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Case No. COP13482000

IN THE COURT OF PROTECTION
[2019] EWCOP 41

Royal Courts of Justice
Strand
London, WC2A 2LL

Thursday, 15 August 2019

IN THE MATTER OF THE MENTAL CAPACITY ACT 2005

Before:

MR JUSTICE COBB

(Sitting as a Judge of the Court of Protection)

B E T W E E N :

THE HOSPITAL — Applicant

- and -

JJ
(BY HIS LITIGATION FRIEND THE OFFICIAL SOLICITOR) — Respondent

MISS N. KHALIQUE QC appeared on behalf of the Applicant.

MR I. BROWNHILL appeared on behalf of the Respondent.

J U D G M E N T

MR JUSTICE COBB:

1 Today's application in the Court of Protection concerns JJ born on 13 September 1995. He is 23; he will be 24 years old next month and he lives with his parents at their home. JJ is currently an inpatient at the Hospital where he is very weak; as a healthcare professional from the hospital told me earlier in this hearing he is very close to requiring "intensive care" treatment, and she (the healthcare professional currently responsible for his care) is very gravely concerned about his medical condition.

2 The application which comes before the court is made by the Hospital Trust. It is an application which is dated 15 August 2019; the application seeks the following relief, namely, that it is in JJ's best interests to use all reasonable and proportionate measures, including physical restraint, to administer insulin to him and to undertake all observations and monitoring of JJ's vital signs and physiological condition. The reason why the applicant makes this application is further set out in their application form as follows:

> "[JJ] is diagnosed with type 1 diabetes and is currently an inpatient at [the hospital] following a deterioration in his physical health arising from his diagnosis. Currently, [JJ] is noncompliant with his medication regime which involves regular daily insulin injections to manage his condition. [JJ] is in a state of diabetic ketoacidosis which is a life-threatening condition if left untreated. [JJ] is refusing to accept medical intervention or treatment. The application is made to seek the court's permission to enable [JJ's] treating clinical team to provide him with the necessary medical treatment to stabilise his condition."

3 I can say at once that since that application was drafted, I suspect yesterday mid-afternoon, JJ in fact did receive some small amount of insulin which had the effect of bringing him back from the brink of life-threatening diabetic ketoacidosis. So although he is still extremely poorly, he is not in the life-threatening state that he was as reflected on the face of the application.

4 The application is supported by documentary evidence from Dr A, a consultant liaison psychiatrist of the relevant Mental Health Partnership NHS Trust, and Dr. B, a consultant diabetologist at the hospital. I have also had available to me a number of exhibits to the statement of the healthcare professional which reflects some of the earlier consultant intervention and involvement in JJ's treatment. I should add that the healthcare professional from the hospital has only really been involved directly in JJ's treatment since Thursday, 1 August (i.e. very recently). I have also seen a report of the independent mental capacity advocate, IMCA. I have seen one or two other documents but those are the key documents. For the purposes of making my decision, I heard brief evidence from the healthcare professional from the hospital, I heard the representations of IJ and JJ2, and the representations of leading counsel for the applicant Trust and counsel for the official solicitor who, in these proceedings, currently acts for JJ.

5 The case has been heard in the urgent applications court at the Royal Courts of Justice, on 15 August, and I am most grateful to all those who have given up their time to make this hearing possible. If I may I would like to single out for special mention the healthcare professional from the hospital who has plainly given what IJ (JJ's father) and JJ2 (JJ's mother) have described as "superb and patient care" for JJ, and whose obvious interest is in

securing the best outcome for JJ; this has been very plain for me to discern even through the unsatisfactory medium of the partial-telephone hearing.

6 In very short order, the background can be summarised thus. JJ was diagnosed with type 1 diabetes in May 2019. At the time of his first diagnosis, he was provided with emergency treatment and intravenous insulin, and he was discharged the following day, 2 May, for ongoing education and support in the community. Most unhappily, JJ was readmitted two weeks later due to a worsening of his condition. He was in a state of diabetic ketoacidosis but refused treatment for this. Because of the life-threatening condition he was in, it was necessary for the hospital staff then to administer insulin, having restrained JJ. It is fair to observe at this stage that JJ found the whole chapter of this admission extremely traumatic and has had probably some longer-term psychological consequences for him; he is now quite distrustful of some of the medical staff and of the threats to his own liberty whilst in the hospital environment.

7 He was, nonetheless, successfully brought back from the brink of a catastrophic illness and although (and I very much summarise the position here), he was followed up in the community, it is the fact that he was readmitted to the hospital on 15 July, having been brought to the hospital emergency department by his father having collapsed in the GP's surgery. He has been in the care of the diabetologist team at the Hospital since that day with only fluctuating willingness to accept the treatment.

8 As I earlier indicated, in fact, it looked yesterday as if JJ, who had become very, very much more unwell, (his mother told me, "Much the worst I've ever seen him"), was in a life-threatening condition. Mercifully, JJ accepted subcutaneous injunction of rapid acting insulin at about 15:00 hrs and that helped to avert a crisis, but it is right to reflect that that injection is only likely to provide him with relatively modest sustenance, as it were, and that further intervention and injection is inevitable, and it will be required within the next two to three days.

9 The circumstances in which the Court of Protection has a role in making decisions in case of this kind is established by statute, most specifically the *Mental Capacity Act 2005* ('*the 2005 Act*'). Statute requires me to start from the proposition that JJ is assumed to have capacity unless it is established that he lacks capacity; I must not treat JJ as unable to make a decision for himself unless all practical steps to help him to make a decision have been taken without success. The *2005 Act* requires me to note that JJ should not be treated as unable to make a decision simply because he makes "unwise" decisions. The court can only intervene if there is, on an interim basis, reason to believe that JJ lacks capacity in relation both to the conduct of this litigation and the decision relating to treatment. I can only exercise my powers under the *2005 Act* if I am satisfied that it is in JJ's best interests to make the order or give the directions without delay.

10 It is not, I think, necessary or helpful (particularly given the circumstances of the case and the high level of accord that exists between the parties) for me to go on to give a legal treatise on the circumstances in which the *2005 Act* can be used, but it is important to note that there is a diagnostic element to capacity, namely, does JJ have an impairment of or a disturbance in the functioning of the mind or brain and does that have functional implications, namely, does he understand the information he is being given, does he retain it, is he able to use or weigh that information, and is he able to communicate his decision in one form or another? If I take the view that the *2005 Act* can be invoked, then I turn to *section 4* of the *Act* which guides me as to the factors I must bear in mind in making a best interests' decision.

11 Whilst waiting for the hospital yesterday afternoon to provide information on which I could proceed, I drafted and sent to counsel a set of questions which it seemed to me it was necessary for the Trust to consider, and should answer. I will not reproduce those questions now but I am very pleased to note that those questions were forwarded both to Dr A and to the healthcare professional from the hospital in turn, and I propose simply to highlight their answers to the key questions that I asked. One question for Dr A was this, "What is the diagnostic evidence on which I should proceed? Is it said" I asked "that the 'adjustment disorder' meets the criterion under the *2005 Act*?" Dr A, in an email set at 20:10hs last night (I am sorry to have invaded on his evening), said this:

> "In my opinion, the psychological reaction experienced by [JJ] fulfils these criteria and it does constitute a disorder of the mind or brain within the terms of the *Mental Capacity Act 2005*. Further, it is my opinion that it is this reaction that prevents him from weighing up the information necessary to make the relevant decision, including the consequences of that decision or refusal."

12 I may add that the healthcare professional from the hospital, who has not specifically answered that question (recognising that it was more a matter for Dr A), went on to say:

> "In my opinion, he is so unwell medically that there is a clear clouding of his thinking compared to the rest of the submission. He his barely able to engage in conversation."

13 Perhaps it is appropriate that I should pause here to say that reliant upon Dr A's opinion, I have taken the view that there is reason to believe that JJ lacks capacity in relation to both the conduct of this litigation and the decision in relation to his medical treatment.

14 As to the matters concerning treatment itself, that has been most specifically dealt with by the healthcare professional from the hospital who tells me this: (i) that JJ has diabetes, based on the fact that his glucose levels are well above normal, and (ii) that it is type 1 insulin dependent diabetes. As he is young, he is wasting away without treatment. He has high levels of ketones, a by-product of fat metabolism that happens without insulin.

15 In answer to my specific question, "What is the current risk to his health?", she answered bluntly and starkly:

> "He will die in the next week if he continues to refuse treatment but this has now been offset by the acceptance of some albeit suboptimal treatment today."

16 I asked what the treatment is proposed and she answered:

> "As a minimum, this would be three daily administrations of background insulin. Ideal treatment would be daily background with rapid acting insulin to cover mealtime carbs. Given his current metabolic derangement, I would prefer to manage this over the next 24 hours with IV fluids and insulin but, at present, this is not absolutely essential."

17 I asked what the benefits were of giving the treatment and, again, she starkly told me that this would be "to save his life" preventing a serious deterioration in his physical condition.

18 I asked what the *dis*benefits of the treatment were, the side effects and that sort of thing, to which she told me there were none:

> "… other than the psychological distress this may cause JJ, particularly if we need to use restraint."

19 I asked what the consequences were for JJ of not giving treatment. Again, she starkly and bluntly told me that the answer was his death.

20 I asked about JJ's views. She told me that previously he had been totally rejecting of insulin but has no accepted two doses in the last 24 hours. His mother told me this afternoon that his attitudes very much fluctuate depending on the state of his health and recent administration of insulin.

21 I asked what the views of others who are important and relevant to him would be and I was told by the healthcare professional from the hospital that his parents are fully behind the life-saving treatment along with the rest of JJ's family. The nurses and doctors caring for JJ are very keen to treat him. I have had the singular advantage and the privilege of hearing from IJ and JJ2 directly today, in what must be extremely difficulty circumstances. I acknowledge readily that they are, indeed, fully behind this treatment.

22 I asked what arrangements were being made for JJ to participate in the proceedings and had offered the opportunity for him to participate in the hearing by telephone today; he did not feel able to do so.

23 My questions were answered, but within the care plan, it was apparent that there could or would be a need, potentially, for some element of restraint to administer the treatment. A care plan was prepared and circulated, and that has been the subject of cross-examination this afternoon. I will not reproduce the care plan in this judgment. It is there for those engaged in the proceedings to see and I summarised, at the conclusion of the evidence, what amendments need to be made to that care plan to bring it in line with the Official Solicitor's expectations on JJ's behalf of what is, indeed, necessary and proportionate, and in his interests.

24 It is, according to the healthcare professional from the hospital, very difficult to predict how JJ will respond now that orders are to be made, and authorisation given to administer reasonable restraint. Both his parents pray that he will be accepting of the treatment now that there has been this independent and objective evaluation of the need for treatment, but it is, nonetheless, acknowledged across the medical profession, the parents, and the Trust that restraint has to be a matter of last resort and in all circumstances, only such as is necessary and proportionate to give effect to the plan for treatment.

25 As to the future, it is envisaged that there will be a more thorough, detailed, and independent evaluation of JJ's capacity performed by Dr D , a psychiatrist who specialises in diabetology cases and it is envisaged that Dr D will be able to see JJ, I think, on 23 August for the purpose of that assessment.

26 As JJ's father pointed out, (and if I may say so, I am sure he his right about this), JJ desperately needs help to come to terms with this condition. JJ is obviously a bright, thoughtful, engaging, loving young man who his mother said wanted to look top to bottom of the diagnosis of dyslexia when he was a younger person and he will, for his part, want to fully understand, investigate, and familiarise himself, and significantly and perhaps most difficulty accept this condition of diabetes if he is to maintain stable life in the community.

That is a longer-term project, long beyond the remit of today's hearing or the immediate issues that confront us all, but I give voice to them because IJ having articulated them, they resonate very loudly and clearly with me.

27 I turn then back to the immediate application and the relief sought. For the reasons that I have already briefly set out this afternoon, I do consider on the evidence that there is reason to believe that JJ lacks capacity in relation to the issues concerning his treatment. I consider that it is in his best interests that he be treated in accordance with the plan that has been laid out before me by the Trust and I am satisfied that it is necessary and proportionate, and in JJ's best interests to make the order that reasonable restraint can be used in order to administer treatment given that JJ's rights under Article 5 of the European Convention are engaged in that respect.

28 I think that is probably all I need to say as to the main issues in the case. I will ask Ms Khalique to perfect the draft order to reflect that which has happened today and what has been said, and also to make amendments, insofar as they have not already been made, to the care plan to reflect what the healthcare professional from the hospital has agreed should be explicitly set out there.

CERTIFICATE

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