Neutral Citation Number: [2024] EWCOP 20

Case No: 14229260

IN THE COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 10/04/2024

Before :

MS JUSTICE HENKE

- -

Between :

King's College Hospital NHS Foundation Trust	**Applicant**
- and -	
(1) South London and Maudsley NHS Foundation Trust	**Respondents**
(2) GF (by his Litigation Friend, the Official Solicitor)	

- -
- -

Francesca Gardner (instructed by **Bevan Brittan LLP**) for the **Applicant and First Respondent**
Jake Rylatt (instructed by **The Official Solicitor**) for the **Second Respondent**

Hearing date: 4 April 2024

- -

Approved Judgment

This judgment was handed down remotely at 10am on 11 April 2024 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

.....

MS JUSTICE HENKE

This judgment was delivered in private. 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.

Henke J :

My Decision in Summary

1. Having read all the evidence and with the agreement of the parties, on 4 April 2024:

    a. I declared, pursuant to ss.15(1)(a) and (b) of the Mental Capacity Act 2005 ("MCA 2005"), that GF lacks capacity to:

        i. conduct these proceedings; and

        ii. make decisions about his care and treatment for his ulcerated leg, including whether to undergo an above the knee amputation and associated pre- and post-operative treatment.

    b. I found that it is lawful and in GF's best interests to undergo surgery to have his right leg amputated above the knee and to receive care and treatment in accordance with the terms of the treatment plan dated 3 April 2024.

    c. Pursuant to s.16 of the MCA 2005, I consented on behalf of GF to the provision of the treatment set out in the treatment plan dated 3 April 2024.

2. When I gave my decision on 4 April 2024, I indicated that I would hand down a brief judgment shortly thereafter. Publication with the consent of all the parties has been delayed until after the amputation has taken place.

My Decision in Full

Introduction and Relevant Background

3. This is an application dated 22 March 2024 by King's College Hospital NHS Foundation Trust (the "Acute" Trust). The application is supported by the South London and Maudsley NHS Foundation Trust, who is the First Respondent. The patient at the heart of the application is GF. The Acute Trust is responsible for GF's physical care. The South London and Maudsley Hospital NHS Foundation Trust is responsible for GF's mental health through the Mental Health Liaison Service. GF is the Second Respondent to these proceedings. He acts within these proceedings by his litigation friend, the Official Solicitor.

4. GF is 60 years old. On 23 February 2024, he was admitted to hospital via A&E. He had been taken to the hospital by his niece AB, who was concerned he had burns or wounds to his right leg and was walking with a limp. At the hospital, GF was reported to be disorientated. He was saying his sores were caused by lasers and Wi-Fi which was hitting his legs. He was reviewed by the Mental Health Service and noted to be psychotic with clear delusional thought content. On examination, what his niece had suspected were burns were actually thought to have been caused by infection.

5. GF was transferred to a ward in the Acute Trust for treatment with intravenous anti-biotics. On examination and, as of 22 March 2024, he was found to have necrotic ulcers on his right ankle and leg secondary to occlusion of vascular supply to his lower limb. The ulcers are septic. He is pyrexial despite intravenous antibiotics being given. The multidisciplinary team of professionals at the Acute Trust propose an above knee amputation. Without it, the

prognosis is that of further deterioration and death within weeks. At the moment, although GF is unwell, he is haemodynamically stable. Without surgery in the next few weeks, he will become haemodynamically unstable, and surgery will no longer be an option. More conservative wound management will not resolve the problem. The unanimous view of those treating him is that surgery must take place as soon as possible before it too becomes an unviable option for GF.

6. GF has a long-standing history of paranoid schizophrenia. He was first diagnosed 20 years ago. He fits the criteria for ICD-10 F20.0. He has had several psychiatric admissions but none since 2013. GF is intermittently non-compliant with his medication when in the community. When seen by the Community Mental Health Team in January 2024, he reported that he had not taken his medication for about a year. He is not presently acutely unwell, but he has some baseline chronic psychotic symptoms. He takes aripiprazole. He could be given more aggressive treatment to help improve his mental state but not within the timeframe required for the surgery he requires. It has been noted that whilst he is on the ward, he will often comply with a lot of reassurance and multiple approaches. He has continuing delusions around "lasers" which are longstanding and persistent. He is likely to be resistant to treatment to some degree. He has refused interventions for his legs saying the ulcers have been caused by "rays" that are implanted in him. He also refers to bad spirits causing him ill health. He has, on occasion, maintained that there is good blood flow to the leg and that there is nothing wrong with it, so he does not need surgery. He has on other occasions thought his leg was burned rather than anything more serious. On others he has said that he has not fully ruled out surgery but wants more time to consider this. Over time, he has seemed to accept amputation but would prefer a below knee amputation.

These Proceedings

7. The Official Solicitor was placed on notice of this application by email dated 18 March 2024. The application before this court was made on a COP1 dated 22 March 2024 and issued on 25 March 2024. On 28 March 2024 the court made a transparency/reporting restrictions order and gave directions to enable the application to be heard. Those directions established a hybrid hearing before me on 4 April 2024.

The Issues for the Court

8. The issues before me were:

    a. Whether GF lacks capacity to (i) conduct these proceedings and (ii) make decisions as to his medical treatment, in particular in relation to an above knee amputation and associated pre and post operative treatment.

    b. If so, whether it is in GF's best interests to undergo the amputation and receive the treatment set out in the treatment plan as placed before the court.

Representation and Final Position of the Parties

9. At the hearing before me, the Acute and Mental Health Trusts were represented by Ms Gardner of Counsel. GF was represented by his litigation friend the Official Solicitor who instructed Mr Rylatt of Counsel. I am grateful to them for their assistance. They rightly identified that I did not have before me any evidence from a consultant anesthetist. Hence, although GF had already undergone preliminary testing such as "stress" testing, provision

was agreed between the parties and approved by me to enable this application to come back before me if the Consultant Anesthetist assessing GF before his operation raised any issues of concern. With that mechanism in place, an agreed order was placed before me in the terms summarized at the beginning of this judgment.

10. Although not parties to the proceedings, GF's nieces AB and C also attended the hearing. They each spoke to me and confirmed their agreement to the order. Both expressed their views that the amputation was necessary to save their uncle's life. It was evident to me that their uncle was precious to them and that he was part of an extended family in which he and his life were valued. AB thanked all involved in the case for the diligence and sensitivity. As she told the Official Solicitor's representative, she just wants it over as they (the family) can see GF failing.

11. DF, GF's brother, did not attend the hearing itself but his views were before the court. He had been spoken to by the Official Solicitor's representative and he too supported the amputation of his brother's leg above the knee. He too clearly considered that such an operation was indeed in his brother's best interest and was necessary to preserve GF's life. He said he would have done it himself if he could save his brother's life.

12. The overall finding I make is that it is obvious that GF is part of a large family which cares about him deeply. His nieces and his brother have all participated in the process that has led to this hearing and they very clearly want to do what is best for GF and to preserve his life.

This Judgment

13. Whilst this matter has ultimately been agreed, I have considered it important to publish this short judgment for two reasons. Firstly, this case has been heard in public subject to a transparency/reporting restrictions order. I consider that where, as here, a case has been listed for a final hearing in public, if it is reasonably practicable, a short judgment should be published so that the public may know, if they wish, what has happened and why it has happened. Secondly, GF should have a record which he can access at his will which sets out why he has had his leg amputated and the steps that were taken to make sure that that amputation was in his best interests. GF did not want to see me as part of the hearing. However, I am conscious that his views on the operation have been sought by the Official Solicitor and those treating him. I have recorded a summary of those views in this judgment, and I have factored those views into my decision making. He should know that and the outcome of this hearing, which after all is about him.

Capacity

14. I begin by considering the issue of capacity.

15. I have reminded myself that there is a presumption of capacity - s.1(2) MCA 2005.

16. The burden of proving incapacity lies with the party asserting a lack of capacity; a determination that P lacks capacity must be established on the balance of probabilities - s.2(4) MCA 2005.

17. A person 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.

18. A person is not to be treated as unable to make a decision merely because he makes an unwise decision - s.1(4) MCA 2005.

19. Any act done or decision made on a person's behalf must be made in his best interests - s.1(5) MCA 2005

20. Regard must be had to the principle of least restriction - s.1(6) MCA 2005.

21. A lack of capacity is defined in Section 2(1):

> "*For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time, he is unable to make a decision for himself in relation to the matter because of an impairment of or a disturbance in the functioning of the mind or brain.*"

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] as confirmed by the Supreme Court in *A Local Authority v JB* [2021] UKSC 52 at [65].

22. The first question is whether a person is unable to make a decision for himself in relation to the "*matter*" which the court must identify in order to determine whether or not a person is able to make a decision for him or herself. This formulation also requires identification of the *"information relevant to the decision"* which will include, under s.3(4) MCA, the reasonably foreseeable consequence of deciding one way or another or failing to make a decision.

23. In *PCT v P, AH and The Local Authority* [2009] COPLR Con Vol 956 at [35] Hedley J noted that *"really difficult cases"* generally revolved around the application of s.3(1)(c): he described the ability to use and weigh information as *"the capacity actually to engage in the decision-making process itself and to be able to see the various parts of the argument and to relate one to another".* He considered the *"cumulative effect"* ([37]) of the various aspects of the person's presentation before reaching the conclusion that he lacked capacity to make decisions on residence and contact.

24. While expert evidence is of considerable importance when assessing capacity and will be determinative of whether or not there is an impairment of the mind for the purposes of s.2(1), the decision as to capacity is one for the court: *PH v A Local Authority* [2011] EWHC 1704 (COP) at [16] as applied in *Kings College NHS Foundation Trust v C* [2015] EWCOP 80 at [39].

25. I have before me a capacity assessment dated 19 March 2024 and statement dated 21 March 2024, both of which are provided by Dr B. Dr B is a Consultant Psychiatrist and Clinical Director in Acute and Urgent Care. Dr B is on the GMC Specialist Register for Liaison Psychiatry and has been a Consultant in Liaison Psychiatry for 10 years. She has expertise and experience in complex capacity assessments.

26. I find that the assessment identifies correctly the decision to be made as "whether GF has capacity to decide whether to undergo the proposed surgical procedure, an above-knee

amputation". Further, I find that Dr B correctly identifies that the relevant information for that decision is as follows:

a. he has been diagnosed with paranoid schizophrenia;

b. he has an ulcer on his right ankle that has become seriously infected;

c. surgical treatment, an above knee amputation, is required to prevent the infection spreading;

d. without the surgical treatment he will very likely die;

e. more conservation wound management will not resolve the issue; and

f. the surgical treatment must take place as soon as possible.

27. In her view, GF is able to appreciate that something is wrong with his leg and that he needs treatment for it. However, he does not understand that the ulcer has become infected, and he does not understand that the antibiotics he has been given have not worked. It is Dr B's opinion that he does not understand the consequent risk of overwhelming infection, possible sepsis and ultimately death. GF listened carefully as Dr B tried to explain to him what was wrong with his leg and why he needed surgery. However, he did not appear to understand the relevant information. Dr B's experience is not isolated. GF has had the pertinent information explained to him on a number of occasions by clinicians, but the evidence is that he is unable to recall key points about his condition, in particular he could not recall that his leg was not responding to antibiotic treatment. In Dr B's opinion GF is not able to retain relevant information. Whilst GF is willing to engage in the decision-making process, GF is unable to weigh up the risks and benefits of treatment. He cannot use the information he has been given to make a reasoned decision. He cannot weigh the relevant information. Dr B is satisfied that GF's inability to make a decision about the amputation of his leg and his care and treatment plan is because of his diagnosis of paranoid schizophrenia and that his condition is possibly also impacted by delirium linked to the infection of his leg. Whilst Dr B's opinion is that it is possible that treating his delirium may slightly improve his mental state, she considers that his chronic residual symptoms of schizophrenia mean that it is unlikely that there would be a significant improvement which would bring about any meaningful change in his decision-making capacity.

28. Whilst Dr B considers that GF cannot make the decisions himself, she is of the opinion that he is able to express his wishes and feelings. He told Dr B that he would prefer to take a non-surgical approach, involving antibiotics, dressings and soaks. However, he appeared to accept her explanation that this did not seem to be adequate, and that more serious intervention was necessary. He did not seem to recall the detailed discussions he has had with other clinicians about surgery, but when prompted by Dr B, he expressed a desire not to have this, until he had given more time for the other treatments to work, i.e. that he had not completely ruled this out.

29. On 27 March 2024 GF was visited by an agent of the Official Solicitor. In conversation he was gentle in demeanour and courteous in both tone and manner, although obviously disordered in his thinking. Over time she gained from GF that he would be okay with having an amputation, but he had hoped it would be lower down. GF has told his treating

team that he does not want to die and would have the amputation "if his life depended on it".

30. I find that GF's conversation with the Official Solicitor's agent captures GF's character and how he presents. He is obviously gentle and respectful. He can express his wishes and feelings, but those are expressed in the context of his obviously delusional beliefs and disordered thinking.

31. The manner in which GF spoke to the Official Solicitor's representative is concordant with the opinion evidence of Dr B which I accept.

32. On the basis of all the evidence before me, I find on the balance of probabilities that GF:

    a. is unable to understand the relevant information that the ulcers are infected, have not responded to antibiotics and that there is a consequent risk of overwhelming infection and possible sepsis and death;

    b. is unable to retain relevant information in that he is unable to repeat information just given to him about his condition and treatment; and

    c. is unable to use or weigh the relevant information. Whilst he does not challenge or question it, he does not fully understand it and thus cannot make a reasoned decision.

33. I find that the causative nexus between GF's paranoid schizophrenia and his functional ability to make the decision is met. I find that GF is unable to make a decision for himself in relation to the amputation of his leg and his treatment plan because of an impairment or disturbance in the functioning of his mind or brain.

34. Accordingly, and pursuant to s.15 MCA 2005, I make a declaration that GF lacks the capacity to make decisions about his amputation and his care and treatment plan as placed before this court.

35. Further, based on the evidence before this court, I find that GF does not have litigation capacity to conduct these proceedings, applying *An NHS Trust v P (by her litigation friend, the Official Solicitor)* [2021] EWCOP 27.

Best Interests

The Law

33. I now turn to consider what treatment is in GF's best interests. There is no definition of best interests under the MCA 2005. Section 4 provides so far as is relevant:

> "*(1) In determining for the purposes of this Act what is in a person's best interests, the person making the determination must not make it merely on the basis of—*
>
> *(a) the person's age or appearance, or*
>
> *(b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about what might be in his best interests.*

(2) The person making the determination must consider all the relevant circumstances and, in particular, take the following steps.

(3) He must consider—

(a) whether it is likely that the person will at some time have capacity in relation to the matter in question, and

(b) if it appears likely that he will, when that is likely to be.

(4) He must, so far as reasonably practicable, permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him.

(5) Where the determination relates to life-sustaining treatment he must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.

(6) He must consider, so far as is reasonably ascertainable—

(a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity),

(b) the beliefs and values that would be likely to influence his decision if he had capacity, and

(c) the other factors that he would be likely to consider if he were able to do so.

(7) He must take into account, if it is practicable and appropriate to consult them, the views of—

(a) anyone named by the person as someone to be consulted on the matter in question or on matters of that kind,

(b) anyone engaged in caring for the person or interested in his welfare ….

as to what would be in the person's best interests and, in particular, as to the matters mentioned in subsection (6)."

36. In terms of the approach to best interests, Lady Hale in *Aintree v James* [2013] UKSC 67 at [35] said:

"*The most that can be said, therefore, is that in considering the best interests of this particular patient at this particular time, decision makers must look at his welfare in the widest sense, not just medical but social and psychological; 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 are interested in his welfare, in particular for their view of what his attitude would be.*"

37. No single element of s.4 has priority. As Lady Hale continued at [39]:

"…in considering the best interests of this particular patient at this particular time, decision-makers must look at his 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."

38. Sanctity of life remains a fundamental principle of law in this jurisdiction. As per Sir Thomas Bingham MR in the Court of Appeal in *Airedale Trust v Bland* [1993] AC 789 at p. 808, *"a profound respect for the sanctity of human life is embedded in our law and our moral philosophy".* It is not determinative of best interests however, as per Dame Butler-Sloss P in *Bland* at p. 820F-G, *"the case for the universal sanctity of life assumes life in the abstract and allows nothing for the reality of Mr Bland's actual existence".*

39. As the Code of Practice recognises, there are a limited number of cases in which it may not be in a person's best interests to prolong life. Paragraph 5.31 sets out:

"*All reasonable steps which are in the person's best interests should be taken to prolong their life. There will be a limited number of cases where treatment is futile, overly burdensome to the patient or where there is no prospect of recovery. In circumstances such as these, it may be that an assessment of best interests leads to the conclusion that it would be in the best interests of the patient to withdraw or withhold life-sustaining treatment, even if this may result in the person's death. The decision-maker must make a decision based on the best interests of the person who lacks capacity. They must not be motivated by a desire to bring about the person's death for whatever reason, even if this is from a sense of compassion. Healthcare and social care staff should also refer to relevant professional guidance when making decisions regarding life-sustaining treatment*".

40. Section 4(6) requires consideration of a person's past and present feelings, beliefs and values and *"other factors"* he would be likely to consider if able to do so. This will include any religious or cultural beliefs formerly held.

Options for Treatment

41. In this case there are in theory three treatment options for GF. They are:

    a. an above knee amputation;

    b. multiple surgeries including revascularization surgery with aorto-femoral bypass, a surgical debridement of all the necrotic tissues, followed by a prolonged course of antibiotics for any deep infection to settle, if required a skin graft would also be performed; or

    c. conservative medical management by way of continuous intravenous antibiotics accepting of the fact that he will die of sepsis.

The Medical Evidence

42. To assist my decision making, I have before me a statement from Dr C who is a Vascular Consultant employed by the Acute Trust and Dr A, a Consultant in Diabetic Foot Medicine also employed by the Acute Trust. They have been involved in the Multi-Disciplinary Foot Team discussions about GF's treatment. It is the collective view of all involved in those discussions that GF's right lower leg is extensively gangrenous and necrotic and unsalvageable. GF is likely to suffer life–threatening sepsis if the leg is not amputated. Other treatment options have been considered including an aortic-femoral bypass/revascularization which would improve blood supply to the wound and allow healing. However, the procedure would take 6-8 hours and given the acute infection GF is not considered to have sufficient physiological reserve. The collective view is that major amputation is the only viable treatment option for GF. The extent of the necrosis in the calf and the presence of aorto-bi-iliac occlusion means that the amputation must be above-the knee. The surgical procedure will take about an hour. It has, I am told, the advantage of being a definitive procedure for GF from which he is likely to recover well.

My Analysis

43. I remind myself that I should only endorse the care and treatment plan if I consider that plan to be in GF's best interests. In that regard I have in mind s.4 MCA 2005. According to s.4(2) MCA 2005 I must consider all the relevant circumstances of the case before coming to a decision.

44. I accept the unchallenged medical evidence placed before me. I find that all reasonable treatment options have been considered in this case. The clinical evidence is overwhelming. The collective medical opinion is that an above knee amputation is the only realistic option.

45. I place the medical evidence in the balance with all the other evidence in the case including the wishes and feelings of GF. I have already set out in this judgment some of the things that GF has said about the treatment options in this case. Recently, when GF spoke to the Official Solicitor's agent, he said he '*was okay with [the amputation] but I wish it could be lower down'*. I consider that that expression of preference has to be weighed in the context of GF's recurrent wish to live and that the medical evidence does not support a below knee amputation.

46. The medical evidence is accepted by those who care for GF and have his best interests at heart. His brother and his nieces all support the proposed above knee amputation. They clearly accept that it is the only way to preserve his life. They are very clear they want GF to live.

47. The surgery proposed for GF is, of course, not without risk. There are potential physical risks namely bleeding, infection, neurovascular damage, scarring, swelling, discomfort, significant reduction in mobility, failure to rehabilitate, myocardial infarction, stroke, death, and phantom limb pain. In addition, there are risks that arise out of a General Anesthetic in every case where such an anesthetic is administered.

48. I also factor in that the operation may impact GF's mental ill health. The treatment will involve amputation which may prove distressing to him. It is hard to predict the potential impact on GF's mental health if he was to have the treatment against his wishes. The amputation may well become incorporated into his chronic delusions. However, as things are GF cannot mobilise without use of a wheelchair, he is fully dependent on others and

confined to hospital and he is likely to be in pain. Without the above knee amputation, he will become increasingly unwell physically, increasingly delirious (which would likely present as confused and potentially agitated) and I am told that he will eventually die of sepsis, which is contrary to his expressed wish to live.

49. Therefore, placing all the factors into the balance and looking at GF's holistic welfare, there really is only one outcome in this case which I can sanction as being in GF's best interests. Accordingly, I find that it is lawful and in GF's best interests to undergo surgery to have his right leg amputated above the knee and to receive care and treatment in accordance with the terms of the treatment plan dated 3 April 2024. Pursuant to s.16 of the MCA 2005, I consent on behalf of GF to the provision of the treatment set out in the treatment plan dated 3 April 2024.

50. That is my judgment.