Neutral Citation Number: [2021] EWCOP 8

Case No: 13075734

IN THE COURT OF PROTECTION
IN THE MATTER OF THE MENTAL CAPACITY ACT 2005
IN THE MATTER OF TM

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 21/01/2021

Before :

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

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Between :

PENNINE ACUTE HOSPITALS NHS TRUST **Applicant**

- and –

TM (by his litigation friend, the Official Solicitor) **Respondent**

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Mr Parishil Patel QC (instructed by Hill Dickinson LLP) for the **Applicant**
Miss Katie Gollop QC (instructed by the Official Solicitor) for the **Respondent**

Hearing dates: 21st January 2021

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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 members of the public and 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 anonymity of the respondent and members of his 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 urgent application made by the Pennine Acute Hospitals NHS Trust in respect of a male patient, TM. It is not possible to be entirely accurate about TM's age, but he is thought to be 42, and is believed to come from Zimbabwe. The applicant Trust are seeking to perform a bilateral below-knee amputation, upon TM, without which his treating clinicians believe he will develop sepsis and suffer life-threatening renal and cardiac failure very soon. TM strongly objects to the proposed surgery and treatment, and says he believes that his condition will improve without it.

Background

2. On 30th December 2020, TM was admitted to hospital having been found, collapsed, at a bus shelter in Manchester. He was believed to be street homeless and was admitted to hospital by the acute medical team. At that stage, he was manifestly confused, and strongly resistant to any kind of care or assistance. He was initially treated for a suspected soft tissue infection in his legs, but it was discovered that he had an acute kidney injury, secondary muscle damage and accompanying anaemia.

3. TM was given treatment for his kidney damage and gradually began to improve, and he was co-operative with CT imaging of his brain. Within the limitation of CT imaging process, TM's results indicated changes to the brain's white matter, which appeared to be chronic.

4. TM's treating team of nurses and clinicians spoke to him in order to communicate something of their medical findings, as well as to attempt to glean an understanding of his medical history. His lack of engagement in those inquiries led professionals to query, initially, whether there was a language barrier impairing communication.

5. It was possible to secure urgent imaging of TM's lower legs. The team were alert to the risk of, what is referred to by treating consultant Dr Michael Riste, as 'compartment syndrome' and sepsis. TM was assessed as lacking capacity, by a Dr Devine, on 3rd January 2021, to make decisions about his medical care.

6. Sadly, the results could not have been worse. They demonstrated acute limb ischaemia. Orthopaedic and vascular teams reviewed the scanning and were consulted in relation to TM's medical care. He was diagnosed with severe bilateral frostbite to his feet, from which the team drew the reasonable inference that TM had been living on the streets for some time.

7. On 5th January 2021, Mr Madan, a vascular surgeon, reviewed TM and concluded that neither foot was viable. He advised that a below-the-knee, bilateral amputation (in respect of both legs) was the only appropriate surgical option. It is important to record that when being confronted with this tragic diagnosis, TM immediately declined treatment. He has resisted it ever since.

8. Amongst a battery of investigations and tests carried out on TM was an HIV test, which returned a positive result. Furthermore, TM's T-cell count was high enough to indicate that he had not been taking any HIV medication for some time.

9. TM has not been forthcoming about his medical history, his situation or circumstances in life. He was, however, able to indicate that he had been receiving treatment for HIV and identified to clinicians a doctor in Wolverhampton who had been responsible for the prescription of his medication. However, when Dr Riste contacted the doctor identified by TM, he had no record of treating a patient with TM's name. In discussions with the lead consultant, Dr Riste, TM alluded to having consumed alcohol, possibly to excess, in the past. Dr Riste was quite clear that this did not feature in his recent medical history. TM denied any abuse of drugs or other substances, and Dr Riste confirmed in oral evidence there are no indications, physically or otherwise, that TM has been a drug user.

10. On 6th January 2021, TM was again assessed in respect of his capacity to take decisions regarding his medical treatment. This assessment concluded that he was unable to weigh the consequences of his actions in the sense of appreciating the consequences of his decision either to comply with, or refuse, surgery. This presented a very challenging situation for his treating clinicians.

11. On 7th January 2021, TM was reviewed by Dr Ahmed, a psychiatrist. The assessment is described in evidence as having been a difficult one in which TM seemed reluctant to engage. However, it was clear to the psychiatrists that there was no evidence of any psychosis. The position of Dr Ahmed and the team was to continue to treat TM under the aegis of the Mental Capacity Act (MCA 2005).

12. After arranging imaging, TM was then reviewed by Mr Sheikh, a burns consultant based in Wythenshawe. Mr Sheikh was asked specifically to give an opinion about whether, given TM's age, there was any other alternative to the amputations. Sadly, Mr Sheikh arrived at the same conclusion as his colleagues and agreed that both feet were not viable and required amputation.

13. Mr Sheikh was also clear that the consequences of refusal of surgery would be catastrophic, and would occur quickly, namely, septic infection, followed by death. Again, that situation was made clear to TM, I have no doubt in sensitive terms, but he did not engage with any discussion.

14. Dr Riste told me he had seen his patient on no fewer than 10 separate occasions, and on each occasion (to a degree informally), he was evaluating TM's capacity to weigh and sift these difficult matters, in order to come to a conclusion for himself in respect of medical treatment. On each occasion, Dr Riste was satisfied that he lacked capacity to do so.

15. On 7th January 2021, further blood tests showed concerning results. TM has been described as extremely immunosuppressed, in consequence of his HIV. The high levels of the HIV virus and his CD4 (T-cell) count signalled to Dr Riste, as I have noted above, that it had been some time since TM had been taking his medication.

16. In that context, I was told that the abnormalities in the CT imaging permit a number of potential explanations. It may be that it represents a degree of HIV-related disease or inflammation; it may be that the atrophy or disintegration of the white matter in the brain could be explained by what is termed as PML (Progressive Multifocal Leukoencephalopathy). This may, to some extent, explain TM's current cognitive difficulty in making rational judgments or recalling significant history prior to and

during the course of his admission. Dr Riste observed in oral evidence that TM's responses would also fit with a depressive episode, noting that he had entered discussions with psychiatry about whether it was worth starting him on anti-depressants. Ultimately this was discounted in light of the potential interactions with other medications and the time constraints given the inevitable delay before anti-depressant medication would be effective.

17. TM has not been able to give an account of his life or treatment with any kind of detail at all. In particular, he has not revealed where he was living prior to becoming homeless. Insofar as he has given an address, it has not been possible to confirm it. He has given three different dates of birth (though all in the same year) and has explained that he has not pursued legal extension of his leave to remain in the United Kingdom, describing himself as, in effect, an 'overstayer'. Miss Gollop QC, on behalf of the Official Solicitor, speculates that this factor may underpin something of TM's reluctance to give detail about his past, perhaps reflecting an anxiety that it will result in his deportation or even a worry about incurring costs in hospital for his treatment.

18. TM's severe kidney impairment will likely require treatment in an intensive care unit, following the significant deterioration of his kidneys on 16th January 2021. I was told that this deterioration had advanced, notwithstanding TM's compliance with intravenous fluids. Further, abnormalities were observed on a CT chest scan. During the course of the last seven days, TM has also been noted to have chest pains, which gave rise to concerns on behalf of the cardiac team.

19. It is evident that the investigation and management of TM's raft of medical challenges has been impaired by either his inability or his unwillingness, to engage fully with medical professionals. I have noted already that he complied with the CT scanning. It is also the case that he was prepared to comply with MRI scanning until he saw what was actually involved in that process (being restricted to a noisy and confined space for an extended length of time) and declined at the last minute. He has been compliant with his HIV medication while in hospital which, if I understand the evidence correctly, he takes himself. He has also cooperated with the intravenous fluids.

20. There is therefore a great deal of medical treatment with which TM has been compliant, and he has received supportive therapy for renal failure.

TM's participation in the hearing

21. During the course of this urgently listed hearing, there was discussion between me and the advocates as to whether I should visit TM remotely using the video conferencing platform. One of the surprising developments following the Court's move to video conferencing platforms during the pandemic is that it has become much easier for judges to visit the protected party. There was widespread agreement that I should meet with TM and I am pleased that I was able to do so.

22. Even from my short visit with him, and my observations of him on the ward with Dr Leann Johnson (who has been with him for most of the day), it is obvious to me that he is receiving a very high quality of care.

23. It transpired that TM did not have any language barrier. He is a fluent English speaker. I attended him with Ms Tracy Hollamby, of the Official Solicitor's office, who acts on

TM's behalf. In the light of all I had heard, it came as something of a surprise to me, that he engaged with me easily, openly and with great courtesy. I found him to be an intelligent man and an articulate one. He told me something of his circumstances. In particular, he said he really enjoyed nature, the outdoors, and he was very interested in bees. As I deliver this judgment, he is present on the video conferencing platform, and I have noticed him move and become more visibly engaged at this point. He has lived for many years in Manchester. He and I discussed football, discovering we supported the same team. He had obvious enthusiasm for it and up to date knowledge. We spoke a little bit about his life in the past. He told me he had a young daughter and with obvious parental pride, he told me that she was very pretty and bright. He was modest enough to consider something of her intelligence came from her mother, though perhaps some from him too. He told me he had not seen his daughter for some time, but he was unable to say for how long. He told me the name of his partner, but only her first name, saying that she had no second name, and that his daughter lived with her in Wolverhampton. I note that TM has referred elsewhere to having been treated by a doctor in Wolverhampton.

24. When I asked him about the amputation and about his kidney condition, he was reluctant to engage with my summary account of the consequences of there being no treatment. He was very clear that he would get better. I was left with a very strong sense that he wanted to get better. I had little doubt, when assessing his evidence, that he was keen to see his daughter. His enthusiasm for his football team and for nature (as described above) also signalled to me a man who was interested in and engaged with life. In short, a man who wanted to live.

25. This impression, in our short meeting, confirmed everything that Dr Riste told me from his ten or so meetings with TM. This was not a man who had expressed a wish to die, rather than have this treatment. This is a man who has consistently maintained, and I consider genuinely believes that he would get better without treatment. Unfortunately, that possibility is entirely irreconcilable with the medical evidence.

26. It has not been possible, for all the reasons I have alluded to, to identify any family members, friends, or relatives, either in the UK or in Zimbabwe. It is therefore difficult to identify any evidence which would cast light on the code by which TM has lived his life and which might assist in trying to understand TM's resistance to life-saving treatment.

27. In summary, the overwhelming medical consensus is that in order to avoid an imminent death, TM needs surgery, and needs it quickly. The surgery involves below the knee bilateral amputation of both legs. In the last 24 hours, the situation has become pressing and grave. Both advocates, Mr Patel QC for the applicant NHS Trust, and Miss Gollop QC for the Official Solicitor, have gone to great lengths to ensure that the court has sufficient materials before it despite the urgent circumstances in which this case was listed.

Legal Framework

28. It is well-established and uncontroversial that any adult who has the capacity to decide whether or not to accept life-sustaining medical treatment is entitled to refuse it. As Lord Goff elaborated in **Airedale NHS Trust v Bland [1993] AC 789 at [864]**: *'…if an adult patient of sound mind refuses, however unreasonably, to consent to treatment*

or care by which his life would or might be prolonged, the doctors responsible for his care must give effect to his wishes, even though they do not consider it to be in his best interests to do so'.

Capacity

29. As I observed in **Avon and Wiltshire Mental Health Partnership v WA & Anor [2020] EWCOP 37 at [30]**, the presumption of capacity set out in Section 1(2) MCA 2005 is buttressed by the imperative not to treat a person as unable to make a decision merely because the outcome of their decision is unwise (Section 1(4) MCA 2005); it is the ability to take the decision, not the outcome of the decision, which is the focus: **CC v KK and STCC [2012] EWHC 2136 (COP); Kings College Hospital NHS Trust v C & V [2015] EWCOP 80**. This cornerstone of the court's assessment of a person's capacity to make a decision for him or herself remains equally applicable where the outcome of the person's decision is an untimely and unpleasant death.

30. However, it does not follow that the outcome of a decision is wholly irrelevant to the court's assessment of capacity where a person's ability to understand and weigh the consequences of a decision is in contention.

31. Mr Patel contends that capacity is the central issue in this case. Though Miss Gollop originally agreed, this changed as her thinking evolved, in an inevitably dynamic case. Miss Gollop submits that the applicant NHS Trust has failed to adduce sufficient evidence to displace the presumption that TM has capacity to make his own decision about whether to consent to the amputation of both of his legs. She referred me to the following points in support of this position:

    i) Clearly, TM is able to understand some aspects of his medical treatment e.g. he understood, without the need for explanation, what a lumbar puncture involved and refused it; and

    ii) Ms Tracy Hollamby, of the Official Solicitor's office, produced a note of a telephone attendance on TM in which she asked him, if it were a choice between having the operation and living, or not having the operation and dying, what would he want. TM responded that he did not believe he was going to die, but that he felt losing both feet would be worse.

32. She emphasises that, on each occasion that TM has been asked about amputation and treatment, he has declined it. He has consistently refused the procedure. But what is significant to my mind is the fact that, equally consistently, he has been unable to acknowledge the consequences of refusing treatment. Indeed, it is plain to me that he does not take on board those consequences or understand them; he simply insists that, in fact, he will get better without further treatment. This puts TM in a fundamentally different position from a patient who, having understood that refusing treatment would very likely lead to their death, nevertheless considers this preferable to the consequences of receiving the treatment.

33. TM's comment, recorded in his conversation with Ms Hollamby, is a departure from everything he has said to his treating clinicians, including Dr Riste. Moreover, it was not what he said to me. I have no doubt that Ms Hollamby was able to communicate comfortably and spontaneously with TM. However, his comment to her, from which it

has been extrapolated, that he would prefer to die rather than face the amputation of both feet, is an isolated comment which jars with the preponderant evidence in relation to his wishes and feelings. Indeed, it is striking that this remark was immediately proceeded by his assertion that he would be alright without treatment. Whilst Ms Gollop has put much weight on this remark, in conjunction with the other factors she identifies and I have set out above, I do not consider that this single remark can sustain the evidential weight that she attributes to it.

34. Dr Riste has, as I have mentioned, spoken with TM on ten separate occasions and identifies his unwillingness or inability to engage with the medical realities as the most consistent and striking feature. Dr Riste was of the clear impression that TM genuinely and honestly believed that he would get better without medical intervention. This accords exactly with my own impression on speaking to TM. It is on this basis that Dr Riste concluded, correctly in my view, that TM lacks the ability to understand and weigh the information necessary to decide whether to consent to the amputation.

Causal link between an impairment/disturbance in the functioning of the mind or brain and functional elements of s 3 MCA 2005

35. Miss Gollop further submitted that I should find that TM had capacity on the basis that the applicant Trust has not demonstrated, on the balance of probabilities, that TM's inability to contemplate the consequences of refusing treatment is *because of* an impairment of, or a disturbance in the functioning of, the mind or brain. She referred me to **Kings College Hospital NHS Foundation Trust v C [2015] EWCOP 80**. At paragraph 34 of that judgment, Macdonald J refers to the need for '*a causal connection between being unable to make a decision by reason of one or more of the functional elements set out in s 3(1) of the Act and the* 'impairment of, or a disturbance in the functioning of, the mind or brain' *required by s 2(1) of the Act'*.

36. There are many reasons why TM may not be able to appreciate and understand fully the importance and significance of the proposed treatment. Dr Riste has considered that this incapacity may be related to the atrophy of the white matter of his brain; it may be due to a depressive illness; it may even be related to the condition of PML (see above) arising from his HIV. But whatever the cause, it is clear to Dr Riste, that the functioning of TM's brain is impaired to such a degree that it renders him unable to weigh and sift the relevant factors involved in making the decision to consent to the amputation.

37. It is clear therefore that there are a number of identified pathologies which separately or in combination are likely to explain the disturbance or functioning in TM's mind or brain. It might well have been possible to be more precise if TM had been able to cooperate with the MRI scan. It is a misunderstanding of section 3 MCA 2005 to read it as requiring the identification of a precise causal link when there are various, entirely viable causes. Insistence on identifying the precise pathology as necessary to establish the causal link is misconceived. Such an approach strikes me as inconsistent with the philosophy of the MCA 2005. What is clear, on the evidence, is that the Trust has established an impairment of mind or brain and that has, in light of the consequences I have identified, rebutted the presumption of capacity.

38. I find that TM is unable to weigh and sift important factors that enable him to take the decision in contemplation here, and I consider that to be attributable to the functioning of the mind or brain for the reasons I have set out above. At risk of repetition but to

avoid any ambiguity, I am satisfied that TM lacks the capacity to take medical decisions concerning the treatment of his necrotic legs and his failing kidneys for himself.

Best interests

39. Mr Patel says that if I find that TM lacks capacity, there can be no question but that his best interests lie in his receiving the medical treatment advised. Miss Gollop, though initially ambivalent, came ultimately to the conclusion that TM's resistance had been so consistently expressed that his wishes should be respected notwithstanding his lack of capacity. In some circumstances there will be force in such a submission. Indeed, I took that approach in **Avon and Wiltshire Mental Health Partnership v WA & Anor (Rev 1) [2020] EWCOP 37; Barnsley Hospital NHS Foundation Trust v MSP [2020] EWCOP 26**. However, in both those cases, it was significant, in my analysis, that P recognised that refusal of treatment would lead to certain death. TM does not recognise this. As I have been at pains to emphasise, the life force beats very strongly within him. TM wants to live. He has an entirely misguided belief that he will recover without any treatment. The pervasiveness of this misguided belief contracts and substantially diminishes the weight that might, in other circumstances, properly be given to consistently expressed wishes.

40. Miss Gollop made two further submissions in support of her contention that medical treatment should not be given. In the light of TM's social isolation, she pointed to what she perceived to be a likely lack of support following the amputation. She also highlighted the length of time TM would need to spend in hospital following the operation.

41. When questioned by Miss Gollop, Dr Riste was not able to confirm whether TM would be eligible for prosthetics, given his insecure immigration status. This question took him unawares and he did not know the answer. Miss Gollop submitted that I am required to factor in the possibility that TM may not be provided with prosthetics, and that the treatment may result in his using a wheelchair for the rest of his life. This, as I follow Miss Gollop's argument, may be known to TM, along with those considerations set out at para 38 above and may be the real reason he refuses to consent but feels unable to articulate. I do not consider that these arguments are supported by the evidence. They are, at best, speculative.

42. I do agree with Miss Gollop that a bilateral amputation for a relatively young man of around forty-two, and who has enjoyed sports, is a profoundly traumatic prospect. I can understand that some individuals may not feel they have the fortitude to cope with such a disability and may choose not to. This would be their choice and the Court would respect it. I can find no cogent evidence that this reflects TM's thinking. For the reasons I have set out above, I do not consider it does.

43. In relation to the treatment of the kidneys, whilst there may be some incapacity for some time, it is not thought likely that it will involve ongoing long-term renal dialysis. For completeness, I record that Dr Riste could not exclude it, though largely on the basis that he would 'never say never'. That said, I sensed Dr Riste was optimistic that renal dialysis would not be required.

44. In some cases, there would be information from family members that might cast light on P's thinking and beliefs. Here none is available. However, TM's instinctive

enthusiasm for the natural word, his pride in and love for his daughter and his spontaneous expression of his wish to see her, indicate to me a man who would choose to live.

45. TM may read this judgment at some point. I do not know, due to the limitations of this video conferencing platform, whether he is listening to it as I deliver it. I was keen that he should understand my thinking and how I have come to my decision on his behalf. For this reason, in part, but mainly due to the fact that surgery may be possible this evening, I have delivered an ex tempore judgment. I do hope TM will not mind if I make a few, admittedly ad hominem, remarks. TM came to the UK, I accept, approximately 20 years ago. He came, it seems, alone. He has negotiated life's vicissitudes. He tells me, and I am inclined to accept, he has been in regular employment. His short conversation with me gave me the clear impression that he had until relatively recently maintained a life in mainstream society. He strikes me as a man of courage and strength of character. I hope that those features of his personality, as I perceive them, and which have been revealed so slowly and to some extent elusively, will enable him to navigate the significant challenges that he will undoubtedly face.

46. With some hesitation, I record that I have found it deeply shocking to hear how it is possible, in modern Britain, for a relatively young man, living on the streets of a major city, in the enhanced visibility of our present public health crisis, to have suffered in the way that he obviously has. It is at least a little consolation that notwithstanding the pressures on the NHS generally and ICU in particular, TM has received highly skilled, consummately professional and manifestly thoughtful care.