Neutral Citation Number: [2020] EWCOP 10

Case No: 13570527

IN THE COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 27/02/2020

Before :

THE HONOURABLE MR JUSTICE HAYDEN
VICE PRESIDENT OF THE COURT OF PROTECTION

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Between :

Sherwood Forest Hospitals NHS Foundation Trust	**Applicant**
- and -	
C	**Respondents**
(by her litigation friend the Official Solicitor)	
Nottinghamshire Healthcare NHS Foundation Trust	

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Ms Sophia Roper (instructed by **Browne Jacobson LLP**) for the **Applicant**
Ms Fiona Paterson (instructed by **Official Solicitor**) for the **Respondent**

Hearing dates: 28th February 2020

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Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

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THE HONOURABLE MR JUSTICE HAYDEN

This judgment was delivered in public. The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of C and members of C's family must be strictly preserved. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

Mr Justice Hayden :

1. This is an application brought by Sherwood Forest Hospital NHS Foundation Trust in relation to C, who is in her 60s. C lives alone but is supported by her mother, E. I am told that the two spend most evenings together, from late afternoon until around 8 o'clock at night. E is entirely aware of the application, but does not wish to be involved because she regards her primary duty here as protecting her relationship with her daughter.

2. The solicitor on behalf of the applicant Trust has, I am told, explained to E the variety of ways in which she could be involved in helping the court to come to the decisions that it has to take. E is quite adamant that she wishes neither to be a party nor to be heard. Moreover, she does not wish for her views to be communicated indirectly to the court and she has declined to see any documents. This should not be interpreted by those reading the judgment as indicating in any way that she is not concerned with or motivated to protect her daughter's best interests. She is indicating that her carefully considered view is that she wishes to preserve her close relationship with her daughter and does not want to compromise that with any conflict. It is stated that, in the past, C has stopped talking to her mother when she has felt that her mother has in some way gone against her wishes. E considers that she is really the foundation for her daughter's support and pivotal to her physical and emotional well-being. In these circumstances, she perceives to the preservation of that to be her priority. She needs no encomium from me, but I would like to signal to her that I think she has taken entirely the right decision.

C's mental health history

3. C has been diagnosed with paranoid schizophrenia. Quite when that diagnosis was made is not entirely clear, but it has now been in place for a considerable time. Sadly, it has resulted in C being detained, historically, under the aegis of the Mental Health Act 1983. Most recently, she was admitted to the Millbrook Mental Health Unit, located at King's Mill Hospital but under the responsibility of the Nottinghamshire Healthcare NHS Foundation Trust, the second respondent in this application, from 9th June to 22nd October 2019. That admission has been in focus at this hearing. It came about as a result of C's decision to stop taking her medication. In consequence of that decision, I have been told that C suffered kidney failure, which could have been fatal. Happily, it was not. C attributes her recovery to God's intervention.

Circumstances of C's recent presentation

4. On 25th November 2019, C presented to her GP with symptoms of post-menopausal bleeding. This led to a referral to the Trust. Two features require to be highlighted. Firstly, it was C who decided to seek out medical treatment in the first place and, secondly, C who pursued further treatment at the hospital to investigate the cause of the bleeding. All agree that, in this period, C appeared capacitous in her decision making. It requires to be clarified, though, that what she was determined to do was to investigate the source and cause of her bleeding and to see what the treatment options were. That, as emphasised by Ms Paterson, on behalf of Official Solicitor, is different from what has been in focus at this hearing, namely whether C should have a hysterectomy.

5. When C was reviewed by the gynaecology team in November, a hysteroscopy was proposed and that was performed on 10th December. This procedure did not require any

local anaesthetic or sedation. I emphasise that C agreed to the investigation, which, of course, is intrusive and lasts for some 15 minutes. She was entirely compliant with the process. What was noted at this appointment was that C had prolonged vaginal bleeding. She consented, in written format, to the investigation, and those responsible for the investigation are clear that there were no indicators, of any kind, that she lacked the capacity to make decisions regarding the investigation.

6. During the hysteroscopy, a large polyp was found. Unfortunately, it was necessary to arrange a second hysteroscopy at a different hospital to remove it. That is because what was required was a myosure polyp resection device which was not available at the Newark Hospital and required to be performed at the King's Mill Hospital. In simple terms, this is a device attached to the camera that enables a wire to be released which wraps itself around the polyp causing it to fall into a sterile bag, which is then sent to the pathology laboratory. At this second hysteroscopy, a specimen of the endometrial tissue was removed and sent for analysis. It was confirmed that this revealed Grade 2 endometrial cancer. Once again, nothing at all, at this stage, caused any of the treating clinicians to be concerned regarding C's capacity to weigh and analyse the investigations or to make decisions regarding her treatment.

7. Due to the histopathological results, C was inevitably referred to the Cancer Multidisciplinary Team (known as the MDT). The MDT meeting took place on 30th December. A note of the meeting is exhibited in the court bundle. Mr William Dudill, consultant gynaecologist at the applicant Trust, chaired the meeting, at which attended the Deputy Lead Cancer Clinician for Gynaecology, a consultant histopathologist, a consultant radiologist and two gynaecology cancer nurses. The consensus was that there should be a Total Laparoscopic Hysterectomy and Bilateral Salpingo-Oophorectomy, by which is meant a removal of the ovaries and fallopian tubes.

8. At this time, I understand, the MDT were not aware that C had a diagnosis of paranoid schizophrenia. Though that diagnosis had been highlighted in the referral, it had not found its way through to this team. As far as a treatment pathway is concerned, it is irrelevant. But it is a troubling omission.

9. Mr Dudill, from whom I heard evidence, told me that, in his role as gynaecological oncology surgeon, he first met C on 9th January 2020, that is to say, following the MDT meeting. Again, and this is significant, C attended that appointment punctually and without hesitation. She attended with her mother. Mr Dudill met with C, her mother and a specialist nurse, Ms Sarah Halsall, from whom I have also heard evidence today.

10. It is Mr Dudill's usual practice initially to introduce himself as the consultant gynaecologist and then sensitively to outline to his patient the findings of the histopathology and the conclusions of the MDT team. He told C that, unfortunately, they had reached a diagnosis of endometrial cancer, but he emphasised that the cancer was highly treatable and that the prospects were very positive. He conveyed to her the conclusion that a Total Laparoscopic Hysterectomy and Bilateral Salpingo-Oophorectomy were required. In particular, Mr Dudill emphasised, as he tells me is his entirely standard practice, that the majority of endometrial cancer is treated successfully with these procedures and that 90% of patients require no further treatment at all. In explicit terms, he outlined the procedure itself, which is very much less invasive than it would have been a decade or so ago, as involving an operation of about two hours duration and that, in most cases, the patient is back to near normal functioning within a

fortnight. He added that occasionally, and in around 10% of patients, there will be follow-up radiotherapy. Sometimes this will be preventative but at other times intrinsic to the curative process.

11. The radiotherapy in this case would take place at the Nottingham City Hospital around six weeks after surgery, if it were necessary. Ms Halsall, in her short and concise evidence, told me that it would probably require no more than two or three treatments. The interval between those treatments would be dependent upon the patient's wishes and response, but, paradigmatically, they would be undertaken within one and a half weeks in total. They would also require the insertion of a vaginal dilator to assist the patient in minimising pain at any future examination.

12. When Mr Dudill explained all this to C, she was markedly unresponsive and incommunicative: he describes her as "*almost mute*". Because he was not alert to her underlying mental health difficulties, Mr Dudill was unsure as to whether this response was an indicator of shock at hearing such news or related to something more significant. He told me that, in those circumstances, he thought it best for C to spend some time with the cancer nurse, Ms Halsall, for a more informal chat in which she might feel more comfortable in articulating her concerns or expectations. Having facilitated that meeting, Mr Dudill later re-joined them, but noticed that C continued to be very withdrawn. However, despite her presentation, C agreed to go ahead with the operation and also signed the necessary consent forms.

13. The treatment that I have outlined above is, I am told, generally regarded as the gold standard treatment for women with endometrial cancer. Patients are followed up for three years and there is considered to be only a small chance of recurrence. There are other surgical options, with which it is not necessary for me to further burden this judgment and which, I am satisfied, fall somewhat short, in the circumstances of this case, of the plan for C. Mr Dudill outlines that plan in his statement (dated 26th February 2020) in these terms:

> *"24. Treatment should ideally take place within the next month but at the latest be performed within 3 months. Without treatment it is likely that the cancer will progress causing metastatic disease throughout the abdomen and chest and symptoms such as pain, bleeding shortness of breath and ultimately death. It is difficult to estimate how quickly CC's cancer will progress if left untreated because for obvious reasons there are no clinical trials which cover this.*
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> *25.The exact timescale of progression is difficult to estimate but anecodotal evidence suggests that it is likely to progress from early stage to advanced cancer in an untreated patient within around 5 years. The stage of CC's cancer will be determined following histopathological analysis of the hysterectomy specimen following surgery.*

14. Mr Dudill also sets out the mechanics of the plan and the strategic involvement of the consultant anaesthetist and intensivist.

15. Despite having agreed to the surgery, it became clear in the weeks that followed that C had disengaged. When it was pursued, she was adamant that she did not want the

treatment. She expressed the view that "*only God could cure* [her] *cancer*" and, though properly and, in my judgement, sensitively challenged, she rejected any idea, for example, that God might act through the intervention of medical treatment.

16. A joint assessment of her capacity to understand and evaluate the nature of her treatment was made on 19th February 2020 by Mr Srini Vindla, a consultant gynaecologist and Dr Caroline Innes, a consultant psychiatrist. Although neither is C's treating clinician, it is perhaps significant to note that C was happy to engage with them, albeit constraining herself to her already expressed view. Dr Innes reminded C of a previous occasion when she had been treated by the doctors following an admission pursuant to the Mental Health Act, once when she experienced kidney failure and on another occasion, infected abscesses. C remembered these and told Dr Innes that she had recovered because it had been God's will. She said that God had made her start drinking again. She attached no significance to the impact of the depot antipsychotic medication. At the interview Dr Innes reports C as being calm. She did not appear physically unwell and she had not obviously lost weight. There was no evidence of self-neglect. The pauses in her conversation might indicate some auditory hallucination but I did not get the impression from her statement that Dr Innes was convinced of this. Dr Innes described C's presentation as *"objectively flat but not depressed"*. Her speech was said to be *"quiet but coherent"*. She refused to explain any of her reasoning but her concentration did not appear to be impaired.

17. Dr Innes concluded that C still had symptoms of chronic schizophrenia and that there were suggestions of delusional beliefs. She considered C is unable to weigh the evidence required to make an informed decision in relation to her treatment and her inability to engage in weighing the consequences indicated a lack of capacity relating to her consent to treatment. It is important that I emphasise that Dr Innes considered whether a change in C's treatment or medication for her mental illness might serve to promote capacity, but concluded that it would not.

18. When C was a younger woman, before the cloud of paranoid schizophrenia descended upon her life, she was noted to have been a very happy and outgoing young person. Her interest in religion began only after her mental health problems developed. I hope that these religious beliefs may, in some way, have been a comfort to C. But it requires to be identified that her expressed religious beliefs have become a facet of her mental health problems and a channel for delusional thoughts. For example, she has in the past believed herself to be pregnant, carrying the child of God. This has been a delusion of such vibrancy for her that she has carried it through to purchasing baby clothes for the child she believed she was carrying. It is important therefore to disentangle capacitously held religious beliefs from the delusional views here. It requires some sensitivity.

19. The preponderant evidence that I have sought to highlight indicates a woman who wanted to address her post-menopausal bleeding, to identify the appropriate treatment and cooperate with the investigative process. As I have stated, whilst C still appeared capacitous she signed forms consenting to treatment. Subsequently, perhaps in consequence of the shock, she clearly lacked capacity and her rejection of the treatment, which is clinically so manifestly in her best interests, is predicated on a delusional belief structure which manifests itself in the language of religion.

20. Of course, the fact that the clinical best interests are clear does not mean, automatically, that C's 'best interests' more generally, lie in her having the surgery. That can only be

determined by a wider examination of C's circumstances, consideration of her relationships, endeavouring to understand who she is and the code by which she lives her life.

21. In considering this wider canvas it emerges that C, with the support of her mother, has a full and varied life. She plainly has a strong, important relationship with her mother and she has an enduring commitment to her niece, of whom she speaks with affection. When capacitous, there is nothing at all to indicate that she is in any way disenchanted or weary with life. On the contrary, the indicators are that she is enthusiastic for it, notwithstanding the challenges that her mental health condition has posed to her over the years.

22. Yesterday, when I saw the written application in this case, I was very concerned that with a diagnosis of this kind, made on 30th December 2019, surgery was not contemplated until March 2020. I was also concerned that what was anticipated in these proceedings, by the lawyers, was a series of investigations, envisaging a hearing in a few weeks' time. There has been delay. However, having heard all the evidence, particularly emphasising the limited aggression of the cancer (stage 2), I am satisfied that the delay will not have had adverse impact on C. By this I mean the cancer has not been neglected.

23. Here, the delay was attributable primarily to the fact that C appeared, up to and including 9th January 2020, to have been entirely capacitous. Only when suspicions were aroused did it emerge that she was not. Although the initial referral to the hospital had flagged up the fact of her paranoid schizophrenia, it is clear that the information relating to that diagnosis was not shared to the extent that it should have been with the team of treating clinicians. I see no reason why that should have occurred. In the future, where there is such a diagnosis, it should be regarded as requiring prominence in the medical records. This is not intended in any way to stigmatise the patient, but to seek to ensure that they are provided with treatment in a way which places them on an entirely equal footing with capacitous individuals in the same situation.

24. The second reason leading to the delay arises from the anxiety that all medical professionals understandably face when they are required to contemplate the restraint or coercion of a resistant, incapacitous patient. These are incredibly difficult challenges, but delay only serves to compound that challenge. Those faced with these difficulties must always recognise that delay is likely to be inimical to their patient's care and that the time scales for intervention constructed around the patient must focus unwaveringly upon that patient's best interests. The delay here has not exacerbated the risk arising from the cancer but it may have, indeed I consider it likely to have added avoidable stress to C and her family.

25. In the past, though C has expressed herself as resistant to treatment, ultimately, she has cooperated and restraint does not appear to have been necessary. If there has been coercion, it has been only of the most minimal nature.

26. I heard telephone evidence from a Dr Savvopoulou, psychiatrist. She told me that her instinct, having known C for some time, was that whilst she would not express agreement with treatment, she would be unlikely to resist it when, as she put it, *"the alternative options are removed"*. Dr Savvopoluou properly emphasises that this is ultimately no more than her professional instinct. In the course of exchanges with

counsel it was noted that even when orders permitting a proportional degree of coercion and restraint are made (rare as they are), they frequently prove to be unnecessary. Their significance is as a *"back up"* in the event of determined resistance.

27. Because I was not prepared to countenance delay, the case was called in and it has been possible, with the assistance of extremely experienced counsel, to resolve the issues today. I am satisfied that it is in the best interests of C to have the surgery. I do not find that to be a delicate balance. There is amongst all lawyers, doctors and judges a strong instinct to preserve human life (Aintree University Hospital NHS Trust v James [2013] UKSC 67; Kings College Hospital Foundation Trust v Haastrup [2018] EWHC 127 (Fam)). Here there is clear evidence of a likely prospect of a successful outcome, where the alternative is that C would die. Moreover, as I have indicated, there is much to indicate that C, when capacitous would want to live. Her decision, as I have detailed above, to seek out treatment and in fact consent to it orally and in writing I consider to be a powerful indicator of her wishes when capacitous. Accordingly, I am able to make the declarations the Trust seeks.

28. In this case, it has not been possible for the Trust to put a plan together outlining the details of the coercion and/or restraint that would be considered to be proportionate in the event of C's resistance. The absence of this plan is a direct consequence of my decision to cause the case to be heard quickly. I am able to make the best interest declarations I have indicated but they are not to be given effect until the plan has been put together and approved initially by the Official Solicitor and subsequently by this court. In the event that such approval is not forthcoming the case is to be restored before me, on short notice if necessary.