Neutral Citation Number: [2020] EWCOP 5

Case No: 13545196

IN THE COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 14/01/2020

Before :

THE HONOURABLE MR JUSTICE HAYDEN

- -

Between :

(1) Sherwood Forest Hospitals NHS Foundation Trust **(2) Nottingham University Hospitals NHS Trust**	**Applicants**
- and -	
H **(by her litigation friend the Official Solicitor)**	**Respondent**

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- -

Ms Sophia Roper (instructed by **Browne Jacobson LLP**) for the **Applicants**
Miss Sarah Simcock (instructed by **Official Solicitor**) for the **Respondent**

Hearing date: 14th January 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

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 the children and members of their 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 application, brought by Sherwood Forest Hospitals NHS Foundation Trust and Nottingham University Hospitals NHS Trust concerns a Mrs H. She is 71 years of age and lives with her daughter Miss T. I heard from her daughter Miss T during the course of evidence, and it is plain that she is an enormous source of support to her mother.

2. Mrs H is suffering from squamous cell carcinoma ('SCC'), which has manifested on the left cheek. The recommended treatment is surgical excision which will require a general anaesthetic and free skin flap to cover the affected area.

3. Mrs H first became aware that all was not well with her, in mid to late 2018. She sought the advice of her General Practitioner in October 2018 and she made a referral for treatment to the Sherwood Forest Hospitals Trust.

4. In that referral the GP invited a review of her patient, whom she described as having a skin lesion to the left side of her cheek which had been present for the last six months and which had recently slightly increased in size and been itchy. She noted that, in her view, the lesion looked suspicious of SCC and that Mrs H had no history of skin cancer. She emphasised in her recommendation and wrote in a separate paragraph, that Mrs H did have a past medical history of mental health issues including a diagnosis of Bipolar Disorder.

5. In the referral the GP included a succinct summary of Mrs H's past medical history and her medications. She specifically highlighted the diagnoses that Mrs H had received during the course of the previous decade and, in particular recorded that, in addition to the mixed Bipolar Affective Disorder, she had been admitted to hospital, pursuant to the Mental Health Act 1983, in 2014 with a hypomanic episode, depressive symptoms, a history of poor engagement with services and a general lack of insight into her circumstances. The GP's referral proved to be well founded, and her concerns were sadly confirmed by the diagnosis of SCC.

6. Mrs H is currently living at home with her daughter T, who, as I have said, cares for her. She has no history of dependence on drugs and alcohol. She has been known to local mental health services since 2014. She had a previous admission to a mental health unit in 1974, following the tragic death of her daughter in a road traffic accident. Previously, she was aware that she was ill but considered she suffered a recurrent depressive disorder. When ill in the past, she had been depressed and was prone to self-neglect, but did not make any suicide attempts. In 2011, she was involved in distressing litigation concerning pension entitlements. Her daughter told me that it was following the strain of this litigation that her mother's health seemed to spiral downwards.

7. In 2014 Mrs H was admitted under the Mental Health Act, to two successive mental health units. She continued treatment under section 2 and section 3 of that Act, until 24th December 2014. It was at that stage that she was diagnosed with Bipolar Disorder and treated with olanzapine and valproate. I have been told, convincingly, that whilst she was in hospital, she effectively deceived the medical establishment into believing she was taking her medication when in fact she was not. The discharge summary in the medical records describes paranoid and persecutory feelings. It is

plain that this period of detention in hospital had, in itself, a very negative effect on Mrs H and, it may in part, explain why, upon receiving her diagnosis, she refused effectively to engage with it.

8. Mrs H is described by virtually all who have encountered her but, most particularly by her daughter, as "*proud and stubborn"*. It is obvious that she can be very combative when confronted with beliefs which do not accord with her own. It is an important feature of the case that initially, when the diagnosis was conveyed to Mrs H, she appeared to accept it; but my impression from the papers is that that was a deception, not dissimilar to her pretence that she had been taking her medication. She expressed that she would consent to surgery, she engaged with the options for reconstruction and, she expressed interest in the cosmetic result. But that was as far as it went. She did not attend the appointments made to carry out the surgery and, it seems likely that her mental health deteriorated. She entirely rejected the diagnosis of cancer and she expressed herself to be of the strong view that a different doctor had told her the lesion on her face would resolve with the application of cream.

9. She is a well presented, sharp, articulate, inquisitive and intelligent woman. All agree on that. It does not, to my mind, follow automatically that having articulated an alternative diagnosis, which could not in fact be rooted in the evidence and, in refusing to contemplate cancer, one can extrapolate from that that she lacked the capacity to weigh up and evaluate the options. As Mr Pollock, the consultant plastic surgeon who gave evidence before me, observed, people react to such diagnoses in a wide variety of ways. But, as time has progressed it is clear that Mrs H is frequently agitated and unsettled.

10. It was not until the end of last year, more than a year on from the original referral, that proactive steps were made to secure the treatment for Mrs H that she so obviously required. She had in **May 2019** been assessed as **lacking the capacity to make decisions in relation to her medical treatment**, but it was not until 20th December 2019 that an application was made to this Court actively to address her carcinoma. I do not doubt that all those involved in her care have been concerned to do the right thing for her, but it requires to be confronted that the delay in this case may mean that a life is lost that could well have been saved. That is quite simply a tragedy. It is also profoundly troubling.

11. A particularly distressing feature of the chronology is that, following the proactive intervention of Mr Pollock at the end of last year, the growth began to increase very significantly. It is now covering most of the left cheek. It is unsightly; it is protuberant; it is painful; as Mrs H's daughter describes, it is malodourous. She told me how her mother cannot now go out of the house because she is embarrassed by the unsightliness of the growth. She now stays inside all day. It is necessary to put the fire on because Mrs H is cold. Her daughter explained how the warm house intensifies the smell to the extent that, on occasions, *"it causes her to gag"*. She tells me how her mother can no longer put in her dentures, cannot enjoy food and must drink through a straw; how she cannot lie down comfortably at night or sit in a chair; how the reactive depression to her circumstances has led her to become agitated and, talk to herself frequently throughout the watches of the night.

12. What is remarkable about T's account is that it focuses unwaveringly on the issue of how to help her mother; it is entirely free from the rancour, anger and distress that so

often characterises the evidence of relatives who feel that those they have loved, have not been given the treatment they were entitled to. In her simple and unembroidered account of how her mother talks to herself and *"hears voices"*, as Miss T puts it, she was able to help me unify the capacity assessments with her direct lay observations and arrive, with very little difficulty, at the conclusion that this is a woman who is simply unable to absorb and accept the diagnosis she has been given. T tells me that her mother's rambling monologues, throughout the night, are frequently a verbalisation of her emotional struggle to accept the diagnosis. In my judgment, it follows from all this that Mrs H is unable to weigh and evaluate the treatment options. That includes not only the potential for curative treatment but the palliative options too.

13. One of the reasons that treatment was not progressed more effectively was that the treating clinicians were perplexed as to whether it was appropriate and if so in what circumstances for Mrs H effectively to be forced, physically and by coercion if necessary, to attend for her treatment and, if so, how that might be achieved. The reality, in my assessment of the chronology, is that this issue had been identified very clearly by April or, at the latest, May of 2019, and certainly following the capacity assessment on 30th May 2019. I have now, in a number of judgments, emphasised that whilst avoidance of delay is not incorporated into the framework of the Mental Capacity Act in specific terms, it is to be read into that Act as a facet of Article 6 and Article 8. It is self-evident and, indeed, striking, that time here was of the essence and delay was likely to be inimical to Mrs H's welfare. Not only inimical but as it has transpired, potentially fatal. In **London Borough of Southwark v NP & Ors [2019] EWCOP 48** I made the following observations which it seems to me require, once again, to be emphasised:

> *"i. Though the avoidance of delay is not prescribed by the Mental Capacity Act 2005, the precept should be read in to the proceedings as a facet of Article 6 ECHR (see:* ***Imperial College Healthcare An NHS Trust v MB & Ors [2019] EWCOP 29)****. Any avoidable delay is likely to be inimical to P's best interests."*

14. This also dovetails with Case Pathways Practice Direction (PD 3B) and the Part 1 of the Court of Protection Rules 2017. It is helpful highlight the later:

> *"**Overriding objective***
>
> *1.1.—(1) These Rules have the overriding objective of enabling the court to deal with a case justly and at proportionate cost, having regard to the principles contained in the Act.*
> *(2) The court will seek to give effect to the overriding objective when it—*
> *(a)exercises any power under the Rules; or*
> *(b)interprets any rule or practice direction.*
> *(3) Dealing with a case justly and at proportionate cost includes, so far as is practicable—*
> ***(a)ensuring that it is dealt with expeditiously and fairly****;*
> ***(b)ensuring that P's interests and position are properly considered****;*
> ***(c)dealing with the case in ways which are proportionate to the nature, importance and complexity of the issues****; (*my emphasis*)*
> *(d)ensuring that the parties are on an equal footing;*
> *(e)saving expense;*

> *(f)allotting to it an appropriate share of the court's resources, while taking account of the need to allot resources to other cases; and*
> *(g)enforcing compliance with rules, practice directions and orders."*

15. In exchanges with Ms Roper, who has presented her case on behalf of the Trusts with characteristic sensitivity and skill, she recognised that this application, relating to medical treatment, falls within the personal welfare pathway contemplated in Part 2 of Practice Direction 3B. That imposes upon the applicants a range of responsibilities in cases that involve urgent medical treatment or lifesaving medical treatment.

16. In the application of these principles, it is important, firstly to consider whether steps can be taken to resolve, if possible, the relevant issues without the need for proceedings but thereafter it has to be recognised that delay will invariably be inconsistent with P's welfare and, if resolution cannot be achieved, having particular regard to P's own timescales, then proceedings should be issued.

17. If, at the conclusion of the decision making process, there remain concerns that the way forward is finely balanced, or if there is a difference of medical opinion, or a lack of agreement, or a potential complication of some kind, or if there is opposition, then it is highly probable, in those circumstances, that an application to the Court of Protection is appropriate and it is important that consideration **must** (I emphasise) **always** be given to whether an application to the Court of Protection is required.

18. I, of course, have the considerable benefit of hindsight, but even factoring that into my analysis, it is difficult to see why an application was not made in this case at least by mid-2019.

19. I have been shown a number of photographs today. They are at once profoundly moving and also disturbing. They crystallise the issues in the case with uncompromising clarity. When I first saw the photograph of the 15th November 2019, I thought that I was looking at the present size of the lesion. But at some point, between seeing Mr Pollock on 23rd December 2019, and 2nd January 2020 when the second photograph was taken, there was a dramatic increase in the size of the growth. The descriptions do not have anywhere near the impact of the photographs.

20. Also included in the bundle are photographs of Mrs H when she was a young woman including one when she was attending a family wedding. In each of the photographs she is upright, smart, elegantly dressed: one can see why her daughter and others have described her as proud. She has a commanding bearing. She is also, if I may say so, a strikingly good looking and attractive woman. There is a photograph of her wearing and, with obvious pride, the sash of Carnival Queen. There are, her daughter told me, those who still remember her from that time.

21. Mrs H has had one stroke of luck in the last 18 months, and that is that she encountered Mr Pollock, in whom she was able quickly but convincingly to reposit her trust. Her daughter told me of the favourable impression he had made upon her, and how fully receptive she was to his advice. She told me how her mother considered that he *"looked far too young to be a consultant in plastic surgery*", she told me how she thought him to be *"handsome"*. In her daughter's view, Mr Pollock had become the lynchpin in securing a way towards treatment.

22. Mrs H has been sent an appointment card telling her to attend for treatment in a few days' time. She has not, for the reasons I have referred to, taken on board the scope and ambit of the diagnosis, but what is clear is that she finds this awful growth unsightly and, I sense, rather demeaning. She is also tired, which her daughter told me is often a precursor to deterioration of her mental health more generally. The growth has now very significantly, for all the reasons I set out, impacted on Mrs H's quality of life, which is desperately diminished. This combination of her tiredness, the unsightliness of her growth and the trust she has been able to place in Mr Pollock, has enabled a shift in her position. She now welcomes the treatment. That is not to say that she understands it, she is now prepared to engage with it, to remove the discomfort. It reflects her aspiration to be more comfortable. Sadly, it has to be recognised, as Mr Pollock did, that there is a real risk that intervention at this stage may now be too late.

23. There are a number of options. Firstly, there is the *"no treatment option"*. If this is pursued, then I am told the SCC will continue to spread and develop into a fungating lesion, if that has not already happened. Mr Pollock stated there is evidence of macroscopic spread to the lymph nodes on her CT scan on 23rd December 2019, which offers a worse prognosis but is still potentially operable and curable. However, if this were left untreated, it would prove fatal. Mr Pollock also stated that there is the risk of distant metastatic disease, but this may not yet be visible on the CT scan performed. This risk can be better assessed following removal of the lymph nodes during surgery. Given the size of the growth in the photograph of 2nd January 2020, and the presence of lymph node spread, Mr Pollock considers that if left untreated then life expectancy is unlikely to exceed nine months, and may be as little as three months. Involved in that process is an awful progression of disease which requires properly and candidly to be confronted. It would inevitably be painful and distressing; the pain would be neuropathic in nature, and as such, not easily receptive to pain relief, though there could be options for analgesia, including both opiate based substances and specific agents targeted at neuropathic pain. There would be wasting. The tumour could erode into the facial structure, with the risk of a burst blood vessel causing rapid exsanguination, or the development of prolonged pain where the nerves are involved.

24. When dealing with patients with this diagnosis, Mr Pollock observed that he has never encountered one patient who has opted for *"no treatment at all"*. It is not difficult to see why that should be the case.

25. There is the option of radiotherapy. In some circumstances that can be almost, as I understand it, as effective as surgical excision; but Mr Pollock does not consider that the nature of Mrs H's SCC is likely to make that route as effective in her case, having regard to the nature and extent of it, and the high demand on compliance it requires to be effective, the most significant period of which is in the last two weeks of a six-week course. He told me that treatment delivery would involve 5 days a week: that having regard to the history of Mrs H, would be a challenge.

26. The only viable option identified is surgical excision. The growth seen in December, and shown on the first of the two relevant photographs, emanated or protruded from an area below the eye, but expanded in what Mr Pollock describes as a balloon shape, so that the extended part of the growth occluded the lower part of the orbit of the left eye. If we are lucky, it may not be attached. If we are unlucky, it probably means, as I

understand the evidence, that surgical excision is not a viable option. It will not be viable in those circumstances because the reconstruction process to address the wound in the face would require the identification of skin qualitatively strong enough and free from macroscopic tumour to make this effective. That would necessitate, in the eventuality that I have just described, a removal of the left eye. Mr Pollock observes that whilst nobody has elected for the no treatment option in these circumstances, he has encountered patients who are not prepared to accept the removal of an eye. This is not merely a refusal to contemplate further disability or disfigurement, but intrinsic to the removal of the eye is the reality that this represents an extension of the disease that is so advanced, that extensive incurable nerve involvement is highly likely.

27. Mrs H is unlikely to be able to evaluate any of the palliative options, for reasons that I have said. But they are limited. One is that there could be palliative radiotherapy. This involves a process which is not as protracted as curative radiotherapy. It is capable of being, what Mr Pollock has described as, *'fractionalized' or 'hypofractionated'*. By this he means there can be much greater doses of radiotherapy which are given in a reduced number of treatments, because they are palliative rather than potentially curative, are not required to be as deep, and are in essence cosmetic and symptomatic; as such they will not require radiotherapy with anything like the frequency of the curative regime.

28. It is difficult to be any more accurate on this until there is close physical examination and understanding of the extent of the progress of the cancer. I note that Mr Pollock considers that in certain cases, it may only be necessary for there to be one significant blast of radiotherapy.

29. How is Mrs H going to be helped to negotiate this gamut of difficult options? I do not mean in any way to criticise the other treating clinicians, when I endorse T's view that Mr Pollock is likely to be the bridge between the lack of understanding of the condition and the available treatment options. Her daughter tells me that Mrs H simply will not mention the word 'cancer'; she is not prepared to accept it at all.

30. In May 2019, T was so concerned about her mother's mental wellbeing, and the deleterious impact it had on her decision taking in relation to the available treatment options, that she contacted her mother's GP and the treating hospital, who liaised with the GP to arrange an urgent assessment with a Dr Baylis. Mrs H attended but it did not make a jot of difference to her perspective on the diagnosis and treatment. At that stage her behaviour was described by Dr Baylis as *"hypomanic"*. She was, irrational, argumentative, adamant that she did not have cancer, and still asking for cream. Dr Baylis liaised with the GP to arrange an urgent psychiatric assessment.

31. Mrs H was visited by the community psychiatric nurse and the consultant psychiatrist on a number of occasions. I am bound to say that, despite the increasing futility of the exercise, they have repeatedly tried to discuss her cancer with Mrs H and to help her to take decisions in relation to her treatment.

32. The Mental Capacity Act creates what can both conveniently and accurately be described as a presumption of capacity and, where it is absent, imposes upon those best placed to do so, an obligation to deploy all reasonable options available to them in order to promote a return to capacity. A reasonable period before making an

application might have been a week, two weeks, three weeks, but it was certainly not 6 months.

33. Underpinning something of Mrs H's belief structure is her own religious conviction. She believes, as her daughter told me, that *"she knows best"* and that she perceives herself to have a special relationship with God. Miss T has tried to talk to her mother about the nature of her lesion, about going to hospital to have surgery to get it removed but it has been batted away as negative talk resisted by a strong belief that she is going to get better, that she is not going to die, that she's a *"fit as a fiddle"*. She removes herself from the room if her daughter tries to confront this false belief structure.

34. Mr Pollock went to see Mrs H at home, accompanied by the community psychiatric nurse, on Friday 15th November 2019. Her daughter said that there was an immediate warmth to the relationship, and that he was someone she felt her mother was able to trust. She added to this, in her oral evidence, that she had considered her mother had become exhausted and just wanted *"to get it sorted"*, that she had *"had enough"*. Mr Pollock, in his evidence, returned Mrs H's compliment and was plainly impressed by what he described as her lively, curious intellect.

35. I have taken some time to explain the dynamics of the relationships here because, whilst it was initially contemplated that Mrs H should be sedated and physically coerced into treatment, her acquiescence to the treatment is now likely to make that unnecessary. I emphasise that sedation remains the Trusts' fall-back position. It also requires to be highlighted that whilst Mrs H is physically acquiescent, she is not agreeing in any capacitous way. And so, her daughter and Mr Pollock have devised a plan, which is now reflected in the Care Plan, which is, in my judgement, both unusual as well as intensely sensitive.

36. When I first read the papers, I was concerned that Mrs H might be inveigled into serious treatment that she did not understand, in circumstances where there is no longer any plan to try and explain it to her. But as I have been able, through counsels' assistance, to drill down more deeply into the evidence, I have accepted that this is the appropriate and kindly way forward and one that respects, in different ways, Mrs H's dignity, her autonomy and the very grave circumstances that she finds herself in. The plan, I have concluded, is in Mrs H's best interests.

37. It is, and it requires to be recognised as, a different and more subtle form of coercion, but it is also, in my judgement, both proportionate and justified. I am particularly confident in endorsing it having heard the evidence of those who will be involved.

38. For all these reasons, in this ex tempore judgment, I endorse the plan advanced by the Trusts today, subject to the two minor amendments that are to be added. I record that the Official Solicitor similarly endorses the application and that she has been assiduous in ensuring that there be a clear alternative plan identified if, on the day, Mrs H decides that she does not wish to go to hospital.

39. I have mentioned in the judgment that the growth of the lesion has been dramatic in the last few weeks, and I have discussed with counsel the challenges faced by the court and the Official Solicitor in particular, in dealing with applications of such obvious gravity in circumstances where there is not sufficient time for reflection.

Though the application was filed on 20th December it could not be heard until the first day of term, today, 14th January 2020. Whilst the significance of delay cannot be measured in days, Mr Pollock told me it can be measured in weeks and it is in that intervening period that the growth has developed in the way that I have stated. I emphasise, as clearly as I possibly can, that I do not intend any criticism in these remarks, but there may have been alternatives and it may have been possible for the Official Solicitor to have been appointed earlier. I am not, in this judgment, going to suggest how things could be restructured, but Miss Simcock on behalf of the Official Solicitor, has kindly agreed and indeed is enthusiastic to have the opportunity to prepare a short document suggesting how the appointment of the Official Solicitor can be expedited in these cases.

40. On 17th January 2020, I issued guidance relating to medical treatment, responding to the repeated identification of a need for such by the medical profession. It is published separately but it strikes me that the facts of this case provide an appropriate opportunity to set it out in full in the case law:

APPLICATIONS RELATING TO MEDICAL TREATMENT:

Applications to which this practice guidance applies

1. This practice guidance sets out the procedure to be followed where a decision relating to medical treatment arises and where thought requires to be given to bringing an application before the Court of Protection. The procedure is currently being reviewed within the revised MCA Code. That will, in due course, be subject to public consultation and Parliamentary scrutiny. This guidance is intended to operate until such time as it is superseded by the revised Code.

2. It is emphasised that this document is intended to be by way of ***guidance only****.*

3. The practice guidance is directed to those acting for providers and commissioners of clinical and caring services. As set out below, the expectation is that such providers/commissioners should be responsible for bringing any application that is required.

4. The starting point for the making of medical treatment decisions in relation to those lacking decision-making capacity is Section 5 Mental Capacity Act 2005. This provides a defence against liability for the medical professional(s) carrying out the relevant act (including, where relevant, withholding or withdrawing treatment) where they reasonably believe that the person in question lacks the necessary decision-making capacity and that the act in question is in the person's best interests.

5. The fact that certain medical treatments are defined as 'serious'[1] does not determine whether they should be subject to an application to the Court of Protection. Rather they indicate the need for special care and attention to the decision-making process surrounding them, including the appointment of an Independent Mental Capacity Advocate in appropriate circumstances.

6. If the provisions of the Mental Capacity Act 2005 are followed, any relevant professional guidance observed[2] and relevant guidance in the Code of Practice

followed,[3] *including as to the undertaking of the decision-making process, then, if there is agreement at the end of the decision-making process as to:*

a. the decision-making capacity of; and

b. best interests of the person in question,

then, in principle, medical treatment may be provided to, withdrawn from or withheld in accordance with the agreement, without application to the court, in reliance upon the defence in section 5.[4]

7. Paragraphs 8-13 below set out the circumstances in which section 5 either will not or may not provide a defence. If section 5 does not provide a defence, then an application to the Court of Protection will be required."

Situations where consideration should be given to bringing an application to court

8. If, at the conclusion of the medical decision-making process, there remain concerns that the way forward in any case is:

(a) ***finely balanced****, or*

(b) there ***is a difference of medical opinion****, or*

(c) a ***lack of agreement*** *as to a proposed course of action from those with an interest in the person's welfare, or*

(d) there is ***a potential conflict of interest*** *on the part of those involved in the decision-making process*

(not an exhaustive list)

Then it is highly probable that an application to the Court of Protection is appropriate. In such an event consideration ***must*** *always be given as to whether an application to the Court of Protection is required.*

9. Where any of the matters at paragraph 8 above arise and the decision relates to the provision of life-sustaining treatment an application to the Court of Protection ***must*** *be made. This is to be regarded as an inalienable facet of the individual's rights, guaranteed by the European Convention on Human Rights ('ECHR'). For the avoidance of any doubt, this specifically includes the withdrawal or withholding of clinically assisted nutrition and hydration.*

10. In any case which is not about the provision of life-sustaining treatment, but involves the serious interference with the person's rights under the ECHR, it is "highly probable that, in most, if not all, cases, professionals faced with a decision whether to take that step will conclude that it is appropriate to apply to the court to facilitate a comprehensive analysis of [capacity and] best interests, with [the person] having the benefit of legal representation and independent expert advice."[5] *This will*

be so even where there is agreement between all those with an interest in the person's welfare.

11. Examples of cases which may fall into paragraph 10 above will include, but are not limited to:

a. where a medical procedure or treatment is for the primary purpose of sterilisation;

b. where a medical procedure is proposed to be performed on a person who lacks capacity to consent to it, where the procedure is for the purpose of a donation of an organ, bone marrow, stem cells, tissue or bodily fluid to another person;

c. a procedure for the covert insertion of a contraceptive device or other means of contraception;

d. where it is proposed that an experimental or innovative treatment to be carried out;

e. a case involving a significant ethical question in an untested or controversial area of medicine.

12. Separately to the matters set out above, an application to court may also be ***required*** *where the proposed procedure or treatment is to be carried out using a degree of force to restrain the person concerned and the restraint may go beyond the parameters set out in sections 5 and 6 Mental Capacity Act 2005. In such a case, the restraint will amount to a deprivation of the person's liberty and thus constitute a* ***deprivation of liberty****.*[6] *The authority of the court will be required to make this deprivation of liberty lawful.*

13. It requires to be stated clearly that those providing or commissioning clinical and caring services should approach the Court of Protection in any case in which they assess it as right to do so.

Pre-issue steps

14. An application relating to medical treatment falls within the Personal Welfare Pathway. The pre-issue stage of the Personal Welfare Pathway (Practice Direction 3B) should be followed. It is important:

a. to consider whether steps can be taken to resolve the relevant issues without the need for proceedings; but

b. to recognise that delay will invariably be inimical to P's welfare and where resolution cannot be achieved within P's own timescales proceedings should be issued.

15. Lawyers at the Official Solicitor's office are available to discuss applications in relation to medical treatment before an application is made. They should be given as much notice as possible of any application. Any enquiries about adult medical and welfare cases should be addressed to a lawyer in the healthcare and welfare team at the Office of the Official Solicitor, Victory House, 30 to 34 Kingsway, London WC2B

6EX, telephone 020 3681 2751, email: oswelfarereferrals@ospt.gov.uk. In urgent cases please phone to alert a lawyer in the healthcare and welfare team and do not rely solely on email communication as this may not receive immediate attention.

*16. The **Official Solicitor's office is not able to offer an 'out of hours' service**, which means that the Official Solicitor can only participate in hearings that are either (1) listed or (2) made on short notice to the applications judge during court hours. Accordingly, applications to the 'out of hours' Judge should be regarded as exceptional.*

Parties to proceedings

17. The person bringing the application will always be a party to proceedings, as will a respondent named in the application form who files an acknowledgment of service.[7] In cases involving issues as to medical treatment, the organisation which is, or will be, responsible for commissioning or providing clinical or caring services to P should normally (although not always) be the applicant. If the organisation is not the applicant, it should normally be named as a respondent in the application form. The expectation in applications relating to medical treatment is that P would normally be joined as a party. It is therefore important that the applicant provides as fully as possible details (including contact details) for members of P's family and others with an interest in P's welfare.

(Practice Direction B accompanying Part 9 sets out the persons who are to be notified that an application form has been issued.)

18. The court will consider whether anyone not already a party should be joined as a party to the proceedings. Other persons with sufficient interest may apply to be joined as parties to the proceedings[8] and the court has a duty to identify at as early a stage as possible who the parties to the proceedings should be.[9]

Allocation of the case

19. Where a decision has been made to pursue an application to the court in relation to a serious medical treatment decision or in respect of a case involving an ethical dilemma, in an untested area, the proceedings (including permission, the giving of any directions, and any hearing) must be conducted by a Tier 3 judge,[10] unless the Senior Judge or a Tier 3 judge determines to the contrary.[11]

20. In any other case, the expectation is that the court, on making case management directions, on issue, will in gatekeeping under paragraph 2.4(1)(a) of Practice Direction 3B have regard, in particular, to:

a. The seriousness of the consequences for P of the proposed treatment decision(s);

b. The seriousness of the interference with the ECHR rights of P involved the proposed treatment decision(s).

Matters to be considered at the first directions hearing

21. Unless the matter is one which needs to be addressed immediately, at the case management directions upon issue stage the court will list it for a Case Management Conference within 28 days as per paragraph 2.4(1) of Practice Direction 3B. The court at the case management directions upon issue stage will further consider whether it is possible to join P as a party and whether the Official Solicitor should be invited to act as their litigation friend. It should be noted that:

a. the expectation in applications for medical treatment is that P will normally be joined as a party;

b. When P is joined as a party to the application, the Official Solicitor will usually consent to act if invited to so by the court. There is no need for confirmation that there is no other person willing or able to act as litigation friend. The Official Solicitor will therefore normally be invited to act as litigation friend, and the standard practice is that the organisation which is, or will be, responsible for providing clinical or caring services to P will meet half of the costs incurred by the Official Solicitor (as P's solicitor). In urgent cases the issue of P's representation should be resolved as quickly as possible to ensure that those acting for P can quickly take the necessary steps to investigate the case and secure the best possible evidence in the available time scale.

22. At the Case Management Conference, the court will consider the matters set out at paragraph 2.5 of Practice Direction 3B. It will also consider how the press should be notified of the application, and whether such notification should be accompanied by an agreed statement of facts and issues.

Urgent hearings

23. Practice Direction 10B sets out the general procedure to be followed for urgent applications.

24. In urgent hearings in medical treatment cases, the following steps should be taken:

a. proper arrangements should be made for family members to be able to participate in the hearing;

b. the Official Solicitor's office should be alerted so that (if possible) he is in a position to respond promptly. It is to be emphasised, as set out at paragraph 16 above, the Official Solicitor does not offer an 'out of hours' service. The Official Solicitor is prepared in principle to attend very urgent hearings as prospective litigation friend where the caring organisation agrees to pay half of his costs but ideally the Court should be asked to make an urgent order in respect of P's representation if time permits;

c. the Urgent Applications Judge and the Clerk of the Rules are to be alerted at the earliest opportunity that an application is likely;

d. a Word version of any draft order should be made available;

e. any statements in support of an application relating to life-sustaining treatment must set out the salient details of the relevant medical history which precedes the application and an assessment of any material which illuminates P's quality of life;

f. any IMCA or advocate report(s) relating to the treatment decision which are in existence should be filed;

g. Usually, and particularly if written evidence is limited or incomplete, one or more treating clinician should attend in person to provide evidence for the court. If such is not possible attendance may be permitted by telephone, or by video link, to provide evidence for the court.

25. In an urgent hearing, the court will take every opportunity it can to ensure that P is represented before granting substantive relief. Only in a truly exceptional case would the court grant substantive relief without representation. The court will otherwise only grant such interim relief as is urgently required to secure P's interests, and the following steps should then be taken:

*a. The case should then be listed, **avoiding delay**, at the earliest opportunity to permit full consideration of the evidence and representations on behalf of P;*

b. The represented applicant's advocate/legal representative should prepare a note of the hearing as soon as is reasonably practicable afterwards, and file a copy of the note with the court and serve a copy upon (a) the Official Solicitor or any other litigation friend appointed to act for P and (b) any respondent who was not present at the hearing.

Orders

26. In every case, in addition to any declaration made under section 15(1)(a) Mental Capacity Act 2005, the court will consider whether the relief sought should be granted in the form of a declaration of lawfulness under section 15(1)(c) and/or a decision under section 16(2)(a). In so doing, the court will have regard to the statutory purpose of section 16(2)(a) as being to empower the court to make a decision on behalf of P in relation to a matter in respect of which P lacks capacity.

Note 1 For purposes of section 37 Mental Capacity Act 2005 See the MCA 2005 (Independent Mental Capacity Advocates) (General) Regulations 2006, SI 2006/1832, regulation 4. [Back]

Note 2 In the case of decisions concerning clinically assisted nutrition and hydration, treating clinicians are directed to the BMA/RCP Guidance (endorsed by the GMC): 'Clinically assisted nutrition and hydration (CANH) and adults who lack the capacity to consent,' available at www.bma.org.uk/canh. [Back]

Note 3 Note, the Code of Practice must be read together with any subsequent case-law; the Code of Practice is also under review as at January 2020. [Back]

Note 4 NHS Trust v Y [2018] UKSC 46 at paragraph 126. [Back]

Note 5 Re P (Sexual Relations and Contraception) [2018] EWCOP 10 at paragraph 56, concerning the covert insertion of a contraceptive device. [Back]

Note 6 ACCG v MN [2017] UKSC 22 at paragraph 38. *[Back]*

Note 7 Rule 9.13 of the Court of Protection Rules 2017. *[Back]*

Note 8 Rule 9.15 of the Court of Protection Rules 2017. *[Back]*

Note 9 Rule 1.3(3)(e)(ii). *[Back]*

Note 10 Practice Direction 3A, paragraph 2(a). Practice Direction 2A defines tiers of judge. *[Back]*

Note 11 Practice Direction 3A, paragraph 3.

41. By way of postscript I would add that I am very keen that Miss T should be told what I have said in this judgment. I have been asked to withhold publication of the judgment until Mrs H has been seen by the doctors. I do not wish to jeopardise her compliance or add to her distress. Accordingly, I shall delay this judgment being released into the public domain until 3rd February 2020.