Neutral Citation Number: [2018] EWHC 3367 (Fam)

Case No: COP13344294

IN THE COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 22/11/2018

Before :

MR JUSTICE FRANCIS

- -

Between :

A London NHS Foundation Trust	**Applicant**
- and -	
E (by his litigation friend The Official Solicitor)	**Respondent**

- -
- -

Victoria Butler-Cole (instructed by **A London NHS Foundation Trust Legal Services**) for the **Applicant**
Claire Watson (instructed by **The Official Solicitor**) for the **Respondent**

Hearing dates: 22nd November 2018

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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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MR JUSTICE FRANCIS

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.

Mr Justice Francis :

Introduction

1. By an application dated 12 November 2018, a London NHS Trust seeks a declaration that amputation of the left leg through the knee is in E's best interests. In being asked to make this application, I am asked to find that P lacks capacity to decide whether to consent to medical treatment.

2. E was born on the 24 June 1969 and is, therefore, 49 years old. He has been a patient at a London NHS hospital since the end of August 2018. He has a long-standing diagnosis of type II Diabetes and cardiac failure but had not been diagnosed with any mental disorder prior to this admission to hospital. E has a severely gangrenous left foot for which the recommended clinical treatment is amputation of the left leg.

3. A reporting restrictions order was made in this case by Mr Justice McDonald on 16 November 2018. This prevents the identification of E in connection with these proceedings and requires that he be referred to simply as E. I have continued this reporting restriction and have also ordered that the relevant hospital is not to be identified other than as a London NHS hospital. Similarly, I have ordered that none of the experts or treating physicians in this case are identified.

4. The applicant has been represented at this hearing by solicitors and by Counsel Ms Victoria Butler-Cole. The Official Solicitor acts as litigation friend on behalf of E and has been represented at this hearing by Ms Claire Watson. At the commencement of the hearing, the Official Solicitor described this as "an extremely difficult case in which the issue of E's best interests is finely balanced."

Capacity

5. The court heard oral evidence from Dr C who is a consultant liaison psychiatrist based at the mental health liaison team and the diabetes team at the relevant London NHS Hospital. She met with E on 16 October 2018 for a capacity assessment and saw him again on 6 November for a review. She explained that E has declined to have potentially life-saving surgery for his ischaemic foot. Dr C reported that E's explanation for not agreeing to surgical treatment is based on his belief that his foot was not part of the reason his admission to hospital in August 2018 and that it has reached its current state as a result of neglect by the treating team who, in his opinion, should have allowed him to apply ointments and to cover his foot with a dressing. Dr C went on to report that E is unable to process and understand information given to him about the difference between the leg injury which he had a few years ago and the current gangrenous leg as a consequence of his diabetes. E apparently believes that the hospital are offering various treatment in order to "cover up" their previous failures.

6. Dr C was clear that E does not meet the diagnostic criteria for depression or for psychosis and that he is not suicidal. Crucially, however, Dr C has reported that he is unable to understand that refusing surgical treatment is likely to be life-threatening. She reported that E does not understand that there is a very high risk of death unless the operation takes place. Most importantly, Dr C also reported that E had said to her that he does not wish to die.

7. E is said by Dr C to have scored poorly on cognitive testing, the test indicating that he has poor processing of information, poor attention and reduced memory and higher executive deficits. It is thought that the most likely cause of this cognitive impairment is vascular.

8. Dr C's conclusion is that E lacks capacity to consent to this procedure due to his lack of ability to understand and weigh up the information related to the decision. I am told that he also lacks the ability to retain some (but not all) of information related to the decision. Dr C has spent some time discussing and reporting on the most likely cause for this cognitive impairment. For the purposes of the decision that I presently have to make, the cause is probably less important. I simply note that the reported most likely cause is a narrowing of small blood vessels in the frontal subcortical and deep white matter of the brain. This is said to cause a reduction of blood flow to these areas of the brain and is likely to affect E's ability to process acquired knowledge, planning and judgement.

9. Quite properly, the Official Solicitor wanted to obtain an independent report on the issue of capacity and instructed Dr TG to prepare an independent report. Dr TG concluded that he has no doubt that E has significant deficits in comprehension, retention, and ability to weigh matters in the balance. Dr TG concludes that E does not appear to comprehend the extreme seriousness of his current situation; and that his opposition to the proposed amputation does not appear to have any rational basis. He concludes that these deficits in comprehension, retention and ability to weigh in the balance are of a sufficient degree to cause E to lack capacity in relation to decisions regarding medical treatment.

10. Having heard and considered the above evidence, I am in no doubt that I must conclude that E lacks capacity to make decisions in respect of his current medical treatment. In reaching this decision I bear in mind the comments of Peter Jackson J in *Heart of England NHS Foundation Trust v JB* [2014] EWCOP 342 where he said that "it must also be remembered that common strategies for dealing with unpalatable dilemmas – for example indecision, avoidance or vacillation – are not to be confused with incapacity". I am satisfied that, in this case, E is not simply indecisive or vacillating. I remind myself of what Peter Jackson J later went on to say in that same case, namely "what is required is an understanding of the nature, purpose and effects of the proposed treatment."

11. Having decided that E lacks capacity to make the decision himself, I turn now to deal with the best interests test. In so doing I of course have regard to the familiar guidance of Baroness Hale in *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67 at [38]:
"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 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."

12. It has been made clear to me that two options face the court: (i) amputation; and (ii) conservative management. The evidence of Dr V, the consultant diabetologist and foot physician at the London NHS Foundation Trust where he is being treated, is that what is required is a major left lower limb amputation at a level through the knee. This will have the benefit of removing the gangrenous portion of the limb, thereby limiting the toxic and infective load of the putrefactive process. This will reduce the risk of fatality very considerably but it does carry the risk of further infection of the amputated site and there is still a mortality risk with such a complex procedure. There is also the prospect of a highly reduced quality of life in the event that E is unable or unwilling to cope with rehabilitation advice. The clear opinion of Dr V is that there is "an extremely high risk of death" in the event of non-treatment or conservative management.

13. Again a second opinion was obtained by the Official Solicitor and I have the evidence of Mr JS who is a consultant surgeon with immense experience. His comprehensive report sets out the current condition of E. He concludes that he has developed a necrotic infected foot resulting from a combination of diabetes and poor peripheral blood supply. He says that the infection is currently getting into the circulation giving rise to septic episodes, already having a damaging effect on the liver and kidneys. Mr JS concludes that "without treatment this man is inevitably going to die". He says that treatment should include an above knee amputation which should be done as soon as possible.

14. Thus it is that I am faced with the clear choice of surgery which has the prospect of preserving life or conservative treatment which will almost inevitably result in a most unpleasant death.

15. As was carefully explained to the court by Ms Butler-Cole, counsel for the NHS Foundation Trust, identifying E's beliefs and preferences has not been easy. He has expressed or displayed various views and behaviours at different times, many of which are internally inconsistent. These views have included an understandable desire to leave hospital with his leg and an understandable desire to make his own decisions having consulted with members of his own family. He has also expressed to his treating clinicians on one or two occasions the view that he would have surgery if his life depended on it. As I have already noted, E's reasons for refusing treatment do not appear to be linked to concerns about the impact on his quality-of-life, but centre around his false beliefs about whether surgery is needed.

16. As is proper in such cases, Ms Butler-Cole has drawn up a balance sheet of factors. This balance sheet, to which I have added having heard evidence and submissions, may be set out as follows:

    i) **In favour of surgery**

        a) he will die without surgery, probably in a short timeframe. He will suffer pain;

        b) he has not expressed a consistent wish to refuse treatment and at times said that there were circumstances in which he would consent;

        c) surgery is likely to be successful. Dr V suggested that there was approximately a 10% risk of mortality in the event of surgery;

d) there is more prospect of E leaving hospital, in accordance with his wishes, if he has the operation. Even dependent on a wheelchair, he would be able to have a quality of life that many, if not most people would consider acceptable. It is almost certain that he will not leave hospital alive if he does not have the operation;

e) he has a friend, Mr U, who agrees that surgery is in E's best interests.

ii) **Against surgery**

a) he has said on occasions that he does not want surgery and that he wants to be the person who makes decisions, having spoken to his family;

b) the procedure itself carries a risk of mortality which, as set out above, Dr V has put at about 10%;

c) there are risks of other non-fatal problems including phantom limb syndrome, pain, infection and organ malfunction. These risks have to be viewed against the certainty of death without amputation;

d) there is a risk, again put at about 10%, that E will suffer a secondary infection, requiring further surgery. Against this it is noted that he is being treated at a centre of excellence in this field of medicine;

e) E may not be able to have a prosthetic limb and may therefore require a wheelchair to mobilise, together with a significant package of care in order to manage outside hospital;

17. I have listened very carefully to the submissions that have been made. As I indicated, the Official Solicitor started this case, very properly, by expressing no firm opinion other than wanting to hear the evidence. Having heard the evidence which I have summarised succinctly above, the Official Solicitor was in no doubt that he supports intervention by surgery in the manner requested by the NHS Trust. Accordingly, there is unanimity between the Trust and the Official Solicitor. I am indebted to the Official Solicitor for his careful consideration of this case which has assisted me in coming to the clear and firm conclusion that the court should sanction the proposed surgery. I agree with Dr TG's conclusion that, "on balance, and with a significant degree of hesitation and caution, I believe, on the evidence currently available, that E's best interests are best served by proceeding with the proposed amputation". I should add, here, that one of the principal reasons why Dr TG was hesitant was because of E's wish to contact his family to obtain their views. The applicant has tried all possible routes to try to contact E's family and eventually contact was made with E's brother, who supports the surgery taking place.

18. Accordingly, I accede to the application made by this London NHS Trust and I consent to surgery on behalf of E and to the ancillary aspects of the care plan including sedation and, as a last resort, physical restraint. The court expresses the sincere hope that the surgery will be successful and that he will cooperate with a path towards recovery.