This judgment was delivered in public and the proceedings are subject to the Transparency Orders dated 14 December 2023. The anonymity of the parties and the treating clinicians must be strictly preserved and nothing must be published that would identify the parties or the treating clinicians, either directly or indirectly. 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.

Neutral Citation [2023] EWCOP 59

IN THE COURT OF PROTECTION **Case No 11666915**

Royal Courts of Justice
Strand
London WC2A 2LL

22 December 2023

Before

JOHN MCKENDRICK KC
(Sitting as a Tier 3 Judge of the Court)
SITTING IN PUBLIC

Between:

A HOSPITAL NHS FOUNDATION TRUST

Applicant

AND

(1) Ms KL (By her litigation friend, the Official Solicitor)

(2) Mrs KLS

Respondents

Mr Vikram Sachdeva KC instructed by Kennedys for the applicant
Ms Nicola Kohn instructed by the Official Solicitor for the first respondent
The second respondent appeared in person

HEARING DATE: 19 December 2023

APPROVED JUDGMENT

John McKendrick KC:

Introduction

1. These proceedings concern the first respondent's medical treatment and in particular: whether she has capacity to consent to medical treatment for her acute myeloid leukaemia; and if she lacks that decision making ability, what treatment is in her best interests. Important ancillary issues arise in respect of restraint and deprivation of liberty. Ms KL was joined as a party to these proceedings. She is anonymised as Ms KL in this judgment. The Official Solicitor has agreed to act as her litigation friend.

2. The applicant is the treating clinical trust. It issued an application on 14 December 2023 seeking relief pursuant to the Mental Capacity Act 2005 (hereafter "the 2005 Act or MCA") and in particular seeking declarations that Ms KL lacks capacity to conduct the proceedings and to make a decision to consent to the treatment of her leukaemia and an order that the proposed treatment is in her best interests. The email from the applicant's solicitors stated:

> "The Trust is seeking an urgent hearing in light of the circumstances of this case. Please could we request a listing of this matter in the next 2-5 days. The next round of chemotherapy needs to take place as a matter of urgency as a bone marrow biopsy is required next week.

3. The second respondent is Ms KL's sister. She supports the applicant's case. Her mother supports her position.

Procedural Matters

4. On receipt of the application on 14 December 2023, Her Honour Judge Hilder, the Senior Judge of the Court of Protection, considered the papers within hours and transferred the matter to the attention of staff at the Royal Courts of Justice for the matter to be heard urgently by a Tier 3 judge. That same afternoon the Vice President, Theis J., made characteristically careful and detailed orders and directions to ensure the matter could be heard, as was requested, within 2-5 days. The directions were made to ensure the Official Solicitor and the court would have the information necessary to determine the application speedily, having appropriate regard to fairness. In particular Theis J made orders and directions that:

The Trust shall file and serve the following factual evidence by 4:00pm on 15 December 2023 in support of the proposed treatment:

(a) Care Plan(s), including any potential restraint for which authorisation is sought;

(b) Any updating witness statement exhibiting any relevant further information or documentation.

(c) An explanation as to why the statements are dated 1 and 4 December 2023 yet this application was not sent to the court until 13 December 2023 seeking a hearing in 2 –5 days.

The following directions shall apply to that hearing:

(a) The Trust shall file and serve an updated electronic court bundle by 4:00pm 15 December 2023

(b) The Trust shall file and serve a position statement by 4pm 15 December 2023;

(c) The Official Solicitor shall file and serve a position statement by 2pm 18 December 2023.

5. Theis J also ordered that the X Group (who manage the hospital where Ms KL is detained) disclose to the Official Solicitor the records held in respect of Ms KL by 15 December 2023. Permission was given to the X Group to vary or discharge the terms of the order.

6. Theis J also made a transparency order which prohibits naming the parties.

The Background

7. Ms KL is 45 years old. She is of British and Indonesian heritage with a lifelong history of mild to moderate learning disabilities and Emotionally Unstable Personality Disorder.

8. Her mental disorder is said to be *"chronic, enduring and severe, characterised by abnormally aggressive and seriously irresponsible behaviour, with fluctuations in*

mood, physical aggression, impulsivity, low frustration tolerance, lack of insight and judgment. [She] continues to present risk behaviours in the form of impulsivity, unpredictable aggression, assaultive behaviour, property damage, disinhibited and chaotic behaviour."

9. Ms KL grew up with two sisters in the family home. One of her sisters was disabled and died in or around 2013. Her surviving sister is the second respondent, who regularly sees Ms KL and cares for their elderly mother.

10. Ms KL is noted to have exhibited behavioural issues since childhood and aggression towards her mother from an early age. In or around 2008, Ms KL was charged with criminal damage and assault as a result of which she was admitted to a mental health facility pursuant to section 37 Mental Health Act 1983 (hereafter "the MHA or the 1983 Act"). In 2011 she moved to a hospital but despite a relatively prolonged admission, her engagement with psychological therapies was noted to be "minimal'.

11. From 2014 for many years Ms KL had a series of placements interspersed with living with her mother.

12. In August 2021, Ms KL was admitted to an X Group managed hospital (which is anonymised in this judgment as H Hospital) pursuant to s.3 of 1983 Act. Her behaviour was noted to gradually escalate, including incidents of threats, racial abuse of staff, physical violence against staff, spitting, property damage, resulting in her being secluded. She has been detained under section since then at H Hospital.

13. In early February 2023, Ms KL began to complain of a lump on her back. She was noted to suffer from a number of unexplained bruises. In or around 31 October 2023 Ms KL is reported to have suffered from bleeding at her injection site on provision of her depot injection: a full blood count indicated *"an anaemia (Hb 84g/L), severe thrombocytopenia (24x10^9/L) and a marked leukocytosis (268.3 x10^9/L). A blood film demonstrated that >90% of the cells seen were myeloid blasts, and the diagnosis of acute myeloid leukaemia was confirmed with flow cytometry"*

14. On 1 November 2023 Ms KL attended the Trust on s.17 MHA leave. She was admitted, and the Trust began treatment immediately, in the form of standard induction chemotherapy (daunorubicin/cytarabine) with the addition of midostaurin following detection of the FLT3-ITD mutation. She has been the subject of repeated restraint since admission. She has been an inpatient since then and has had very limited section 17 leave from the hospital to visit her mother. She has been visited regularly by the second respondent.

The Hearing

15. The hearing took place, as per the directions of Theis J, as an attended hearing with permission given to clinical witnesses to attend remotely. The applicant was represented by Mr Vikram Sachdeva KC and Ms KL was represented by Ms Nicola Kohn, counsel. I was informed at the outset that Mrs KLS was on the hybrid link. I asked her how she wished to participate in the hearing and whether she had been informed about being a party. She was uncertain, so I determined to adjourn for her to be provided with relevant documents and to speak with the parties' solicitors.

16. It transpired that the bundle I was provided with was not the latest version and lacked important updating witness statements. Contrary to the direction of Theis J, the bundle was filed and served around 9:30 pm on 18 December 2023. In any event this 'latest' version lacked the recent up-to-care plan which included the proposed restraint. This was circulated, in breach of the order of Theis J, at some stage on the morning of the hearing. I was also provided for the first time, and in breach of the order of Theis J, with the witness statement of Dr C on the morning of the hearing. I also record that reference was made to the medical records and I was told a 600 page or so bundle existed, but that had not been sent to the court.

17. Mr Sachdeva sent me an email the evening before the hearing informing me that his solicitor had contacted the X Group on the morning of 18 December 2023, emailing them to provide a capacity assessment of Ms KL by that same afternoon. I was sent a copy of a COP 9 which was served on the X Group around 5 pm on 18 December 2023, seeking to join them as a party. I simply note that there is a dispute between the applicant and the X Group regarding the responsibility for bringing this application.

That is why Theis J directed evidence explaining the delay. I do not propose to comment on the dispute between the applicant and the X group, other than to observe that no public body or private institution tasked with caring for vulnerable people should compromise their charges' welfare through a lack of cooperation.

18. I received two position statements. The applicant's was filed and served around 5 pm 18 December 2023, in breach of the order of Theis J. The Official Solicitor's position statement was emailed to me around 11 pm on 18 December 2023. It was pointed out that Ms Kohn only received the bundle at 9:30 pm. I thank both counsel for their very helpful position statements. Ms Kohn's, in particular, was, if I may say so, a model position statement which has been of invaluable assistance to the court.

19. No COP 9 application was made by the applicant to seek the court's permission to file and serve the bundle, position statement, care plan or evidence, all in breach of the directions of Theis J, out of time.

20. In the light of the above I was required to rise to permit documents to be served on Mrs KLS and to allow myself time to read the various additional documents. I then joined Mrs KLS as a party. I admitted the evidence and documents which were filed in breach of the order of Theis J. I declined to adjudicate upon the application to join the X group but adjourned it.

21. As is apparent below, it became clear during the hearing that the applicant's case was deficient in various respects. I was therefore unable to give judgment or to announce my decision with a reserved judgment. Mr Sachdeva submitted the case was not so urgent that a decision was needed imminently. I directed that further evidence from the applicant be filed and served by 4pm 20 December 2023 and that both parties had permission to file further written submissions on 21 December 2023. I reserved my decision. I received around 400 pages of additional documents on 20 and 21 December 2023. Unsurprisingly the court's list this week has been very busy. None of this makes for a constructive background to determine such important issues for Ms KL.

22. Having considered all the evidence and documents filed before, during and after the hearing, I have concluded that Ms KL lacks capacity to conduct the proceedings and

to make a decision to consent to the necessary chemotherapy to treat her leukaemia and that it is in her best interests to receive the proposed treatment. I authorise restraint for the direct and indirect purposes of receiving intravenous chemotherapy (but not oral chemotherapy) and authorise any deprivation of liberty which arises. I accept a portacath is in Ms KL's best interests and should be fitted under general anaesthesia. I endeavour to set out my reasons for these orders and directions below.

The Evidence

Dr C, Consultant Haematologist

23. The diagnosis is clear: acute myeloid leukaemia, which is a quick and aggressive cancer of the white blood cells.

24. Dr C provided a COP 3 and a witness statement. His COP 3 assessment states:

> *"to give informed consent [Ms KL] would need to understand the nature of the diagnosis of leukaemia and the associated risk of death that is associated with untreated disease. She would also need to understand the risks of chemotherapy including the risks of low blood counts, fever infection, the risk of gut, toxicity including nausea vomiting diarrhoea and constipation. She would need to understand that there are risks of organ toxicity including liver damage, cardiac damage which can be permanent, skin rashes, hair loss. she would also need to understand that there is a risk of long term complications including 2nd cancers and infertility. She would need to understand the likely benefit of treatment in terms of increased probability of curing disease which has probably in the order of around 60- 70%. she would need to be able to retain this information a make a judgement on the basis of it."*

25. Dr C notes that Ms KL's attention span is limited to a few minutes at a time. On this basis he concludes that she is unable to retain information for more than a few minutes, *"particularly if it is complex medical information"*. He notes that Ms KL can communicate her needs, verbally and non-verbally and observes: *"[Ms KL] understands there is a problem with her blood that she would benefit from medicine to make her better*

but a deeper level understanding is missing. This is despite several conversations and support from carers who are familiar with her from [H Hospital]"

26. Dr C notes that he has discussed Ms KL's case with her treating psychiatrist Dr F who has confirmed he "*did not think there were other steps which make material difference to understanding"*. Dr C does not consider there to be any prospect of Ms KL gaining capacity on the basis that *"her learning difficulties are longstanding and not reversible"*

27. In his witness statement he explains that Ms KL has had her first cycle of chemotherapy which she tolerated well. Her 'repeat bone marrow' shows a complete morphological remission, which he says 'means there is no clear evidence of leukaemia down the microscope.' Given her genes, which he has analysed, her chance of cure is "good". He notes she likely has residual leukaemia and it will require a further three cycles of chemotherapy. Each further cycle requires 5-8 days of intravenous chemotherapy to be delivered in a hospital setting. Each cycle comes with associated very low blood counts and the need for blood of platelet transfusions. The risk of infection is very high (50 %) with each cycle. Infection would require immediate broad spectrum intravenous antibiotics. There are wider risks. Given the infection levels there is, he says, a risk of death of around 5 % with each cycle of chemotherapy. For this reason he proposes that it will be necessary for Ms KL to be an inpatient for the duration of her treatment. He notes that a month of rest is required between each cycle of intravenous chemotherapy and that during the initial phase, oral chemotherapy is also provided. He notes that there is a proposal to insert a line under Ms KL's skin to administer future chemotherapy rather than in reliance on the PICC line (many of which Ms KL has pulled out). He notes this would require a general anaesthetic.

28. He gave oral evidence which was consistent with his written evidence. He emphasised how poorly she was when she was admitted and that she has responded well to the treatment provided in November. Future prognosis depended on three factors: i. response to the first cycle of chemotherapy; ii. genetics; iii. patient's toleration of the treatment. On all three bases, with further treatment, the prognosis for Ms KL is good. Without treatment there was a 90 % risk of the leukaemia returning. Her emphasised the high risk of infection and sepsis between cycles of intravenous chemotherapy. He was clear that Ms KL told him she wants treatment and wants to get better.

Dr K, Consultant Haematologist

29. His first statement notes the acute situation the clinicians faced when Ms KL was admitted in early November 2023:

> "[Ms KL] was admitted to the [Trust] on the 01 November 2023. She was assessed within her inpatient psychiatric hospital …….with bleeding from her injection site (following injection of her psychiatric medication). A blood count demonstrated an anaemia (Hb 84g/L), severe thrombocytopenia (24x109/L) and a marked leukocytosis (268.3 x109/L). A blood film demonstrated that >90% of the cells seen were myeloid blasts, and the diagnosis of acute myeloid leukaemia was confirmed with flow cytometry."

30. He notes:

> "Without treatment, [Ms KL]'s leukaemia would have been rapidly fatal (days to weeks) with a significant risk of leukostasis (high white cell count) leading to intracerebral bleeding, strokes or respiratory failure. She therefore received standard induction chemotherapy (daunorubicin/cytarabine) with the addition of midostaurin following detection of the FLT3-ITD mutation. This was administered in her best interests.

31. In his second witness statement which was produced after various bone marrow and genetic tests were undertaken he says this:

> "The standard treatment for acute myeloid leukaemia for somebody of [Ms KL's]'s age is intensive chemotherapy. With four cycles of intensive chemotherapy the cure rate is around 60-70%. If patients do not respond well, they sometimes require a donor stem cell transplant, which is very intensive treatment.
>
> Without further treatment, [Ms KL]'s leukaemia has a >95% chance of recurring in the next 6-12 months. Acute myeloid leukaemia is rapidly (within weeks) fatal without treatment."

32. Therefore he proposes that:

> "Assuming an adequate response on the planned bone marrow biopsy, I would propose continuing with the next cycle of chemotherapy. This would be administered as an inpatient. It carries risks of hair loss, infertility, heart damage, low blood counts (leading to infection, which may be severe and life-threatening), a rash and nausea/diarrhoea. It is very similar to the previous chemotherapy she has already received. The risk of dying because of the chemotherapy is around 5%. Chemotherapy is administered over 8 days intravenously with 14 days of tablet chemotherapy (midostaurin). Patients normally recover their blood counts around 4 weeks after beginning treatment. She would require 1-2 further cycles of intensive chemotherapy following this, assuming she follows a chemotherapy only approach.

33. His third witness statement noted:

> "She will require definitive intravenous access to deliver chemotherapy. She has previously removed peripherally inserted central catheters (PICC lines) 6 times in the last four weeks when she has been agitated. We believe that an implantable port under the skin, which would be accessed when required, would be less distressing, and also avoid the need for repeated line insertions. This would require insertion under general anaesthetic in a small operation.

34. He gave oral evidence. He told me that Ms KL told him she wants to get better and she does not want to die. She would also like to see her mother.

35. After the hearing he produced a further witness statement setting out the pros and cons of intravenous chemotherapy by way of: (i) PICC line; (ii) Hickman lines or (iii) a Portacath. He states the Hickman line is the least preferable but does not offer an opinion between the Portacath and the continued use of PICC lines.

Ms S, Nurse Matron

36. She gave evidence about the levels of restraint being provided to Ms KL. Her written and oral evidence was that whilst Ms KL is supported by four X Group staff on the ward, physical restraint is only provided by the applicant's security team. Restraint from the

security team has been needed through November and December 2023. Ms S sets out the challenges staff face: Ms KL will frequently empty her bowels and smear faeces across the room. She can be aggressive and fight. She gave oral evidence in which she said that restraint was provided not for the purposes of giving Ms KL oral chemotherapy medication but to restrain her to remove dangerous chemotherapy pills she had not swallowed.

37. She told me in oral evidence that restraint was not used to provide the oral chemotherapy tablets but it had been needed to remove the tablets from Ms KL when she was given them but did not swallow them. She said these tablets are dangerous and had to be collected. She referenced a best interests meeting in mid-December 2023 that concluded that Ms KL should not be discharged back to her usual hospital between cycles of intravenous chemotherapy because of the infection risks. She also gave evidence that the meeting concluded it was in Ms KL's best interests to have a portacath inserted but accepted in questions from me there was no evidence about the necessary general anaesthesia and she could not say when the portacath should be inserted. She told me that Ms KL had recently left the ward to visit her mother and this would keep taking place under section 17 1983 Act leave for as long as she was well enough.

Dr AJ, Consultant in Intensive Care Medicine and Anaesthetics

38. As noted above, the applicant's evidence omitted to deal with the pros and cons and risks of the insertion of a portacath, notwithstanding that this was clearly discussed in a best interests meeting in mid-December before the application was issued. The portacath was also identified by Theis J as an issue to be determined at the hearing. The applicant therefore filed further evidence on this issue at 4pm on 20 December 2023. Dr AJ's witness statement said:

> A portacath is a form of long-term vascular access – it consists of a catheter/tube and an injection port that is placed underneath the skin. One end of the tube sits at the entrance to the heart, the other end is connected to the injection post. It is completely implanted, so there are no external parts. To access the portacath, a special needle (Gripper Needle) is inserted through the skin into the port – blood samples can be taken from this and medication/fluids/blood products can be

given. The needle is removed after each treatment, or changed every 3-4 days if the treatment is continuous.

…

The risks of portacath insertion include infection, bleeding, pain, damage to nerve/artery/vein/lung/heart, malposition, thrombosis, blockage, and failed insertion. The risk of pneumothorax [burst lung] and arterial puncture are usually quoted at ~ 5%.

…

The risks of general anaesthetic are low but are specific to the individual patient - risk increases with factors such as age, comorbidities (such as obesity), emergency surgery, and major surgery. The overall risk of death in the UK is quoted at about 1:185,000."

Dr D, The X Group, Speciality Doctor

39. Following the applicant's application to join the X Group as a party, Dr D provided a COP 3 Form after the hearing, on 20 December 2023. She opined that Ms KL lacks capacity to make a decision to treat her leukaemia. She assessed Ms KL on 19 December 2023.

40. I also note, for completeness, that the X Group emailed the court staff with the medical records ordered by Theis J on 20 December 2023. No explanation was provided as to why the X Group breached the order.

Caroline Barrett

41. She is a solicitor and agent for the Official Solicitor. She met with Ms KL on 18 December at the hospital where Ms KL is an inpatient. I set out relevant parts of her most helpful attendance note exhibited to her witness statement:

> ES explained that staff are considering putting in a "portacath" instead of continuing to have external Hickman or Picc lines. She explained that this is a more permanent way of administering treatment. Over time it becomes harder to insert Hickman and Picc lines because of scar tissue, and also [Ms KL] would

> occasionally try to remove external tubes and lines. However [Ms KL] is scared about this because the portacath needs to be inserted under general anaesthetic. She is scared of general anaesthetic and so when you talk to her about it, she will insist that she wants to keep her Picc line. In ES's view this shows that she does have some understanding of what different procedures mean, and when she's experienced something previously she is able to engage with the topic a bit more.

42. Ms Barrett was unable to speak with Ms KL who was agitated and upset that day.

Other

43. I also record that whilst I did not hear evidence from Mrs KLS, she briefly addressed the court. She wanted her sister to get better.

44. At 7 pm on 21 December 2023 I received a further witness statement from the applicant's solicitor and further information in respect of the portacath. No COP 9 application was made to admit this further evidence and information. The information in respect of the portacath (provided by Dr. E, Consultant in ITU and Accident & Emergency) states that it is in Ms KL's best interests to carry out the portacath procedure under general anaesthesia.

<u>The Law</u>

45. Sections 1- 4 of the 2005 Act set out the statutory framework in respect of mental capacity and best interests.

46. Serious medical treatment applications are subject to the *Practice Guidance (Court of Protection: Serious Medical Treatment)* [2020] EWCOP2 issued by Hayden J in January 2020. It makes clear an application to court may well be required in situations where (emphasis added):

> "Further, in a case involving serious interference with the person's rights under the Convention for the Protection of Human Rights and Fundamental Freedoms or <u>where the proposed procedure or treatment was to be carried out using a degree of force to restrain the person concerned and the restraint might go beyond the</u>

parameters set out in sections 5 and 6 of the 2005 Act amounting to a deprivation of the person's liberty, the authority of the court would be required to make that deprivation of liberty lawful."

Capacity

47. MacDonald J set out the relevant capacity principles in the light of the Supreme Court decision in *A Local Authority v JB* [2021] UKSC52; [2022] AC 1322 in *North Bristol NHS Trust v R* [2023] EWCOP 5. Paragraphs 43 and 46 state:

> "The foregoing authorities now fall to be read in light of the judgment of the Supreme Court in *A Local Authority v JB* [2022] AC 1322. The Supreme Court held that in order to determine whether a person lacks capacity in relation to "a matter" for the purposes of s. 2(1) of the Mental Capacity Act 2005, the court must first identify the correct formulation of "the matter" in respect of which it is required to evaluate whether P is unable to make a decision. Once the correct formulation of "the matter" has been arrived at, it is then that the court moves to identify the "information relevant to the decision" under section 3(1) of the 2005 Act. That latter task falls, as recognised by Cobb J in *Re DD*, to be undertaken on the specific facts of the case. Once the information relevant to the decision has been identified, the question for the court is whether P is unable to make a decision in relation to the matter and, if so, whether that inability is because of an impairment of, or a disturbance, in the functioning of the mind or brain.
>
> …
>
> In *A Local Authority v JB* at [65], the Supreme Court described s.2(1) as the core determinative provision within the statutory scheme for the assessment of whether P lacks capacity. The remaining provisions of ss 2 and 3, including the specific decision making elements within the decision making process described by s.3(1), were characterised as statutory descriptions and explanations in support of the core provision in s.2(1), which requires any inability to make a decision in relation to the matter to be because of an impairment of, or a disturbance in the functioning of, the mind or brain. Within this context, the Supreme Court noted that s.2(1) constitutes the single

test for capacity, albeit that the test falls to be interpreted by applying the more detailed provisions around it in ss 2 and 3 of the Act. Again, once the matter has been formulated and the information relevant to the decision identified, the question for the court is whether P is unable to make a decision in relation to the matter and, if so, whether that inability is *because of* an impairment of, or a disturbance, in the functioning of the mind or brain."

48. HHJ Hilder helpfully observed in *S v (1) Birmingham Women's and Children's NHS Trust (2) Birmingham and Solihull Mental Health Trust* [2022] EWCOP 10 at paragraph 49 that:

> "The two clinicians [a psychiatrist and obstetrician] regarded their individual "discussions" with S as clearly distinct and separable parts of the process of assessment. Dr. Jancevic gave oral evidence first and told the Court unequivocally that she was assessing S's mental health and its impact on her decision-making process but the decision as to capacity lay with the obstetrician. Ms. Pretlove was subsequently equally unequivocal in confirming her view that the psychiatrists were best placed to assess capacity. The agreed order of events (discussion with obstetrician first, best interests meeting second, and discussions with psychiatrist last) lays bare a poorly constructed approach to assessment between the treating teams of clinicians. The suggestion that they should have done a joint assessment seemed to come as a surprise.

49. Ms Kohn also relies on the following written submissions:

i. The standard for assessing capacity must not be set too high; all that is necessary is for P to understand the salient factors relevant to a decision: not every nuance or detail *KK v STC and Others* [2012] EWHC 2136 (COP) [69];
ii. As per Hayden J in *LB Tower Hamlets v NB* [2019] EWCOP 27, the court must be cautious in considering what information is relevant to the decision in question – eg the question of the fertility-compromising effects of chemotherapy may have less relevance to a post-menopausal patient; "*It is not*

necessary to have every piece of the jigsaw to see the overall picture" (*London Borough of Tower Hamlets v. PB* [2020] EWCOP 34, para 13).

iii. A lack of capacity is not an off-switch for P's wishes and feelings - *Wye Valley NHS Trust v Mr B* [2015] EWCOP 60

Best Interests

50. These proceedings concern serious medical treatment. Best interests are determined by sections 1 and 4 of the 2005 Act and by following the dicta of Lady Hale DPSC (as she then was) in *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67; [2014] A.C. 591. At paragraphs 18 and 22 the role of the court and its proper focus pursuant to the 2005 Act is identified:

> "Its [the court's] role is to decide whether a particular treatment is in the best interests of a patient who is incapable of making the decision for himself.
>
> …
>
> Hence the focus is on whether it is in the patient's best interests to give the treatment, rather than on whether it is in his best interests to withhold or withdraw it. If the treatment is not in his best interests, the court will not be able to give its consent on his behalf and it will follow that it will be lawful to withhold or withdraw it. Indeed, it will follow that it will not be lawful to give it. It also follows that (provided of course that they have acted reasonably and without negligence) the clinical team will not be in breach of any duty towards the patient if they withhold or withdraw it."

51. At paragraph 39, Lady Hale encapsulated the best interests test and held:

> "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."

52. At paragraph 45, Lady Hale described the correct approach to the court's assessment of the patient's wishes and feelings, within the context of the statutory factors identified in section 4 of the 2005 Act:

> "Finally, insofar as Sir Alan Ward and Arden LJ were suggesting that the test of the patient's wishes and feelings was an objective one, what the reasonable patient would think, again I respectfully disagree. The purpose of the best interests test is to consider matters from the patient's point of view. That is not to say that his wishes must prevail, any more than those of a fully capable patient must prevail. We cannot always have what we want. Nor will it always be possible to ascertain what an incapable patient's wishes are. Even if it is possible to determine what his views were in the past, they might well have changed in the light of the stresses and strains of his current predicament. In this case, the highest it could be put was, as counsel had agreed, that "It was likely that Mr James would want treatment up to the point where it became hopeless". But insofar as it is possible to ascertain the patient's wishes and feelings, his beliefs and values or the things which were important to him, it is those which should be taken into account because they are a component in making the choice which is right for him as an individual human being."

53. Any decision of this court, as a public authority, must not violate any rights set out in Schedule 1 to the Human Rights Act 1998.The best interests test should accommodate an assessment of the patient's rights.

The Parties' Submissions

54. Mr Sachdeva submitted it was clear Ms KL lacked capacity and that the chemotherapy treatment was in her best interests. He accepted restraint should not be authorised for administration of oral medication but should be for intravenous chemotherapy. In further written submissions post-hearing he submitted that:

"You requested submissions on the issue whether the court had jurisdiction to authorise a deprivation of liberty in a patient in a physical hospital on s17 leave from s3 MHA detention.

[Ms KL] is not ineligible within Sch 1A MCA in that situation.

[He then quoted from the MCA Code of Practice at paragraph 4.51]

> "4.51 People on leave of absence from detention under the Mental Health Act 1983 or subject to supervised community treatment or conditional discharge are, however, eligible for the deprivation of liberty safeguards if they require treatment in hospital for a physical disorder.

The correctness of these passages was upheld by Mostyn J *in A NHS Trust v A* [2015] EWCOP 71"

55. Mrs KLS wants her sister to have the treatment.

56. Ms Kohn submitted in writing that the Official Solicitor was broadly supportive of the application. At the hearing she invited me to conclude that Ms KL lacked capacity to consent to the chemotherapy treatment and the ancillary restraint and deprivation of liberty and that such a course was in her best interests to keep her alive. In her post written submissions she dealt with the portacath and the issue of the deprivation of liberty. She submitted:

> "the Official Solicitor is satisfied that the presumption of capacity has been rebutted in this matter and that Ms [KL] lacks capacity to make decisions regarding her medical care and to conduct proceedings"

57. On insertion of the portacath whilst the Official Solicitor supported this in Ms KL best interests, she could not submit how it should be carried out in the absence of proper evidence and a care plan.

58. On the deprivation of liberty she submitted that Ms KL's chemotherapy treatment is medical treatment, not treatment for a mental disorder; it is not *not* in accordance with

the regime (s.3 MHA and s.17 MHA 1983) to which she remains subject; and she is not ineligible to be detained under the MCA.

59. In conclusion, the Official Solicitor submits:

> "The Official Solicitor is anxious that Ms [KL] is provided with effective, timely treatment in accordance with her medical needs and in her best interests. She wishes to assist the court in finding a legal mechanism by which this might be affected. She looks forward to clarity on the Trust's position and hopes to support the insertion of a portacath on receipt of the necessary additional information requested. She understands from conversations with Mrs [KLS] that a further PICC line was inserted on 20 December 2023 and that the plan is for a portacath to be inserted mid-cycle once court approval has been gained.
>
> As a side note, the Official Solicitor has some concerns as to the manner in which this application has been handled, particularly the dilatory manner in which it has been brought to court. Similarly, she is concerned as to the level of communication with Ms KL and her family, particularly her sister Mrs KLS who was unaware of her ability to attend proceedings remotely until advised of the same by the Official Solicitor. She hopes that these matters can be remedied going forward and the family, particularly Mrs KLS are properly involved in the case in accordance with s.4(7) MCA 2005."

Analysis

60. Given the agreement on the principal issues I can state my conclusions shortly.

Capacity

61. I am satisfied on the evidence of Dr C, Dr K, Dr D and the wider background that Ms KL is unable to make a decision to consent to treatment of her leukaemia and to conduct these proceedings. The burden of proof is on the applicant to the civil standard. They have discharged it. The written and oral evidence convincingly

demonstrates that Ms KL is unable to make a decision about her cancer. She is clear she wants to get better and she does not want to die, but she has no understanding of her leukaemia diagnosis, the treatment she needs and is robbed of the ability to weigh up this relevant information. Three doctors have given evidence that is the case, supported by the experienced chemotherapy nurse, Ms S. Mrs KLS agrees. There is no evidence before me that Ms KL can weigh up and understand the risks, pros and cons of her chemotherapy treatment. That inability is caused by her learning disability and/or EUPD. This is supported by the clinical evidence and has not been challenged. There are no practical steps to assist Ms KL to make a capacitious decision in the time available. I am satisfied she lacks the relevant decision making ability for the purposes of sections 2 and 3 MCA and will make a section 15 declaration to that effect. I am also persuaded, for similar reasons, that she lacks capacity to conduct these proceedings, as the Official Solicitor submits.

Best Interests

62. I apply section 4 MCA.

63. Ms KL wishes to live. She wishes to get better. She enjoys her family. She values her autonomy. Her wishes and feelings are clear and she has been able to communicate them to her treating haematology team: she wants to get better and she does not want to die. I place significant weight on her ascertainable and clear wishes.

64. I accept there are significant risks of the further three proposed cycles of chemotherapy treatment. I note the evidence that Ms KL tolerated the first cycle well. I accept the prognosis that she will return to her pre infection life with a 60-70 % prospect if treated. I accept she had very high white cell counts in early November 2023 and was close to death. I accept she is likely to die without treatment. I accept the 5 % risk from death from infection caused by the chemotherapy

65. Her treating team, her family and her litigation friend all support the administration of the further three cycles of chemotherapy. They do so notwithstanding that Ms KL will remain as an inpatient from 1 November 2023 until around the end of March 2024.

This will also require the deprivation of her liberty and some restraint to effect the intravenous chemotherapy.

66. I have very much in mind the arduous nature of the treatment; the prolonged period of inpatient admission; the necessity for X Group staff to be on the ward with a ratio of 4:1 staff and the need for restraint both for mental health reasons and to deliver the intravenous chemotherapy. These are very significant interferences in Ms KL's rights. They are however, entirely necessary and proportionate because without this background to the treatment, she could not be safely provided with the intravenous chemotherapy. She manifestly needs it. The haematology evidence is that her prognosis with the treatment is good. I am concerned the risk of infection is very high because of the ancillary damage done to cells because of the toxic nature of the chemotherapy and I am in full agreement with the clinicians that inpatient admission until March is necessary and very much in Ms KL's best interests to keep her safe from infection when she is weakened by the intravenous chemotherapy.

67. For these reasons the further three cycles of intravenous and oral chemotherapy are in Ms KL's best interests and I make a section 16 MCA order to that effect.

68. I am also persuaded, very late in the day, that the portacath is in Ms KL's best interests. I accept it reduces the trauma of multiple PICC lines and this outweighs the risks of the general anaesthetic.

Deprivation of Liberty And Restraint

69. In *An NHS Trust v A*_[2015] EWCOP 71 Mostyn J considered the applicability of Schedule 1A of the MCA and the issue of ineligibility in the context of a young man, detained under s.3 at a mental hospital, on leave (presumably s.17 although the judgment appears silent on this specific point) to an acute trust for the provision of medical treatment – in that case physical investigation for the organic causes of significant and sudden neurological degeneration. Having followed through the statutory framework he concluded at [13]:

> *"the question I have to ask myself is: is the authorised course of action, which is the course of action to be authorised by me, not in accordance with*

a requirement which the relevant Mental Health Act regime imposes? The answer is no, because the Mental Health Act regime does not touch the proposed medical procedures which are being proposed here. So the conclusion that I reach, having navigated my way through these provisions, is that A manifestly is not an ineligible person, or, to strip out the double negative, he is an eligible person for the procedures which I propose to authorise."

70. Mostyn J revisited this analysis in *A Hospital NHS Trust v CD (by her litigation friend the Official Solicitor), A Mental Health NHS Foundation Trust* [2015] EWCOP 74, where he held:

> *"42. The alternative interpretation, which I adopted in Re A , and which I maintain to be correct is this: if the MHA regime whereby CD is compulsorily detained in a mental hospital imposes a specific requirement for dealing with the problem of the ovarian masses then CD is ineligible to be deprived of her liberty under the 2005 Act for the purposes of dealing with the problem by a different procedure under that Act. It doesn't (obviously) so she isn't ineligible. As I said in Re A this is plainly what the scheme of section 16A and Schedule 1A intends and the matter is conclusively confirmed by paras 4.50 and 4.51 of the Code of Practice. In my judgment it would be ridiculous if the whole case had to leave the Court of Protection with its statutory powers and enter the High Court exercising common law inherent powers by virtue of a pedantically literal reading of para 3(2)."*

71. I will accept, under very limited time, the agreed submissions of the applicant and Official Solicitor that Ms KL is not ineligible to be deprived of her liberty as a patient in hospital for medical treatment albeit she is on section 17 MHA leave. I will authorise the deprivation of her liberty until the next hearing.

72. Very helpfully Ms Kohn has drawn my attention to the decision of Theis J in *Manchester University Hospital NHS Foundation Trust v JS* [2023] EWCOP 33 at paragraph 65. In reliance on this she submits:

> "On the basis that restraint provided outside the circumstances of the chemotherapy treatment remains treatment required to keep Ms [KL] safe and well in hospital for the *purpose* of receiving chemotherapy, it does not fall within paragraph 4 of Schedule 1A *"treatment for mental disorder in a hospital"* – and therefore does not render Ms [KL] ineligible for detention under the MCA."

73. I agree with this analysis. In as much as restraint is required for the direct or indirect purposes of giving Ms KL the chemotherapy she needs to be kept alive, it is authorised pursuant to the 2005 Act. In as much as the X Group staff are required to manage Ms KL at the hospital for the purposes of her mental health challenges, then that is a matter for the relevant 1983 Act authorities.

74. Restraint must be carried out in accordance with terms of section 6 of the 2005 Act and consistently with paragraphs 6.40 to 6.48 of the 2005 Act Code of Practice. The applicant must agree a care plan with the Official Solicitor in respect of restraint. It will be subject to the court's anxious scrutiny at the next hearing (see below).

Conclusion

75. I accede to the relief sought and declare that Ms KL lacks capacity to conduct the proceedings and to decide whether to consent to her chemotherapy treatment. I will order that the treatment proposed is in her best interests.

76. Given the multiple breaches of court orders I am concerned for Ms KL's welfare. The disregard for the orders and directions made by Theis J and the piecemeal nature of how the evidence has been given to Ms KL's litigation friend and family is not simply a procedural hiccup. It has obscured the court's focus on the welfare and safety of Ms KL. Therefore, it is necessary to list this matter for a review hearing in the first week of February, with a time estimate of half a day, to consider the deployment of restraint, and to ensure Ms KL's best interests in respect of cycles 3 and 4 are being properly managed. The parties will agree directions for this. If all matters are agreed then an agreed order can be placed before the court and the hearing vacated. It is

necessary to emphasise the importance of the applicant complying with those directions.

77. Should there be ancillary applications to name the applicant and/or X Group and or seek costs or for any other reason I will make directions to consider such applications.

78. I thank counsel for their considerable assistance and ask they agree an order for my approval today, 22 December 2023, so there can be no further unnecessary delay in Ms KL receiving the treatment she needs. I am particularly grateful to the Official Solicitor, her team and her counsel who have had to grapple with the consequences of the breach of directions by working long hours beyond the reasonable working day.