Neutral Citation Number: [2021] EWCOP 4

Case No: 13701748

IN THE COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 19/01/2021

Before :

THE HONOURABLE MR JUSTICE HAYDEN

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Between :

UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST [1] **DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST [2]**	**Applicants**
- and -	
MN **(by his proposed litigation friend, the Official Solicitor)**	**Respondent**

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Miss Emma Sutton (instructed by Browne Jacobson LLP) for the **Applicants**
Miss Katie Gollop QC (instructed by the Official Solicitor) for the **Respondent**

Hearing dates: 18th 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 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 is an urgent application concerning medical treatment for MN, who has an obstruction in his right kidney which is suspected to be related to bladder cancer. MN is a 60-year-old man who has been diagnosed with paranoid schizophrenia and who lives in a mental health recovery home. The applicants, University Hospitals of Derby and Burton NHS Foundation Trust and Derbyshire Healthcare NHS Foundation Trust, seek, pursuant to the Mental Capacity Act 2005 ('MCA 2005'):

    a. to examine MN by means of a CT scan with contrast; and
    b. if clinically appropriate, to treat MN using a cystoscopy procedure known as transurethral resection of bladder tumour ('TURBT'), which removes tumours using a telescope inserted into the urethra; and
    c. for both procedures to be performed under a single dose of general anaesthetic, which is likely to require MN's hospital admission overnight.

2. In August 2020, MN attended his GP because he was passing a coffee-like substance from his urethra. Whilst he felt able to co-operate with an ultrasound performed on 23rd November 2020, MN has subsequently resisted further investigations or treatment. MN's father died in 2017 having refused treatment for cancer, and professionals believe that MN wishes to follow his father's precedent. MN told a sibling: "*I'm going to do what Dad did"*. MN does not currently experience pain related to his bladder condition, notwithstanding the fact that he has been symptomatic since August 2020.

3. MN's treating urologist, Mr W, considers that MN's symptoms strongly indicate that he has bladder cancer, but absent a CT scan, this is not confirmed. In the event MN has bladder cancer, if left untreated, there is an as yet unquantifiable risk that he will suffer a painful deterioration due to blood clots forming in his bladder and could be prevented from urinating. While the precise timescales are unknown, without a cystoscopy procedure, MN may experience a quicker and more unpleasant death resulting from a cancerous growth metastasising.

4. MN's diagnosis and treatment of suspected bladder cancer is the responsibility of the first applicant, while the second applicant provides the community treatment of MN's mental health. The applicants sought a court order on the basis that carrying out the proposed CT scan and cystoscopy treatment would likely require a degree of restraint which would amount to a deprivation of MN's liberty.

5. The specific procedures to investigate and treat MN's probable (but not inevitable) bladder cancer are:

    a. CT scan with contrast; and, if clinically appropriate, and if bladder cancer is the (or a) cause of the obstruction;
    b. Cystoscopy procedure with surgery performed via telescope (transurethral resection of bladder tumour, 'TURBT').

6. Such surgery would enable the surgeon to 'debulk' a tumour if one is present. This is relatively non-invasive, involving a release of an electronically operated wire during

the course of the cystoscopy which effectively wraps itself around the tumour and excises it. The debulking of a tumour would enable MN to urinate painlessly, and would extend MN's life and improve his quality of life as his condition progresses. The CT scan, cystoscopy and any TURBT (or other clinically indicated procedure such as removal of a kidney stone) would be completed at one sitting and under a general anaesthetic, and an overnight stay in hospital would probably be required.

7. If bladder cancer is confirmed on investigation, the treatment options are one or a combination of:

    i) radiotherapy;

    ii) surgery to remove the bladder;

    iii) chemotherapy; or

    iv) palliative care only.

8. Mr W, confirmed in oral evidence that following the CT scan and cystoscopy procedure, the options for MN would need to be considered at a multi-disciplinary team meeting, as there are currently too many unknowns at this stage to identify an appropriate post-operative plan.

9. I am delivering this judgment in the midst of the 'second wave' of the Covid-19 pandemic. Hospital admissions, and the consequent pressure on intensive care units and more generally, presents a challenge for all concerned. In his evidence before me, Mr W referred me to the National Cancer Waiting Times Monitoring Dataset Guidance (Version 11.0, September 2020). This I assume to be the most up-to-date guidance available. It provides that the proposed treatment here should generally be scheduled within 31 days of a formal diagnosis. While a formal diagnosis has not been made due to MN's refusal to engage in investigations, it is, as I have indicated, considered highly likely by MN's treating clinicians that he has bladder cancer. As a result, the applicants originally asked the court to list a substantive hearing today, so that treatment might take place on 21st January 2021. As a consequence of the severe restriction on the number of beds available to elective surgical patients, due to Covid-19, I was informed that it was unlikely to be possible for the procedure to take place before March 2021. I was told in oral evidence by Mr W that while enquiries had been made with two neighbouring NHS Trusts about the availability of elective urological surgery, the other Trusts face similar (or worse) situations. Mr W explained that currently, in addition to the extremely limited number of beds available for elective surgical cases (around an eighth of the Trust's pre-pandemic capacity), an ITU bed would not be available for MN in the event he had an adverse reaction to the procedure. This is because the ITU beds are fully occupied by Covid-19 patients.

10. Thus, we find ourselves in the invidious position where, notwithstanding the fact that MN's condition requires urgent examination and treatment, it is simply not deliverable. Without knowing the size of the obstruction, it is difficult for the treating clinicians to predict MN's prognosis without treatment. However, in the likely event that MN does have bladder cancer, it will eventually metastasise, if it has not already done so, and sadly cause his death.

Procedure

11. Permission to bring this application is sought pursuant to section 50(2) MCA 2005 on the basis that the criteria set out in section 50(3) MCA 2005 are met. Both of the applicants have a clear connection to MN as the public bodies responsible for his treatment and the application is made in order to provide MN with medical treatment. The provision of life-sustaining treatment is the benefit to MN of the declaratory relief and orders sought. In light of the repeated unsuccessful attempts to engage MN to date and his longstanding diagnosis of paranoid schizophrenia, I agree that this benefit cannot be achieved in any other way.

12. By way of completeness, I reiterate that I have made a transparency order preventing the identification of MN, members of his family, his treating clinicians and any material or information that identifies or is likely to identify where any person listed above lives, or is being cared for, or their contact details.

13. The Official Solicitor has been appointed as MN's litigation friend. As yet, MN's sister and brother have not been joined as parties. MN's sister has confirmed that she does not wish to be joined to these proceedings as a party. The Official Solicitor requires time to speak further with MN's brother and sister to see whether they can cast any light on MN's resistance to treatment and she intends to do so.

14. This hearing concentrated on the following issues:

    a. Pending the determination of the substantive application, whether there is reason to believe that MN lacks capacity to conduct proceedings, and make decisions about investigations or examinations and treatment relating to the obstruction identified in his right kidney;
    b. Whether to make an interim order authorising emergency treatment to be delivered by medical professionals, and the likely restraint of MN such a course of emergency treatment would involve;
    c. Whether the final hearing should consider the lawfulness of different post-investigation treatment options in the event bladder cancer is formally diagnosed; and
    d. Delaying the listing of the final hearing in light of the information about the limited availability of elective surgery during the Covid-19 pandemic.

Background to the application

15. The ultrasound performed on 23rd November 2020 revealed a gross hydronephrosis (dilation) of MN's right kidney, which suggested that the kidney has been obstructed for some time. This is most commonly caused by bladder cancer. On the same day, MN refused a cystoscopy. MN further refused a CT scan scheduled for 4th December 2020. His treating clinicians convened a 'best interests' meeting on 21st December 2020 at which it was agreed that a further CT scan without contrast should be attempted. However, on 31st December 2020, MN refused to engage with this.

16. On 5th January 2021, at a further best interest meeting, MN's clinicians agreed that the only treatment option available, and the least restrictive for MN, was undergoing a CT scan with contrast under general anaesthetic, and the TURBT procedure if clinically

appropriate. It was the clinical view that if a malignant cancer is found, radical treatment (including radiotherapy or chemotherapy) would not be in MN's best interests due to his likely unwillingness to comply, and that palliative only care would instead be provided. As set out in paragraph 8 of this judgment, that was not the oral evidence of Mr W. His oral evidence was that there are so many unknowns at this stage, that the further treatment plan for MN would need to be considered by the MDT after the CT scan, any TURBT and the results of histology.

17. On 12th January 2021, the applicants made this application. On 15th January 2021, Mr W provided an updated witness statement outlining the extreme restriction on the number of beds available for elective surgery due to the ongoing Covid-19 pandemic.

Reason to believe MN lacks capacity

18. MN was assessed by Dr T, a consultant psychiatrist, on 29 December 2020. Dr T concluded that MN "appears not [to] have ability to grasp information being imparted to him regarding the serious nature of his medical issues. MN asserts that he is passing coffee in his urine. It is apparent that MN is unable to understand, retain and weigh the relevant information". This can be attributed to his diagnosis of paranoid schizophrenia, which is an impairment of the function of his mind or brain for the purposes of section 2(1) MCA 2005. Miss Gollop QC, who acts on MN's behalf via the Official Solicitor, advances no challenge to Dr T's conclusion.

19. Accordingly, I am satisfied, for the purpose of section 48 MCA 2005, there is reason to believe that MN lacks capacity to conduct these proceedings, and to make decisions about the investigations and treatment of his identified kidney obstruction. Miss Sutton, on behalf of the applicants, bears in mind my judgment in **DP v London Borough of Hillingdon [2020] EWCOP 45 and** recognises that there is no power to make an interim declaration.

20. As yet, MN has not been informed of these proceedings and as a result, he has not had the opportunity to express his wishes or feelings in relation to receiving pain-relieving emergency treatment for blood clots, as distinct from the primary treatment for his suspected bladder cancer. In the course of exchanges, both Miss Sutton and Miss Gollop recognised that these views would have to be canvassed and given that the emergency treatment would be triggered by very significant pain, required careful investigation to be investigated.

21. Mr W within his witness statement dated 15th January 2021 envisages that medical treatment 'would continue to be against MN's wishes and feelings and therefore the applicants would like the courts prior approval so that an emergency situation can be dealt with effectively' Miss Sutton invited the court to make an interim order that it was in MN's best interests for his treating clinicians to take steps to provide emergency treatment to him (whether by use of restraint or sedation) in accordance with the emergency treatment plan dated 15th January 2021. Additionally, to the extent that the arrangements set out in the emergency treatment plan amounted to a deprivation of MN's liberty, the applicants sought authorisation, providing always that any measures used to facilitate or provide the arrangements were the minimum necessary, and that all reasonable and proportionate steps were taken to minimise distress to MN and to maintain his dignity.

22. Miss Sutton recognised that clinicians could rely on section 6(7)(a) MCA 2005 and provide life sustaining treatment (between now and the final hearing) and/or, rely on section 6(7)(b) and do '*any act'* which they reasonably believe to be necessary to prevent a serious deterioration in MN's condition while a decision is sought from the court. Additionally, Miss Sutton recognised that section 4B MCA 2005 authorises steps to be taken which would deprive MN of his liberty if the steps consist wholly or partly of giving MN life-sustaining treatment or doing any vital act whilst a decision is sought from the court. The concerns raised by the applicants, and the reasons submitted by Miss Sutton regarding the necessity of an order were:

    i. Any concerns that clinicians have regarding the lawfulness of treating MN against his will without a court order is likely to result in delay which is inimical to his welfare;
    ii. Although MN is currently pain free, there is an 80% chance that he has invasive bladder cancer and a consequential risk that treatment will be required – particularly if a return hearing is not for another 8-9 weeks (week of 15th or 22nd March 2021);
    iii. An order made at a case management hearing based on a structured plan is preferable to an urgent out of hours application being made to address the lawfulness of emergency treatment given/ to be given to MN;
    iv. The order is permissive only as regards the deprivation of liberty, and restraint would only be used as a measure of last resort. The plan specifically provides that MN would be asked to attend hospital voluntarily in the first instance.

23. However, I am clear that it would be inconsistent with the principles of the MCA 2005 for the Court pre-emptively to authorise the deprivation of MN's liberty in circumstances where both the nature of the potential emergency situation could be anticipated (the foreseeable impact of blood clotting related to bladder cancer), and where MN's wishes and feelings might be sought and recorded in advance. I repeat that both counsel recognised and accepted the force of this.

24. Accordingly, I have directed that the interim order sought by the applicants is only operative (pending the final hearing) if all of the following conditions are met:

    i. MN is in pain and/or discomfort and/or is unable to urinate;
    ii. MN's views have been canvassed regarding having emergency treatment (it having been explained to him that such treatment would release him from pain and/or discomfort and/or would enable him to urinate);
    iii. The emergency treatment would include releasing any blood clots in his bladder (or other clinically indicated and operable obstruction) preventing him from urinating;
    iv. MN continues to express a resistance to emergency treatment.

    My instinct is that if MN is in great pain, and unable to pass urine, I consider it unlikely he would resist treatment and help.

Scope of the application

25. I considered the fact that, at the best interests meeting of 5th January 2021, certain options for MN's long-term treatment were specifically discussed. In the (highly likely) event that after a CT scan, bladder cancer is diagnosed, the options for MN's treatment are:

    a. Radiotherapy, which would involve MN having to lie still on a table similar to a CT scanner, every day for four to six weeks;
    b. Surgery to remove MN's bladder (a cystectomy) which would involve major surgery and a portion of MN's small bowel to be formed into a stoma through which urine would flow into a bag which would need to be emptied regularly;
    c. Palliative care only; and
    d. Chemotherapy, which would involve MN receiving IV infusion cycles over a period of time.

26. While it might be possible to provide MN with palliative radiotherapy lasting between one and two days, I note that Mr W considers that MN's objections are likely to make what he terms 'curative treatment' unrealistic. I accept his evidence. It is highly unlikely MN would co-operate with an onerous regime of chemotherapy or radiotherapy. I also consider that Mr W is correct to say that removal of the bladder and the insertion of a stoma is likely to cause MN acute distress and to provoke active resistance. Compulsion of treatment by force would be corrosive of MN's dignity.

Return listing for the final hearing

27. I was profoundly concerned about the risks for MN of adjourning a decision about his treatment until March 2021. In his evidence, Mr W explained that because MN has an obstructed kidney, he is likely to have a muscle-invasive bladder cancer. This means that it is very unlikely that it will be possible to cure MN with the TURBT procedure alone. However, if MN had a superficial (rather than muscle-invasive) cancer, there is a risk that by delaying treatment, the cancer becomes muscle-invasive and more difficult to treat. Further, assuming MN has a muscle-invasive cancer already, delay increases the risk that the cancer will metastasise elsewhere in his body. Mr W re-emphasised that in any event, MN was very unlikely to be offered radical curative treatment, such as chemotherapy followed by the removal of the bladder (cystectomy), for the reasons I have outlined above. Instead, the objective of the treatment would be to prevent bleeding and blood clots. This was unlikely to be affected by whether or not MN's bladder cancer had metastasised.

28. I pressed Mr W as to whether the pressures on the hospitals he had contacted within the two neighbouring Trusts might abate before March 2021. Specifically, I queried whether the extensive rollout of the Covid-19 vaccines amongst those in their 80s and 70s might take the pressure off the NHS by mid-February 2021, which I understand to be the time by which it is hoped that virtually all in that age group would have been offered a vaccine. Mr W informed me that it is his experience that those in these age groups are not ventilated on intensive care units, and consequently, that the pressure was unlikely to ease significantly for the foreseeable future. He did however consider that by mid-March 2021, the position ought to look much better.

29. Invidious though the situation is, I have been reassured that MN has not been disadvantaged or deprioritised in consequence of his general functioning, and the

vulnerability inherent in his lack of capacity. It also requires to be said that given the paucity of options, in the face of MN's resistance to treatment, the impact of the delay is not as catastrophic as it might be in different circumstances.

30. For these reasons, I have concluded that a final hearing should be listed in the week of 15th March 2021 or the week of 22nd March 2021, with a time estimate of 1 day. With the assistance of counsel, I have made the necessary directions to ensure that hearing is effective.