Neutral Citation Number: [2020] EWCOP 35

Case No: 13619286

IN THE COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 02/07/2020

Before :

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

- -

Between :

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST	**Applicant**
- and -	
KD	**Respondent**
(By her litigation friend, the Official Solicitor)	

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- -

Mr Mungo Wenban-Smith (instructed by **Hull University Teaching Hospitals NHS Trust**) for the **Applicant**
Ms Nicola Greaney (instructed by the **Official Solicitor**) for **KD**

Hearing dates: 2nd July 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 following a remote hearing conducted on a video conferencing platform and was attended by the press. 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judgment) in any published version of the judgment the names and addresses of the parties and the protected person must not be published. 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 Hull University Teaching Hospitals NHS Trust (the "Trust"). It concerns KD, a 57 year-old woman who has a longstanding diagnosis of paranoid schizophrenia and is a lifelong heavy smoker, who I am told continues to smoke around 60 cigarettes per day. Her current medication consists of the anti-psychotic Clozapine, Norethisterone and a mood stabiliser, Valproic acid. KD is represented by the Official Solicitor, who has accepted an invitation to act as her litigation friend.

2. KD has developed right-sided pneumothorax, commonly known as a collapsed lung. Her right lung is described as totally collapsed. KD was scheduled in the operating list of Dr Ahmed Salah, a consultant cardio-thoracic anaesthetist at the Trust's Castle Hill Hospital (the "Hospital") in Hull since 1992, as an urgent case on Tuesday, 30th June 2020 but this did not proceed because KD objected to the procedure taking place that day. She had arrived on the ward on Sunday 28th June in anticipation of the surgery, having previously been an inpatient on the respiratory unit at the Hull Royal Infirmary for just under two weeks.

3. It is proposed that KD undergo a surgical intervention. It is described as right-sided video-assisted thoracoscopic bullectomy and pleurodesis, a form of what is commonly known as "keyhole" surgery, the details of which I shall set out below. The need for this arises in consequence of what is in fact a second pneumothorax. Mr Vasileios Tentzeris, her consultant thoracic surgeon, has explained to me in simple language, that when the lung collapses because there is a hole in it, the lung, which he described as being like a balloon in a barrel, deflates, the air is compressed and it has to be reinflated. Mr Tentzeris was contacted by the respiratory consultant at the Royal Infirmary on 28th June and then met KD once she had arrived at the Hospital on 29th June and on another three occasions on 30th June.

The legal framework

Capacity

4. There is a presumption of capacity: s.1(2) Mental Capacity Act 2005 ("MCA 2005"). The burden of proof lies with any party asserting a lack of capacity and must be established on the balance of probabilities: s.2(4) MCA 2005.

5. The principles of the MCA provide that, in addition to the presumption of capacity,

   i. a person ("P") is not to be treated as unable to make a decision unless all practicable steps have been taken to assist him or her to do so without success (s.1(3) MCA 2005);
   ii. P is not to be treated as unable to make a decision merely because he makes an unwise decision (s.1(4) MCA 2005);
   iii. any act done or decision made on P's behalf must be made in his best interests (s.1(5) MCA 2005);
   iv. regard must be had to the principle of least restriction (s.1(6) MCA 2005).

6. P lacks capacity in relation to a matter if, at the material time, he or she is unable to make a decision for himself or herself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain (s.2(1) MCA 2005). This is the "single test" for capacity albeit that it falls to be interpreted by applying the more detailed description given around it in sections 2 and 3 MCA 2005 (**PC v NC and City of York Council [2013] Civ 478 at [56]**). The single test consists of three elements:

   i. the functional test: is the personal unable to make a decision for him or herself?
   ii. the diagnostic test: is there an impairment of or disturbance in the functioning of, the mind or brain?
   iii. is there a "causative nexus" between the mental impairment and the inability to decide?

7. The functional test, pursuant to s.3(1) MCA 2005 provides that P is unable to make a decision for himself if he is unable (at the material time (s.2(1)) to a) understand the information relevant to the decision; b) retain that information; c) use or weigh that information as part of the process of making the decision; d) communicate his decision by any means. The information relevant to the decision includes the reasonably foreseeable consequence of deciding one way or another or failing to make a decision (s.3(4) MCA 2005).

Best Interests

8. Any act done or any decision made on P's behalf must be done or made in P's best interests (s.1(5) MCA 2005). Best interests are not defined under the MCA 2005 but are to be ascertained by reference to the s.4 checklist. A determination of best interests must consider all relevant circumstances which include (s.4(11)) those of which the person making the determination is aware and those which it would be reasonable to regard as relevant. In particular, pursuant to s.4(2) MCA 2005, a determination must take the following steps:

   i. consider whether it is likely that the person will at some time have capacity in relation to the matter in question, (s.4(3)(a)
   ii. if it appears likely that he will, when that is likely to be (s.4(3)(b) MCA 2005);
   iii. encourage P to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him (s.4(4) MCA 2005);
   iv. consider, so far as is reasonably ascertainable, the person's past and present wishes and feelings, the beliefs and values that would be likely to influence his decision if he had capacity and the other factors he would be likely to consider if he were able to do so (s.4(6)(a)-(c) MCA 2005);

v. take into account, if it is practicable and appropriate to consult them, anyone named as someone to be consulted, (s.4(7)(a)), anyone engaged in caring for the person or interested in his welfare (s.4(7)(b) MCA 2005).

9. Best interests decision-making is not a matter of substituted judgment but requires decision-makers to:

> "*look at 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*." **(Aintree University Hospitals v James [2014] AC 591 [39])"**

Analysis

10. Before I turn to the medical plans for KD, I must first address the issue of her capacity in accordance with the test set out above. It is not lightly assumed she lacks capacity merely because she has a longstanding diagnosis of paranoid schizophrenia. Even with this condition, it may be possible to understand, retain and weigh the issues that arise. However, KD suffers from active persecutory delusions which impair her ability to understand and take decisions. She has had the benefit of a community psychiatrist, Dr Graham Harkness, for some 10 years with whom she has an easy and comfortable professional relationship. Dr Harkness has concluded that KD does not have the capacity properly to evaluate and weigh the medical issues around the proposed treatment in this case. The primary impediment, he considers, is KD's unspecified anxiety which involves a generalised belief that rather than being there to help her, as they self-evidently are, the doctors may be motivated by some more hostile animus.

11. It is important to emphasise that the treatment which is proposed is essential to save KD's life. She will die without it. It is regarded by cardio thoracic surgeons as a relatively straight forward procedure. Mr Tentzeris told me that in a recent study he is about to co-publish, he has not been able to find a single case where a patient has died from this procedure in the last 10 years in the Hull /Leeds area. It is a "keyhole" procedure and usually takes no more than 25-30 minutes. It has every prospect of success for KD.

12. There has been an attempt, at the Royal Infirmary, to reinflate the lung more conservatively in accordance with the relevant protocols. This involves the insertion of drains into the lungs while waiting for the hole in her lung to heal itself. This did

not work for various reasons, including KD's dislodging of the drains on a number of occasions, and is no longer clinically indicated.

13. When Mr Tentzeris spoke to KD, she told him a number of bizarre stories. KD indicated she did not want to undertake the surgery because she felt it might change her mental state. In a conversation yesterday with Dr Harkness, she also expressed an anxiety about undergoing the procedure on particular dates in the month. As the Official Solicitor has established from Dr Harkness, there is also a history of KD not being able to make a capacitous decision about a major gynaecological procedure in 2018.

14. I have little difficulty in coming to the conclusion on all the evidence that KD does not have capacity to make a decision about what treatment for her lung is in her best interests, as a result of the mental impairment caused by her paranoid schizophrenia.

15. It strikes me that the treatment that is in KD's best interests is clear, as set out in the witness statements from Dr Saleh (consultant cardio-thoracic anaesthetist) and Mr Tentzeris, as amplified in their oral evidence. Together, they illuminate the way forward clearly in a concise and focused manner that is to be commended in the context of an urgent application such as this.

16. In his statement Dr Saleh describes the proposed procedure as follows:

> *"10. Due to the fact that KD is a heavy smoker, she developed a right sided pneumothorax (or what is commonly known as a collapsed lung). To explain how this happens, the lungs behave like a balloon. When smoking, the surface becomes very weak. If a little crack develops then the whole lung collapses.*
>
> *11. Due to KD's current condition she is having to be actively monitored on vital parameters. She has electrodes attached to her and we are monitoring her heart rate, blood pressure, oxygen levels and pulse. It is vital that we check how her condition is progressing haemodynamically. With a fully collapsed lung, if a little bit more air enters in the pleural cavity that that can push the heart and strangulate the blood supply. This is called tension pneumothorax, which causes an immediate collapse of blood pressure (bringing it very close to zero) and this needs to be treated in seconds otherwise the patient will die. KD is currently in a high observation area of hospital where we can do this within seconds. The Trust has an on-call and on-site cardiothoracic team who are more than qualified to put a drain in to treat this as a matter of emergency.*
>
> *The procedure proposed and how it would happen*
>
> *12. The operation I am proposing, Right Video-Assisted Thoracoscopic bullectomy and pleurodesis, is a relatively big operation but in my profession, it is very common, and it is the simplest operation I will be doing that day. The procedure allows me to find the area of defect and repair it.*

> 13. *Once the anaesthesia is in place, I would use double lumen ventilation which means there would be separate tubes in each lung. While KD is asleep she would be breathing with one lung only, and the other would be intentionally deflated so I can operate on it.*
>
> 14. *I am proposing Video Assisted Thoracic surgery (in common parlance "keyhole surgery"). I make one to three small incisions or cuts on the skin, and go through the chest wall to the pleural cavity. Of the three holes, one has a camera (so I can see the operation on a screen in front of me) and the other two holes (which would be less than 1cm in length) allow me to insert instruments (which I use like chopsticks almost) down into the cavity. Those instruments have different ends to them and they allow me to do the procedure on the lungs.*
>
> 15. *The first part of the operation is identifying the weak area and isolating it. The repair itself requires me to use a lung stapler, which will seal the hole in the lung shut. This is called a bullectomy. It takes minimal amount of time (seconds to few minutes) to seal it once you have found the correct area.*
>
> 16. *Then second part of the procedure, the pleurodesis, fuses the lungs on the chest wall. What I want to do is to create an irritation on the lung. That irritation causes inflammation, which acts like a superglue and sticks the lung onto chest wall. There are several ways one can do that, one way is to use medically treated and sterile TALC powder which acts like a foreign body, creates inflammation and sticks the two together. I then fill the lung out with air.*
>
> 17. *From my point of view this surgery is very straightforward and a very common procedure. The operation itself takes around 15 to 20 minutes."*

17. Mr Tentzeris amplified this description in his oral evidence when he explained to me that what he creates in this clinical situation is, in effect, an irritation to the lungs which stimulates an antibody reaction that causes inflammation and acts as a kind of glue which sticks the lung on to the chest wall. With some diffidence he describes this as a straight forward procedure.

18. Ms Greaney on behalf of the Official Solicitor, has focused on KD's post-operative aftercare because that will involve around 2-3 days of drainage which, hitherto and in the previous context of the Royal Infirmary, proved to be problematic. There are a number of safeguards which the treating team have proposed and are intended to address these risks, most conspicuously the patient is to be given a pair of gloves or

mittens, rather like boxing gloves, that prevent her from removing the drains that will be inserted to drain fluid from her lungs.

19. Following the meeting that KD had with Dr Harkness yesterday, KD is now rather more resigned and compliant to the proposed surgical procedure. It may be that following the support she has received KD is not displaying the same level of agitation seen at the Royal Infirmary. In any event, the safeguards, including the gloves, are there in the care plan should they be required. KD may not understand that the drain is there for a good reason and so the mittens will be an important measure.

20. There has been some discussion, when evaluating the overall risk matrix, as to the extent to which the present Covid-19 pandemic has to be factored into the risk analysis. There are a number of points here that are of importance. Firstly, due to the fact that KD presently has no drains from her chest, the surgery needs to happen urgently and is contemplated in the next 24 hours. Secondly, a repetition of the earlier option of draining KD's lungs and waiting for the lungs to heal themselves is likely to take a great deal longer, thus exposing the patient to a greater risk of infection, as well as being clinically contra-indicated. Thirdly, I am told by Dr Saleh that the hospital procedures are so strict in terms of testing, isolating and screening for the area of the hospital where KD is situated, that the risks of contracting the virus are significantly reduced, albeit they cannot be eliminated altogether. Additionally, KD is unlikely to have brought the virus into hospital as she has recently tested negative and has been in hospital for 2 weeks. However, if KD contracted the infection she is considered to be very high risk. The doctors will wear full protective equipment throughout the operation.

21. There are of course risks involved in any operation affecting the lungs, but here the evidence indicates that the risk is probably as low as it could be in any surgical procedure. Dr Tentzeris has identified the risk of stroke, heart attack, pulmonary embolism as approximately 1%. He considers the risk intrathoracic injury also to be no greater than 1% or the risk of bleeding or infection to be no greater than 10%. It follows from all that I have said above that the operation is urgently required and I have no difficulty in concluding that the surgical intervention and proposed aftercare is in KD's best interest. I endorse the care plan which is described in Dr Saleh statement in such clear and patient focused terms that I consider it useful to set out in full:

> *"22. We are proposing that the surgery should take place in the afternoon of Friday 3 July. KD can have a light breakfast before 7 am and then stop eating, but she will be able to drink up to 2 hours prior to her surgery KD has fasted before (on the 30th June) and I understand that it should not be a problem.*
> *23. The surgery must take place under general anaesthetic. This is because during*
> *the surgery, the affected lung need to be isolated and to do this a special tube needs to be put down the airway to ventilate each lung separately, and a patient*
> *needs to be asleep for that.*
> *24. Normally the general anaesthetic is given through an lV, which uses a cannula to put medication into the vein so we can inject the*

anaesthetic through it. I need cooperation from the patient in order to do this.
25. I would normally give those who are nervous a pre-med with a strong painkiller
in it. This will remove the anxiety, making them a bit more relaxed, and it helps with pain relief afterwards as well. I would propose to give this medication to KD. The pre-med I normally will give is an oral medication called oxycodone, which is a very strong opiate. I am not proposing to give KD any more sedative as I will not treat her any different than any other patient. Once she has received this, KD will be relaxed rather than drowsy.
26. At around the same time I would also give an injection of a medication called hyoscine which is to dry the airways. This is because the tubes which go down into the lungs can make them very irritable and cause lots of secretions.
27. The patient would then wait between 60-90 minutes before come to theatre.
28. When KD is brought down to theatre, she will be checked in and then a small plastic cannula will be put in her hand or arm (it is usually put in the back of the hand).
29. I will then inject a drug called propofol which will put KD to sleep.
30. Once she is asleep I will administer a muscle relaxant called suxamethonium. This is very short acting, and used to paralyse the muscle to allow the tube (called a double human tube) to go down and allow her to be put on a ventilator.
She will also be given a drug called Fentanyl, which is a very strong pain killer. This is required even though KD would be asleep to reduce the pan because the operation is painful and pain still has an effect on the brain and the body (this is
called "the stress response").
31. Once the tube is in I would give another muscle relaxant called vecuronium which is long acting.
32. I will then maintain anaesthetic with an inhalation anaesthetic called sevoflurane. This is required to keep patients asleep because propofol has a very short half life.
33. I will also give an antibiotic at this point, flucloxacillin, to reduce the likelihood of surgical site infection.
34. During the operation I would be running background fluid through the cannula.This is because KD will have been fasting for some time
35. At the end of the operation when the surgeon is finished I will give the reversal which will reverse the effect of muscle relaxant. That would be two drugs: glycopyrolate and neostigmine."

22. Mr Wenban-Smith and Ms Greaney were kind enough to take a contemporaneous note of this ex-tempore judgment. With little amendment I have been able to publish it. I have done so, not because the case raises any complex point of law or medicine but because I consider that any judgment of this kind, involving treatment to an incapacitated individual against their expressed wishes, always requires proper public

scrutiny. Additionally, the case contributes to a wider body of knowledge available to treating clinicians as to the type of case that should be brought to court. I agree with the Trust's decision that this case required an application to be made. It is entirely consistent with the guidance: **Serious Medical Treatment, Guidance [2020] EWCOP 2**. I should like to record my gratitude to Counsel and the doctors for their assistance in this case.