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IN THE COURT OF PROTECTION  
[2019] EWCOP 7



No. COP13380646

Royal Courts of Justice  
Strand  
London WC2A 2LL

Tuesday, 29 January 2019

Before:

MR JUSTICE FRANCIS  
(sitting as a Judge of the Court of Protection)

IN THE MATTER OF THE **MENTAL CAPACITY ACT 2005**  
AND IN THE MATTER OF **FG**

B E T W E E N :

KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST Applicant

- and -

FG  
(by his litigation friend, the Official Solicitor) First Respondent

- and -

SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST  
Second Respondent

**ANONYMISATION APPLIES**

MR R. HADDEN appeared on behalf of the Applicant and Second Respondent.

MS D. POWELL QC appeared on behalf of the First Respondent.

J U D G M E N T

*(Transcript prepared without the aid of documentation)*

MR JUSTICE FRANCIS:

1. By an application dated 25 January this year, but issued yesterday, that is 28 January, the King's College Hospital NHS Foundation Trust seeks an order in the following terms in relation to FG:
  - (a) a declaration that FG lacks capacity to make decisions regarding the medical treatment for his physical health conditions;
  - (b) that it is lawful and in FG's best interests for him to undergo an operation to repair his right shoulder fracture/dislocation; and
  - (c) that it is in his best interests to receive any sedation and anaesthesia his clinicians think necessary to allow the operation to be done.
2. The matter has come in front of me today as urgent applications judge.
3. The King's College NHS Foundation Trust has been represented by Mr Rhys Hadden. Very much at the last minute, because of the nature of the application, the Official Solicitor has stepped in to represent FG as his litigation friend, and the Official Solicitor has in due course instructed Ms Debra Powell QC. I am grateful to both counsel for the care that they have given this case, which has by all of us been prepared very much at the last minute.
4. The South London and Maudsley NHS Foundation Trust has been added as second respondent because that is the hospital which is responsible at the moment for FG in terms of his mental health, an issue to which I shall shortly turn. I say from the outset that the application is supported by the South London and Maudsley NHS Foundation Trust.
5. The application is not opposed by the Official Solicitor but the Official Solicitor has been very careful to point out to me, as is right, that he is not in a position formally to agree to the application. However, it is common ground – and turning to my note of what was submitted to me on behalf of the Official Solicitor by Ms Powell – the Official Solicitor accepts that the evidence as to capacity displaces the presumption in relation to this single decision. I will come back to that in a moment.
6. FG has been an inpatient at what we refer to as “the Ward” since 26 September 2017, following his transfer from another hospital. FG is 37 and he has a longstanding diagnosis of treatment-resistant paranoid schizophrenia, characterised by paranoia and persecutory delusions.
7. The matter comes before the court today because on or about 12 January 2019 FG complained of pain to his shoulder. Examinations and x-rays a couple of days later, at the Princess Royal University Hospital, revealed that FG was suffering from a dislocated and fractured right shoulder that, in the opinion of the medical team, requires manipulation and/or surgery under general anaesthetic. That is, in surgical terms, a relatively straightforward procedure and it is relatively well accepted that people with that condition need that treatment. However, FG has consistently declined to have surgery under general anaesthetic for his right shoulder. I pause there to note that he is right-handed. It is also relevant that he is somebody who enjoys engaging in physical activities, such as chopping wood and fishing, something which necessarily requires the ability to use his arms.

8. Following a number of capacity assessments, the professional view is that FG lacks capacity to make this decision under the Mental Capacity Act 2005. It is clear, and accepted common ground, that the first decision I have to make is whether FG has capacity to make a decision as to whether he should have the treatment in respect of his right shoulder to which I have just referred. As I have said, it is the common ground of the two NHS Foundation Trusts that he lacks the capacity to make this decision and I have indicated that the Official Solicitor has accepted that the evidence as to capacity displaces the presumption. Nevertheless, it is necessary for me, as the judge, first of all, to deal with the issue of capacity. In view of the common ground of all three parties to this case, I think I can deal with that issue reasonably quickly.
9. FG has had a number of periods of admission to hospital for compulsory treatment. They date back as long ago as 2002, again in 2005, in 2011 and in 2013. It was in January 2015 that his current and longest admission to hospital commenced. So it was that in January 2015 he was admitted as an inpatient at another hospital and then, as I have said, in September 2017 transferred to the Ward.
10. In order to assess the issue of capacity I have the report of Dr Julia Hurn, dated 15 January 2019. She is a consultant psychiatrist. She is the responsible clinician and the treating consultant for FG's mental health. I have a second assessment of hers dated 22 January 2019. I also heard her oral evidence in court today when she was asked questions both by Mr Hadden and by Ms Powell.
11. Dr Hurn, whose experience is set out in her report, is satisfied that FG lacks capacity to make a decision about treatment for his dislocated and fractured shoulder owing to an impairment of the functioning of his mind due to paranoid schizophrenia. She told me that he was able to communicate his decision, namely that he wished not to have any surgical or manipulative treatment under general anaesthetic. Thus it is that I have somebody who has indicated his own wishes and feelings, which are that he does not have this surgery, and I am being asked to decide that he lacks the capacity, in spite of those expressions of wishes and feelings.
12. The history of this case shows that FG has had a long history of paranoid delusions, including a belief that a number of people in authority (including MI5) are conspiring against him. The Official Solicitor's representative, Mr Edwards, was able to see FG this morning at ten o'clock and I have a comprehensive note of that meeting. Given that this case started by about noon, I am very grateful indeed to Mr Edwards for the speed and efficiency with which he was able to conduct that interview. It is neither necessary nor appropriate for me in this short *ex tempore* judgment to set out the detail of that note. However, it is apparent that one of the issues that has been relevant to FG is whether he can withstand a general anaesthetic. He is taking the well-known drug called Clozapine, which is a drug which is administered to people suffering from the mental difficulties with which FG is afflicted. FG has been concerned about whether that will clash with the effect of an anaesthetic and the evidence clearly before me is that it will not. FG has said that he will not be able to stand up to the anaesthetic. He says that it is something that his uncle is organising, who "works at the top for MI5". FG said he is not too sure of the details but that he does not think he needs such a harsh treatment. He said he does not want the surgery, that his word is final and that he cannot believe that the Hospital Trust would go to the effort and expense of involving the court or that the court will make an order in the terms that are sought. FG has also said that his pulse is too weak for an anaesthetic and that his heart is too weak for an anaesthetic. There is no evidence before me to support either of those two latter propositions.

13. In the light of the long history of mental difficulties, it is obvious that FG has suffered for some years from various paranoid delusions. I also have a capacity test which was carried out by Mr Al-Shoaibi, who is the orthopaedic registrar at the King's College Hospital NHS Foundation Trust. Mr Al-Shoaibi has reported that FG has been provided with information around his diagnosis and treatment options by several different medical officers. He refers again to the diagnosis of paranoid schizophrenia. He has delusions, he says, about MI5 and about his body. He says that FG has been concerned that his injury was a result of an outside force. He said, and I accept, that his paranoia is directly impacting on his capacity to make a decision around his treatment because he is very fearful of anaesthetic and the surgeon's knife. Mr Al-Shoaibi has reported that FG understands only some of the information discussed with him about his injury and the proposed treatment. FG has apparently reported that his shoulder is "not my problem". On prompting, however, he has acknowledged that his arm is sore at the moment and it is obvious, as I will mention later, that the arm is, in effect, unusable at the present time.
14. In the light of the two assessments that I have referred to from Dr Hurn and the capacity test that I have just referred to from Mr Al-Shoaibi, and based on the submissions by Mr Hadden, supported by Ms Powell, I am completely satisfied that FG lacks the capacity to make this decision in respect of this treatment. I have been urged by Ms Powell, and I agree that she is correct, to make it clear that I am dealing only with this single decision. This is not a lack of capacity decision that goes beyond that.
15. Having found that FG lacks capacity to make this decision, I have to apply the very well-known test to see whether I, as the judge, feel that it is in his best interests for the surgery to take place. There is a carefully set out care plan. What I am being asked to do is to say that it is lawful and in FG's best interests for him (a) to be administered sedation, covertly and/or using physical restraint with the minimum necessary physical force at the Ward; (b) to be conveyed to the Princess Royal Hospital; (c) to undergo an operation under general anaesthetic to manipulate his right proximal humerus fracture and dislocation and/or proceed to an open reduction and internal fixation if necessary, that fixation being with plates and screws; (d) to receive pre- and post-operative medical care at the Princess Royal Hospital associated with the above treatment; (e) to receive appropriate aftercare at that hospital until fit to be discharged, and (f) to be transferred back to the Ward, provided that all such steps are taken in accordance with the care plan.
16. The law in relation to the best interests test is well-known certainly to all of the lawyers in this case. As I would have expected, it has been set out by Mr Hadden in his position statement. In paragraphs 38 and 39 of that he properly refers the court to the very well-known leading judgment in *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67. I canvassed with counsel that I was not proposing, unless they wanted me to, in an *ex tempore* judgment in an urgent case, with other cases still waiting outside court to be heard, to set out the details of the law where it is so well-known to us, but I make clear that I am familiar with that case and I have re-read the relevant passages of it and I am aware that the focus is on whether it is in the patient's best interests to have the treatment rather than on whether it is in his best interests to withhold or withdraw it.
17. What then is the evidence in relation to the need for the treatment and how do I carry out the necessary balancing exercise? There is no doubt about the medical diagnosis, which is already set out by me above. The range of possible treatments for FG and their attendant risks and benefits are set out in a statement of Mr Abhinav Gulihar who is employed as a consultant orthopaedic surgeon by the King's College NHS Foundation Trust. I have his statement, dated 24 January. He was not able to attend court today for professional reasons but I did

hear evidence instead from Mr Osman Khan, his locum orthopaedic consultant. Mr Khan is the admitting consultant. He said that he and Mr Gulihar, as he put it, “more or less made the statement together” following a discussion. Therefore, I am satisfied that Mr Khan was able to answer all of the questions that might otherwise have been put by counsel to Mr Gulihar.

18. The range of possible options for FG are as follows: (a) do nothing, (b) manipulation under general anaesthetic where no incision is required and (c) the surgery to which I have referred above. What is the effect of doing nothing? I have already referred to the fact that FG is right-handed. FG has effectively conceded that his right arm is at the moment unusable. It is clear, from what I have heard, that one of the things that FG would like to be working towards in terms of future treatment for his mental health difficulties is to attend a therapeutic rural community project. That is a project where there is a home but where there is an attempt to rehabilitate people and there are a number of activities and, as I have set out already, FG particularly enjoys activities such as chopping wood and fishing. I should have thought, and based on what I have read I am satisfied, that those are things which would be highly beneficial to his wellbeing and his prospects of recovering from, or at least improving from, the difficulties which have afflicted him now for so long.
19. It is evident from all that I have heard and, frankly, common sense, that if nothing is done in respect of his arm he will not engage in those activities. I am completely satisfied that to do nothing would not be in his best interests and that something has to be done. Doing nothing will leave him with effectively a useless arm, will presumably leave him in pain and it is evident that doing something – that is one of the options (b) or (c) to which I have already referred from paragraph 21 of Mr Hadden’s note – will be likely to cure or considerably improve the condition, although it is accepted that there would still be some loss of function even if manipulation goes well.
20. It cannot be known whether manipulation or further surgery will be needed until the process is carried out. The hope would be, as described by Mr Khan, that manipulation would enable the surgeon, with the assistance of others, to manipulate the joint back into place. Only x-rays at the time will be able to tell whether that has successfully taken place and it is at least possible, if not likely, that surgery will be needed to reduce the dislocation. Surgery would, as I have said, involve the internal fixation of the fracture with plates and screws and is classed as an open reduction. It would involve making an incision at the front of the shoulder, reducing the shoulder back in joint and, if necessary, fixing the fracture together with plates and screws. Plainly manipulation is less invasive than the surgery but, equally plainly, both of them have to be carried out under general anaesthetic.
21. As I have indicated, FG does not want this operation to take place but I have already said that he lacks capacity to make that decision. Insofar as it has been possible to obtain the views of any family members, his older brother and mother have apparently been able to accept that surgery might be in his best interests. The brother R and his mother have both communicated to the hospital that it would be in FG’s interests to have the surgery under general anaesthetic. The unanimous view of the health and social care professionals is that it would be in his best interests to have the proposed treatment.
22. There are some difficulties. The first difficulty is sedation. The application by King’s College Hospital NHS Foundation Trust supported, as I have said, by South London and Maudsley NHS Foundation Trust, is that there is permission from me for professionals to administer sedation covertly, in the event that FG continues to resist being transferred from the Ward to the Princess Royal Hospital. This issue has troubled me somewhat because it is a considerable invasion of one’s liberty. It also, it seems to me, involves what I referred to in discussion as

“trickery” because what would happen would be that the medication to sedate FG would be mixed with a drink in the hope that he would swallow it without noticing, and be naturally and easily sedated. Conversely, he could be offered sedation and might refuse it and, on the basis of what I have read and been told, he probably would refuse it.

23. Then there is the question of whether he would be given chemical sedation under restraint. Restraining him not only would have, it seems to me, potential mental health risks, in that it would be a very, very unpleasant experience for him, but restraining him would probably involve restraining him by his shoulders because, after all, if he is jumping up and down or trying to get away from the bed where he is going to be injected with this chemical sedation, it is very likely that there would be injury to his shoulder, the very shoulder which is already dislocated and fractured.
24. I accept that there can be exceptional circumstances in which the administration of covert medication is better than forced chemical injection under restraint. There would be very few circumstances in which it will be appropriate to administer covert medication in this kind of way and each case will have to be decided on its own facts. I do not imagine there are any rules or specific guidance that one could set out. A judge would have to decide it on a case by case basis. But having regard to the mental health and physical health matters to which I have just referred, I am satisfied that if the surgery is to take place there should be permission to the treating team to administer covert medication in this way to sedate him.
25. One of the difficulties of having the surgery, apart from the question of sedation, is the possibility that FG does not comply with the post-operative regime. Following surgery, his arm would be placed in a sling which he would be required to wear at all times for the first two to three weeks and for a total of six weeks. Overall healing of the fracture would take around three months and overall recovery of the injury would take about twelve months. I note from Mr Gulihar's statement, with which Mr Khan agrees, that FG could expect recovery of good function but it is unlikely that he will have completely normal function of the shoulder. Mr Gulihar's statement also states that with that surgery and recovery, he would be able to do activities of daily living as well as activities that involve manual work and heavy lifting. Mr Khan also agreed with this in oral evidence.
26. I have been very troubled though about the possibility that FG decides not to cooperate post-operatively and there is even the risk, as we have heard today from Mr Khan, that failing to cooperate could result in the wound being opened and even in the plate and the screws becoming loose. When carrying out the best interests balancing exercise, I have this very much in mind. But having decided, as I have set out above, that something has to be done, the risk, it seems to me, of FG not cooperating post-operatively is one that has to be taken in his best interests. Just because FG does not consent to the surgery does not mean necessarily that he will not consent to the post-operative procedures. Once he realises that the operation has taken place, it has to be hoped – and there is some evidence for this because of the way he has reacted in other situations to procedures that he has not wanted – that he will cooperate with the post-operative regime to which I have referred.
27. Doing nothing leaves him with effectively an unusable arm and pain and standing back, as I must, and applying the best interests tests, I am satisfied that, subject to the carefully managed care plan, it is in his best interests to have the proposed procedure. I have been shown a care plan, which is to be found at E7-17. The basis on which the Official Solicitor has said that he does not oppose but cannot agree to the proposed treatment is on the basis of that care plan and it is approved by me. The care plan recognises that the proposed procedure may involve distress to FG as he may object to complying with a transfer from the Princess Royal Hospital

or back to it or with any treatment to his shoulder following admission, and I have dealt with the question of sedation.

28. Therefore, I do make the declarations both as to capacity and as to treatment that are sought in the draft order. It is common ground that paragraph 4 of that draft order should be deleted. I do accept, and it is accepted also by the Official Solicitor on behalf of FG, that the proposed procedure will amount to a deprivation of his liberty and I authorise that deprivation of his liberty to the extent that is necessary and on the basis that any measure used to facilitate or provide the arrangements shall be the minimum necessary and that all reasonable and proportionate steps are taken to minimise distress to FG and to maintain his dignity. I approve the nursing care plan that has been set out and referred to.

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