do that, then there will be no difficulty. She says that she believes that many of the difficulties may cease after he finishes a course of diazepam that, on 5 July 2018, was due to finish in approximately two to three weeks.

25. Her second statement, dated 16 August 2018, said that the pressure sore was reducing in size. Again the statement repeated her belief that her brother had capacity; that he did not wish to undergo the surgery; that there was no need for the surgery as it can be managed conservatively; that he should have stool hardeners; and that, if he had stool hardeners, there would be no risk of further infection and indeed he could be treated as an outpatient. She considered that he had not had optimal nursing care and, as a result, the wound had not been given the chance to heal. She asserted that, if the wound is given sufficient time, it will heal. She thought that the medication that was given to him to manage his psychosis may have delayed the healing of the wound. The diazepam has made him drowsy. She repeats that, if he was alert, he could tell the nursing staff of the bowel movements and be taught to use a bedpan.

26. She also says that a reduction in his blood pressure medication has compromised his circulation and delayed his healing, but I do not understand where that comes from. She says that there are likely complications with the colostomy. She refers to the risks of surgery. Her father passed away after an operation and she was concerned that SJ would suffer post-operative delirium. In her statement of 22 August 2018, she was concerned that the colostomy reversal, if it ever can be reversed, would be difficult and that faeces could leak out of the bowel and into the abdominal cavity. She considers that SJ needs trips out of the hospital to improve his wound and his mental health and that it may be his antipsychotic medication that is affecting his capacity and preventing him from worrying about things.

27. As I have indicated, she has not attended court. She made an application two days ago for me to adjourn the case, but she knew that I had not granted that application and that I intended to deal with it at the beginning of this case today. She made it clear in various emails that she was not sure whether she would be coming or not. I refused her application for an adjournment in her absence this morning for the reasons given in my *ex tempore* judgment. I was told by counsel after lunch that she had contacted them again and said she might be able to be here by 4.00 or 4.15. The court simply cannot wait to see whether a litigant is prepared to come or not, particularly so late in the court day. In any event, she has not attended. Moreover, by then, I had heard most of the medical evidence and the urgency of this case had become quite apparent.

28. I make it clear that both the NHS Trust and the Official Solicitor support the orders that I am being asked to make. They both submit to me that the evidence points clearly to a potential catastrophe if this operation does not take place reminding me that the patient's life expectancy now being some four to six months without this colostomy.

29. I heard from three doctors. Dr M, the consultant psychiatrist, confirmed her two reports and did not have anything more to add. She said that the patient continues to lack capacity. He doesn't really understand. He is unable to weigh up the benefits and the risks and the likelihood of infection and death if the operation is not perfomed. I accept her evidence.

30. I then heard from Dr A. He was giving evidence in place of Dr C who is unavailable. He is a specialist in anaesthesia and intensive care and he had seen SJ yesterday. He agrees completely with Dr C. I have already indicated that he told me the meaning of "morbidity" and he indicated that he considered that, in that regard, the most serious complication could be a deterioration of the wound and an infection, but if that was to occur they would treat it with antibiotics. It might require a further surgical intervention, but he was quite clear to me that the risks of not proceeding with this operation were far greater than the risks of proceeding with it. His assessment yesterday has not changed his position. He accepted that the wound was getting smaller, but it was still a considerably sized wound. He told me it was 10cm by 8cm and still 2-3cm deep going to the bone. I have seen photographs of the wound and it is to my untrained eye an extremely unpleasant and serious wound about which I have grave concerns. He said that, whilst he was examining the patient, SJ opened his bowels without telling them and the faeces were soiling the edge of the wound. He said that SJ did not warn them that he was about to do so. He was asked to do so and said that he would, of course, tell them if he was about to do so. He then opened his bowels a second time, again without telling them. The doctor was quite clear in his own mind that SJ was unable to tell them when he was going to open his bowels. He said that notwithstanding padding and dressing to cover the wound, the faeces were likely to invade the wound on every occasion because of the proximity of the wound. He said that the inflammatory markers for the patient go higher whenever there is an infection and he took the view that the patient simply will not get better if there is ongoing infection of the wound. It spikes with sepsis approximately once per month. It never gets back to normal due to the ongoing wound. He has been slightly better in the last month and that has given them the window to undertake this operation. The wound is still Grade 4, which is the worst possible wound. He said, and I accept, that the nursing care given to SJ has been exceptionally good and it has improved the position to some extent, but what they are concerned about is an infection that becomes untreatable, whether by antibiotic immunity or for some other reason. The consequent septic shock that the patient will then undergo is likely to lead to respiratory failure, cardiovascular failure, kidney failure and then death. He thought the prospects of that happening if the patient got septic shock were between 80 and 90 per cent. That, therefore, is the reason why he gave a four to six month life expectancy in the absence of this operation taking place. He said the prospects of the patient getting

better without the operation were negligible and SJ was particularly susceptible to septic shock if the operation did not take place.

31. This afternoon I heard from the consultant surgeon, Mr V, in slightly unusual circumstances. He gave his evidence in part from a taxi, in part on the pavement outside his house and in part inside his house, but I was able to hear him quite clearly and I do not believe that that in any way affected the Article 6 compliance and the right to a fair trial. He told me that, if this surgery is not performed, this man will die. Indeed, he said he was quite surprised that the patient had survived this long. He said he would be really surprised if the patient went on for more than another four to six months, but that was a very rough estimate and it was difficult to say. I accept that. I acknowledge that it is possible that the patient would, in the absence of the operation, go on for four to six months or possibly even slightly longer, but I accept the doctor's evidence that, without this operation, the prospects of SJ dying an unpleasant death are extremely high. The doctor said that contamination of this wound will still occur even if the wound gets smaller. There is continuous contamination with bacteria and he is particularly worried by an antibiotic-resistant infection, such as the Klebsiella that the patient had in June 2018. He said that now was the ideal time for surgery. This window will not remain open indefinitely and it will be impossible to perform the operation once the patient gets sepsis again. The reason for the operation is to prevent sepsis. He said that many of the points that were made by SJ's sister were completely wrong. For example, it is completely wrong to allege that there will be any effect on the patient's urinary function by performing a colostomy. He does not agree that there will be any greater susceptibility to further ulcers around the colostomy bag than for any other diabetic, but if there were, it would be much easier to treat than the wound on SJ's back and he will receive the full package of care. Bags will be replaced when necessary and the doctor did not consider that any of the complaints made by the sister in that regard have any force whatsoever.

32. In answer to Ms Khalique for the Official Solicitor, he said that the use of diazepam had absolutely nothing to do with SJ being incontinent. He said that you would need an extremely large dose to cause a loss of sensation to that extent. It is his neurological condition that causes his incontinence. SJ is simply not aware of when he is going to open his bowels and he has, in any event, only been on diazepam for part of the period.

The doctor said that having harder stools does help reduce infection, but they have not achieved control despite medication to date and this situation cannot go on for months and months or even years. I remind myself that Dr A told me that yesterday, despite medication to harden the stools, the faeces still infected the wound on the two occasions that SJ passed stools whilst Dr A was present. He said that, indeed, there could be a problem with hardening the stools as SJ might get stool impaction which would require emergency surgery. He said they cannot carry on like this. That was the evidence that I heard and I accept unreservedly the evidence of all the doctors.

33. I will set out the law briefly. I accept and must apply the best interest principle that underpins the Mental Capacity Act. Under section 1(5):

> *"An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests."*

"Best interest" is not defined in the Act, but there is the check list which says the following:

> *"(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) I must also 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)."

34. The case law is to be found in a number of decisions, including *Re A (male sterilisation)* [2001] FLR 549 at page 555 where "best interest" was defined as "encompassing medical, emotional and all other welfare issues". King J in *An NHS Trust v DE* [2013] EWHC 2562 said:

"The courts have considered how s4 is to be applied in a number of reported cases. There is consensus that, as matters stand, the following should be borne in mind:

i) The decision must be made in DE's best interests not, in the interests of others although the interests of others may indirectly be a factor insofar as they relate to [his] best interests.

ii) The court is not tied to any clinical assessment of what is in DE's best interests and should reach its own conclusion on the evidence before it.

iii) Best Interests is an objective test.

iv) The weight to be attached to the various factors will, inevitably, differ depending upon the individual circumstances of the particular case. A feature or factor which in one case may carry great, possibly even preponderant, weight may in another, superficially similar case, carry much less, or even very little, weight.

v) There is no hierarchy in the list of factors in s4 and the weight to be attached to the various factors will depend upon the individual circumstances.

vi) There may, in the particular case, be one or more features or factors which, as Thorpe LJ has frequently put it, are of "magnetic importance" in influencing or even determining the outcome.

viii) The declaration should not be sought if… disproportionate and not the least restrictive step. Risk management is better than invasive treatment.

ix) The decision is for the Judge not the expert. Their roles are distinct and it is for the Judge to make the final decision…"

Although the past or current wishes and feelings of the patient cannot be determinative if he lacks capacity, they are important factors.

35. I was referred to Munby J's decision in *Re M; ITW v Z* [2009] EWHC 2525 in which he said:

"*… the weight to be attached to their wishes and feelings must depend upon the particular context…"*

Later:

"… the degree of [the patient's] incapacity, for the nearer to the borderline the more weight must in principle be attached to [his] wishes and feelings…

b) the strength and consistency of the views being expressed by [him];

c) the possible impact on [him] of knowledge that [his] wishes and feelings are not being given effect to...

d) the extent to which [his] 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 [his] wishes and feelings, if given effect to, can properly be accommodated within the court's overall assessment of what is in [his] best interests."

36. Finally, in *Aintree University Hospitals NHS Foundation Trust v James* [2003] UKSC 67, the Supreme Court made it clear that the Court of Appeal had been wrong to focus on what the reasonable patient would decide and emphasised that the patient's own wishes and feelings must be properly considered. The things which are important to him should be taken into account because they are a component in making the choice which is right for him as an individual human being.

37. I have listened very carefully to the evidence in this case. I am quite clear that the medical opinion is, and I accept the medical opinion, that if this colostomy does not happen this patient will continue to remain in this hospital and will, regularly, get recurrent sepsis that has to be treated, as a result of the infected wound and faeces coming into contact with that wound. I find as a fact that, at some point, likely to be within the next four to six months, but possibly longer, SJ will get a resistant infection that cannot be treated by antibiotics. The consequence of that will be that SJ will get septic shock that the doctors cannot treat. His vital organs will begin to fail and he will die. On the other hand, the treatment that is being recommended, although not without any risks, involves significantly fewer risks now than before. I take the view that the remaining risks are entirely justified given the high probability of SJ's death if this course of action is not taken.

38. I accept that the morbidity aspects, although higher, are not likely to be life-threatening. The chances of his life ending as a result of this anaesthetic is 2.3 per cent which I consider, in the circumstances, to be an acceptable risk given the extremely high probability of death if the operation does not take place. I take the view that the higher morbidity statistic is also justified on the basis that these possible complications can be treated in hospital without huge difficulty, including even the more serious complications. I find that, if SJ has this colostomy he is likely to tolerate it and, indeed, to be much happier as a result of it. I think it equally likely that, with the colostomy, the wound is more likely to heal quickly than if the operation does not occur and the wound continues to be infected by his faeces when he passes them.

39. So everything points to this operation being authorised by me and taking place. The only thing that is against it is SJ's wishes that it does not take place and, to a lesser extent, the wishes of his sister. I am quite clear that I should, in the circumstances of this case, overrule those wishes. I am of the view that the reason why SJ does not want the operation is because he believes that it will cause him further pain. That is not the evidence of the doctors. Indeed, the evidence of the doctors is that he is more likely to be in significant pain if he does not have this operation and I accept their evidence. It appears that as a result of his diabetes he has a high pain threshold and I am quite clear that there is unlikely to be any significant pain in any event as a result of this operation.

40. I am equally clear that I should reject all the other points that are made on his behalf by his sister. The vast majority of them are completely contrary to the evidence that I have heard and I reject them. Although I accept that the pressure sore is reducing in size, it is quite clear to me that it is not going to be the solution to SJ's problem. I reject the sister's contention that her brother has capacity. I do not accept her point that the need for surgery is unnecessary and he can be managed conservatively. I do not accept that stool hardeners will be the answer. I do consider SJ has had optimal nursing care, but still remains in the position that he is today, although fortunately that optimal nursing care has at least given a window for this operation to take place. I do not accept that this problem will go away by the time the pressure sore has healed. I doubt it will heal completely in any event without this operation. I do not accept that the medication to manage the psychosis has had any effect on delaying the healing of the wound. I do not accept the diazepam has had any effect on his incontinence and I do not accept that if he was alert he would be able to tell the nursing staff of bowel movements to enable them to use the bedpan. I do not accept that the reduction in the blood pressure medication has had anything to do with this at all.

41. So far as the likely complications with the colostomy are concerned and the risks of surgery, I have already satisfied myself that they are reasonable and that the risks are far less than the risks of him not having this colostomy. Everything points overwhelmingly to him having the operation. Finally, although there is some chance of some postoperative delirium, I am satisfied that it will be on a very short-term basis. I therefore reject completely the points made on behalf of the sister.

42. I am clear that this is an operation that should now take place as being overwhelmingly in SJ's interests. I take the view that, if he had capacity, he would, in fact, see that and would wish to save his life in that way. There is absolutely no indication that he really wants his life to end. I am quite clear that, if he could understand the evidence that I have heard today from the three doctors, he would say "Judge, I do not know why we are in court; of course I must have this operation. Please do it quickly". Because of his incapacity, he is unable to weigh the matters up in this regard. But for that very reason I take the view that I should overrule his wishes, notwithstanding having very carefully considered all the law on this point and the wishes as he has set them out both to the doctors and to the Official Solicitor. I therefore approve the order that is sought on his behalf by the NHS Trust.

43. I do take the view that this should be the end of this case. I do not consider that it is helping either SJ or his sister. I am sure that, if the matter had been adjourned and the case not finally determined by me today, it is likely that it will cause greater difficulties for SJ and I am clear that that should not happen.

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