



Neutral Citation Number: [2024] EWCOP 150

Case No: COP 1418847T

COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 05.02.2024

Before :

Miss Nageena Khalique KC sitting as a Deputy High Court Judge and a nominated Judge of the Court of Protection

Between :

**X NHS Foundation Trust
- and -
RH**

Applicant

Respondent

Mr Vikram Sachdeva KC (instructed by Kennedys) for the Applicant
Mr James Berry (instructed by the Official Solicitor, as litigation friend) for the Respondent

Hearing dates: 20, 22 December 2023

Approved Judgment

This judgment was handed down remotely at 10.30am on 05.02.2024 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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<p>This judgment was delivered in public and may be published. A transparency order has been made.</p>

Miss Nageena Khalique KC sitting as a deputy High Court Judge:

Introduction

1. This case concerns a 40-year-old man whom I shall refer to as ‘RH’ who is currently detained under section 3 of the Mental Health Act 1983 (“the MHA”) in a psychiatric Hospital (‘P Hospital’). RH suffers from an enduring mental illness, namely hebephrenic schizophrenia, which is characterised by disorganised behaviour and speech, mood incongruence, hallucinations and delusions. RH has also been diagnosed with severe bilateral hydronephrosis, chronic urinary retention and declining kidney function for which he now requires surgical intervention.
2. The applicant Trust brings this application for declarations and orders, pursuant to sections 4A, 15 and 16 of the Mental Capacity Act 2005 (“the MCA”), that RH lacks capacity to:
 - i. make decisions about his inpatient admission;
 - ii. decide whether to having urological surgery;
 - iii. litigate these proceedings;and further, that it is lawful and in RH’s best interests to be admitted to an acute hospital (‘W Hospital’)
 - iv. to undergo the proposed urological surgery under general anaesthesia (‘GA’);
 - v. to receive related care and treatment; and
 - vi. for physical and chemical restraint to be used to facilitate the treatment, manage his behaviour and prevent him leaving W Hospital until he is medically fit for discharge; and
 - vii. to the extent that RH is deprived of his liberty within the meaning of Article 5 of the European Convention on Human Rights (‘ECHR’) authorisation of the restraint plan in order to carry out the Care Plan.
3. By an order dated 18 December 2023, the Official Solicitor, having accepted the invitation to act, was appointed as RH’s litigation friend. Although not a party, RH’s mother (‘Mrs H’), with whom he has a good relationship, has been actively involved in the discussions around both RH’s mental and physical health.
4. I was told that Mrs H was likely to be working on the day of the hearing but had spoken to the Official Solicitor sharing her views on the proposed treatment, indicating that she did not wish to be joined as a party and had nothing further to add, although she would attend if the court wished her to do so. Mrs H was also sent a link to join the hearing remotely but did not attend. Given her clearly expressed views via the Official Solicitor, which supported the Trust’s application, it was not necessary for her to do so, and no party required her attendance.

Procedural history

5. Before dealing with the substantive issues, it is important to reflect on the procedural history in this case which regrettably has been somewhat haphazard and unsatisfactory. The COP1 (dated 8 December 2023), COP3, three witness statements and an inchoate draft Care Plan were filed after-hours on Thursday, 14 December 2023 as an urgent application with an email requesting a hearing date within 2-5 days and a time estimate of half a day. The email highlighted in bold that “*The Trust is seeking an urgent hearing in light of the circumstances of this case. Urgent treatment is required due to the risk of death as RH is unlikely to be a suitable candidate for dialysis given his mental state*” and further that it was “*for urgent consideration and listing as a matter of urgency*” [my emphasis].
6. The case was considered on the papers the following day and transferred to the Royal Courts of Justice for urgent consideration by a Tier 3 Judge. On 18 December 2023, Mrs Justice Theis made a Transparency Order (which prevents naming of the parties and individuals), a Third Party Disclosure Order and a Case Management Order directing the Trust to file and serve factual evidence by 11am on 19 December, including a detailed Care Plan and an explanation as to why the application dated 8 December had not been filed sooner. The timetable was tight because of the urgency asserted by the Trust, and a hearing was listed on 20 December 2023.
7. Meanwhile, the Official Solicitor diligently carried out her investigations which included sending out an agent to visit RH to ascertain his wishes and feelings and making contact with RH’s mother. An attendance note was duly filed on 19 December 2023. A statement dated 19 December 2023 from the Trust’s solicitor stated that the delay in issuing and filing the application was due to the need for input from and liaison between the psychiatric and medical teams in order to finalise the Care Plan which was approved by them on 14 December 2023 (as it transpires this was not the final approved Care Plan which was not forthcoming until 22 December 2023 and which was subsequently revised and filed as an agreed Care Plan on 3 January 2024).
8. Unfortunately, the Trust did not comply with the directions to file and serve further evidence or its position statement by 1pm on 19 December 2023. In the early hours of 20 December 2023, I received a position statement from leading counsel Mr Vikram Sachdeva KC, representing the Trust, which was closely followed by two further statements from Mr S, RH’s treating Consultant Urological Surgeon, and Dr L, Consultant Forensic Psychiatrist and RH’s Responsible Clinician.
9. Shortly before the hearing, I received the Official Solicitor’s position statement which had been prepared by counsel, Mr James Berry, in which he stated that due to the Trust’s position statement having been served so late, there had been limited opportunity to consider it, and furthermore the medical records appeared incomplete with significant gaps in the medical history. There was also a further statement from Dr A, Consultant Anaesthetist, which was outstanding from the Trust.
10. On 20 December 2023, the Trust requested further time to file a final Care Plan. I delayed the start of the hearing to allow Dr A’s statement to be filed along with what I had hoped would be a final Care Plan, to enable both the Official Solicitor and the court to consider all the material before any oral evidence was heard. A flurry of emails ensued with various versions of a Care Plan and Dr A’s second statement.

11. At the start of the delayed hearing, Mr Sachdeva KC apologised for the manner in which the application had been brought, the delay in filing the evidence and for what still appeared to be an inchoate Care Plan. At this point, and with the agreement of the parties, I proceeded to hear oral evidence from Dr L and Mr S, who were attending remotely and had been waiting patiently on the video platform, with the reassurance that a final Care Plan would be served imminently and before Dr A (who would speak to the Care Plan) gave oral evidence.
12. Mr Sachdeva then sought permission to call a new witness, Ms C (who was a registered mental health nurse with experience of caring for RH) to speak to the anticipated Care Plan (which had still not been finalised or filed). This announcement came as a surprise to the Official Solicitor and the court, particularly as no witness statement from Ms C had been filed. With some reluctance and given what I perceived to be the urgency of the matter, I granted permission to call this witness on the basis that she was said to have had input into the Care Plan particularly around the use of physical and chemical restraint at P Hospital and in the transfer of RH to W Hospital.
13. I shall deal with Ms C's evidence in more detail below, but it became immediately apparent that Ms C was not entirely familiar with the version of the Care Plan that was before the court, nor had she seen some of the statements from other witnesses which were relevant to it. At this stage, I decided to adjourn the proceedings. As I have already said, the manner in which the case was presented was haphazard, if not chaotic. Whilst I accept Mr Sachdeva's gracious and well-meaning apologies, the delay in finalising the Care Plan and producing a witness at the 11th hour resulted in me having to adjourn the hearing, direct that a complete and final Care Plan be filed and re-list the matter with the attendance of Ms C and Dr A, for a further half day to conclude the evidence.
14. Having made arrangements to hear this matter within two days, I was then informed by Mr Sachdeva that the matter was in fact not 'urgent', no date for the procedure had been fixed, and the application had been made to avoid waiting until 'it was an emergency'. This was difficult to reconcile with the fact that the application had been clearly marked as urgent and a hearing date within 2-5 days was requested where it was said that there was a 'risk of death' if the surgery was not performed urgently.

Background

15. RH has had numerous in-patient admissions for psychiatric care and treatment since 2000. Recently, his quality of life has improved due to a change in medication enabling him to enjoy regular section 17 MHA leave to spend time overnight and at social events at his mother's home. His paranoid delusions are said to persist, but his overall presentation has improved with the possibility of a community discharge in the future.
16. RH's recent physical problems relate to declining kidney function which was picked up on blood tests noted by his GP, who made an urgent referral on 21 July 2022 for an assessment at W Hospital. The GP noted that RH had previously been under the urology team, but it had not been possible to undertake a cystoscopy due to his non compliance due to his mental health. RH missed two appointments for repeat ultrasound scans but did attend on 11 July 2022. That ultrasound scan showed severe

bilateral hydronephrosis and significant post-void residual volume consistent with chronic urinary retention.

17. RH was subsequently seen at W Hospital by Dr K in September 2022. He did not engage but his mother was present and was told that it was possible that there was an obstruction to the flow of urine through RH's urinary tract and that his bladder was unable to empty which was putting pressure on his kidneys. If RH's bladder was not decompressed or unobstructed then his kidney function would gradually decline over time and this could ultimately result in kidney failure leading to death. It was said that RH was unlikely to be a suitable candidate for dialysis given his mental health.
18. RH was placed on the waiting list for a cystoscopy and insertion of an in-dwelling supra-pubic catheter under GA. This is not the surgery that is now proposed by the Trust, but it was scheduled to take place on 24 January 2023. It did not go ahead and there then seems to have been a very long gap (some 9 ½ months) before RH's case was discussed again on 13 November 2023 at a multidisciplinary team ('MDT') meeting. In attendance were the surgical, psychiatric and anaesthetic consultants, Mr S, Dr L, and Dr A respectively. The outcome of the MDT meeting was that RH should be admitted as a day case on 5 December 2023 to W Hospital for urological surgery, specifically a cystoscopy +/- bladder neck incision and urethral dilatation +/- insertion of a long-term in-dwelling catheter. The minutes of that meeting record that all in attendance were in agreement and that an application to court was not necessary.
19. However, on 21 November 2023, Mr S wrote to Dr L explaining that he had spoken to RH's mother (after the MDT meeting) who was concerned about RH pulling out the catheter if this was a long-term plan. Mr S stated that he now felt the risks associated with RH pulling out a catheter were too great, even if it meant RH's life expectancy was likely to be reduced due to a decline in his kidney function without catheterisation.

The proposed treatment

20. On 8 December 2023 the Trust drafted the application filed at court on 14 December 2023 at 20.46 hours in which the plan no longer included the insertion of an in-dwelling catheter. The procedure now proposed includes the insertion of a telescopic camera to examine the bladder under GA and X-ray examination of the kidneys with contrast. If RH is found to have a bladder neck stricture or a urethral stricture, this will be treated by way of a minimally invasive procedure (an incision). There may need to be a catheter inserted but this would be for about 24 hours and sedation would be administered if necessary to prevent RH from forcibly removing it. If there is no clear and treatable cause for the urinary retention, the MDT will discuss the findings and reconsider what options for treatment can be offered and what is in RH's best interests.

The issues

21. The issues before the court are:
 - i. First, whether RH lacks capacity to conduct these proceedings and make decisions about his inpatient admission and the treatment of his urological and kidney condition including his post operative care;

- ii. Second, whether it is in RH's best interests to undergo the proposed treatment *per* the Care Plan;
- iii. Third, whether it is in his best interests to authorise the use of physical and chemical restraint and the deprivation of RH's liberty *per* the Care Plan.

The legal framework

Capacity

22. Capacity falls to be assessed in accordance with the well-established principles and requirements set out in sections 1-3 of the MCA.
23. The Supreme Court in *A Local Authority v JB* [2021] UKSC52; [2022] AC 1322 held at paragraph [65] 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.
24. For a person to be found to lack capacity there must be a causal connection between being unable to make a decision by reason of one or more of the functional elements set out in section 3(1) of the Act and the 'impairment of, or a disturbance in the functioning of, the mind or brain' required by section 2(1) of the Act: *York City Council v C* [2014] 2 WLR 1 at [58- 59] McFarlane LJ and *JB supra* at [65]:

"*...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.*"
25. In *PCT v P, AH and The Local Authority* [2009] COPLR Con Vol 956 at [35], Hedley J described the ability to use and weigh information as '*the capacity actually to engage in the decision-making process itself and to be able to see the various parts of the argument and to relate one to another*'.
26. Within the context of section 3(1)(c) MCA, it is not necessary for a person to use and weigh every detail of the respective options available to them in order to demonstrate capacity, merely the salient factors *CC v KK and STCC* [2012] EWHC 2136 (COP) at [69] and *per* Hayden J in *LB Tower Hamlets v NB* [2019] EWCOP 27 at paragraph 13: "*It is not necessary to have every piece of the jigsaw to see the overall picture*".

Best interests

27. Best interests fall to be assessed in accordance with s.1(5) and s.4 of the MCA. When determining what is in a person's best interests, consideration must be given to all relevant circumstances, to the person's past and present wishes and feelings, to the beliefs and values that would be likely to influence their decision if they had capacity, and to the other factors that they would be likely to consider if they were able to do so: section 4(6) MCA.

28. 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.

29. In *M v N (by her litigation friend, the OS), Bury Clinical Commissioning Group* [2015] EWCOP 9, per Hayden J at [28] and [30]:

‘...where the wishes, views and feelings of P can be ascertained with reasonable confidence, they are always to be afforded great respect. That said, they will rarely, if ever, be determinative of P’s ‘best interests’. Respecting individual autonomy does not always require P’s wishes to be afforded predominant weight. Sometimes it will be right to do so, sometimes it will not. The factors that fall to be considered in this intensely complex process are infinitely variable e.g. the nature of the contemplated treatment, how intrusive such treatment might be and crucially what the outcome of that treatment maybe for the individual patient. Into that complex matrix the appropriate weight to be given to P’s wishes will vary. What must be stressed is the obligation imposed by statute to inquire into these matters and for the decision maker fully to consider them.’

30. In *Barnsley Hospital NHS Foundation Trust v MSP* [2020] EWCOP 26, Hayden J considered whether it was in P’s best interests to continue to receive life sustaining treatment against his strongly held wishes. At [47] Hayden J held that:

‘In a real sense this is not a case about choosing to die, it is about an adult's capacity to shape and control the end of his life. This is an important facet of personal autonomy which requires to be guarded every bit as jealously for the incapacitous as for the capacitous’.

31. In *Aintree University Hospitals NHS Trust v James* [2013] UKSC 67; [2014] 591 the Supreme Court had considered the first case to come before it under the MCA. Baroness Hale, giving the judgment of the court, stated at [39] that:

“.... in considering the 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; 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 towards the treatment is or would be likely to be; and they must consult others who are looking after him or are interested in his welfare, in particular for their view of what his attitude would be.’

32. The focus is on whether it is in the patient’s best interests to give the treatment: *Aintree supra* at [22]. In considering the outcome of the proposed treatment, particularly in the case of a patient with permanent disabilities, the focus should be on “resuming a quality of life which the patient would regard as worthwhile” at [44].

33. Account must be taken of the views of anyone engaged in caring for the person or interested in their welfare: section 4(7) MCA.

The evidence

Dr L, consultant forensic psychiatrist

34. Dr L is RH's responsible clinician and treating consultant. He completed the COP3 form and has provided two written statements. In addition, Dr L attended the hearing remotely and gave oral evidence. He described how multiple attempts had been made by staff to discuss RH's urinary problems, declining kidney function and the proposed procedure with RH and his mother including why it was necessary to have the operation, and the risks of not having it.
35. Dr L stated that RH denies having any problems with his kidneys, has a persistent delusional belief that doctors want to 'take his kidneys', that there is nothing wrong with his kidney function and he does not need an operation. He is resolute in this view and will become aggressive, rude and/or refuse to engage in further discussion.
36. Dr L's view is that RH lacks capacity because he has an impairment of, or disturbance in the functioning of, the mind or brain, namely hebephrenic schizophrenia which causes fragmented thoughts and paranoid delusions rendering RH unable to conduct these proceedings or make decisions about the proposed treatment at W Hospital. Dr L states that RH's belief that the operation is to remove both kidneys and that the team at W Hospital are trying to kill him is a paranoid delusion.
37. Dr L stated that RH cannot understand the relevant information for the decision about treatment that needs to be made because he refuses to engage in any detailed discussion and dismisses attempts to provide him with information. Further, RH refuses to accept that without the operation there is a significant risk of renal failure and death, which Dr L says shows he cannot use and weigh the relevant information for the decision, but instead repeats his delusional thought that the operation is designed to harm or kill him.
38. Dr L described how physical restraint would be administered by trained mental health staff from P Hospital who would prepare RH prior to his admission to W Hospital and remain with him during his post operative recovery. He confirmed that RH will be managed in accordance with the NICE guideline '*Violence and Aggression: short term management in mental health, health and community settings* (28 May 2015)'. In addition, he stated that verbal de-escalation and 'incentives' will be offered initially to calm and distract RH but if required oral medication (PRN lorazepam) could be administered to assist with any agitation or distress.
39. In his statement, Dr L refers to the use of restraint if there is a deterioration of RH's mental state including the use of intramuscular medication (PRN benzodiazepine lorazepam or promethazine) which is permissible under s63 of the MHA. RH will also be given post-operative pain relief.

40. In terms of impact on RH of undergoing treatment against his will, Dr L felt that RH might be resistive but overall was unlikely to suffer any long-term harm to his mental health. RH had suffered a traumatic experience at W Hospital some years ago having been admitted there for a procedure; he was kept waiting for many hours which resulted in him becoming distressed, aggressive and non compliant. Dr L stated that RH's schizophrenia was treatment resistant then, making it difficult for him to cope, whereas now his mental health has significantly improved due to a new medication regime and as such, he is likely to cope better.
41. Although Dr L felt that there was a 50/50 chance that RH may become resistive and refuse to co-operate, his mental condition has been optimised and coupled with the plan to place RH first on the operating list to prevent any delay, there was a reasonably good chance of RH being successfully managed on this occasion. Dr L and the psychiatric team agree with the Trust's plan and that the treatment is in RH's best interests.

Mr S, consultant urological surgeon

42. Mr S provided the court with two statements and gave oral evidence remotely. There was some confusion as to the options. On behalf of the Official Solicitor, Mr Berry sought clarification from Mr S as to what was now being proposed.
43. In his first statement, Dr S stated that if RH was not found to have any obstruction of his urinary tract then it may be that RH's bladder is damaged such that it is incapable of emptying fully. The usual treatment for this condition would be the insertion of a long-term catheter into the bladder to take the pressure off the kidneys to prevent further deterioration in kidney function. Dr S had said that he did not consider it to be in RH's best interests because it was unlikely RH would cope with a long-term indwelling catheter. There would be a high risk of RH pulling and attempting to remove the catheter leading to serious injury of the urinary tract resulting in bleeding, infection/sepsis and need for further surgery and further catheterisation.
44. Also in his first statement, Dr S stated that the risks of not having any treatment were that "*...the function of the kidney would decline and could result in renal failure over time and accept that this could be terminal. Based on the slow decline that has already occurred I do not envisage this happening rapidly.*" He suggested this decline could take between 3 – 5 years and so RH's life expectancy would be significantly reduced, although such patients can present acutely as an emergency with a severe urine infection resulting in profound systemic infection and worsening renal failure, with a high chance of mortality. It was not clear from Mr S's first statement why long-term catheterisation would not be a better alternative to a significantly reduced life expectancy.
45. In his second statement filed shortly before the hearing, and in oral evidence, Mr S set out a revised position: to perform exploratory surgery under GA, identify whether there was a stricture, and if so, make a small incision at that point to release the blockage.
46. The risks associated with the proposed procedure include urinary frequency, urgency of urination, blood in the urine and pain on passing urine which can be managed with pain killers. There is a <5 % risk of infection and bleeding, <1% risk of

thromboembolism, 70% risk of retrograde ejaculation and subsequent inability to conceive through sexual intercourse. Longer term risks include the need to pass larger amounts of urine so RH will have to increase his oral intake of fluids to prevent dehydration. A temporary catheter may be needed for 24 hours but this will be avoided if possible due to the possibility of RH pulling out the catheter which could lead to further complications and injury. Mr S said this treatment, even with these risks, would be in RH's best interests since it would prevent kidney failure and reduced life expectancy.

47. If no obstruction is found, the MDT team will reconvene and review the findings and consider 'other less common causes' for urinary obstruction and what treatments are available, other than 'no treatment' or long-term catheterisation.
48. Mr S and Dr L both stated that antipsychotic medication may cause weakness in the wall of the bladder which prevents emptying. The MDT will therefore discuss what alternative medication can be used to reduce the adverse effects on the bladder in the event that a stricture is not found to be the cause of RH's urinary retention.

Dr A, consultant anaesthetist

49. Dr A prepared two witness statements, the second being filed during the hearing. Dr A stated that RH is likely to experience agitation after surgery for which will be prescribed minimal quantities of sedative medication, but sufficient to reduce his distress.
50. Dr A said that the psychiatric team from P Hospital with whom RH is familiar will attend with RH and administer any physical restraint if required or medication to manage his agitation and mental state. The anaesthetic team at W Hospital will be responsible for any sedation and pain relief that is required immediately before GA and after surgery. RH's mother will be invited into the recovery area to provide support and post operative restraint would be managed by P Hospital staff. Dr A told the court that he would be the clinician on the day booked for the procedure, and confirmed that this would be undertaken on 9 January 2024, with no other patients booked in the list to minimise distress for RH.

Ms C, mental health nurse

51. Ms C did not file a statement but in her oral evidence explained that she had known RH since his admission to P Hospital three years ago and had noticed how much he had improved following the change in his medication. She indicated that there would be a registered mental health nurse and three healthcare assistants supporting RH who had all undergone training in: '*Reducing Restrictive Interventions Training*' (RIIT) and '*Prevention and Management of Behaviour that Communicates Distress in Adults*'.
52. In line with that training, the team utilises a stepped approach to intervention including verbal explanations, distraction techniques, encouragement and incentivising RH. Ms C stated that if physical restraint is required, the minimum amount of force will be used by trained staff and intra-muscular rapid tranquilisation would only be used as a last resort.

53. During transfer via ambulance, four staff members will accompany RH but a response team (an emergency team of six staff also trained in control and restraint) will also be available if required. In addition, it was agreed that RH's mother will be permitted to travel with RH if she considers that to be in his best interests. The Care Plan identifies the 'core' team of four staff from P Hospital who are familiar to RH and with whom he has a good relationship.
54. Once discharged back to P Hospital, RH will receive care for his physical and mental health needs including post-operative pain relief. If he has a temporary catheter in situ, staff at P Hospital may use restraint as a last resort to prevent RH from removing it and harming himself. There is a physical healthcare nurse available daily at P Hospital who can deal with any issues arising from catheters and suitably trained staff available at other times who can provide catheter care.

RH's wishes and feelings

55. The Official Solicitor's agent was able to speak with RH in the afternoon of 19 December 2023 although RH was reluctant to engage. RH re-iterated what he has said on numerous occasions to the clinical teams: that there is nothing to discuss, there is nothing wrong with him, he is not in pain and does not know why and does not accept that he needs the examination/procedure, and that if the procedure is carried out, his kidneys will be removed by the hospital. He has indicated his wishes and feelings by stating emphatically that he does not want to have the procedure and will not attend the hospital for it to be carried out.

Mrs H's evidence

56. Mrs H's views are documented in the best interests meeting minutes and the attendance note made by a lawyer at the Official Solicitor's office who spoke to her before the hearing. Mrs H states that the proposed treatment is 'vital' to prevent deterioration of RH's kidney function, even though RH does not believe there is anything wrong with him. She refers to a recent conversation where RH told her that he does not want treatment because he is asymptomatic, although he has repeatedly said to clinicians (and the Official Solicitor's agent) that it is because he thinks the hospital wants to remove his kidneys.
57. Mrs H also accepts that restraint may be required but was anxious that RH should not endure a lengthy wait at hospital, as on a previous admission for a planned surgical procedure, he was kept waiting for several hours resulting in him becoming agitated and non-compliant. Restraint was used and it caused him considerable distress, which Mrs H recalls was 'horrid'. She also does not believe that RH could tolerate a long-term in-dwelling catheter and would forcibly remove it or fail to maintain hygiene around it, if he became mentally unwell again. However, she accepts that it is in RH's best interests to undergo the planned procedure as described by the Trust (including the use of restraint) and will support him throughout his admission.

The parties' submissions

The Trust

58. The Trust submits that RH lacks capacity to conduct these proceedings and to make decisions regarding the proposed treatment and Care Plan, relying on the evidence of Dr L and Mr S.
59. The Trust considers that the treatment in the latest iteration of the Care Plan is manifestly in RH's best interests as it will potentially identify a simple cause of RH's urinary blockage and retention, which in turn will prevent deterioration in kidney function and associated reduced life expectancy. It will also reduce the risk of acute infections, sepsis and/or death. If a cause for the urinary blockage is not identified, the exploratory procedure will nonetheless have been of benefit, since the clinical teams can then reconvene and review what further investigations and/or treatment are available. In conclusion, the Trust submits that the risks and disadvantages outlined by the clinicians which include pain, discomfort are relatively mild and are outweighed by the benefits of undergoing the procedure.
60. The Trust relies on section 63 of the MHA for restraint to be used where RH's mental health deteriorates but considers that in relation to any 'additional' deprivation of liberty referable to the planned medical procedure, an order is required from this court. It submits that if it is necessary to use physical and chemical restraint in those circumstances, the measures proposed are necessary and proportionate to the risk of harm and as such it is in RH's best interests for the relevant teams to be able to deploy such measures in order to enable the procedure to take place.

The Official Solicitor

61. The Official Solicitor expressed some concerns as to the Trust's evidence in respect of RH's capacity but following the disclosure of further witness statements and after hearing Dr L's oral evidence, the Official Solicitor did not dispute that RH lacks capacity to (i) make decisions about his inpatient admission; (ii) make decisions as to having urological surgery; and (iii) conduct these proceedings.
62. In relation to best interests, the Official Solicitor highlighted the initial confusion in what was being sought by the Trust in terms of treatment and the lack of clarity in the Care Plan. However, as the evidence unfolded, she submitted that having regard to the risks and benefits, it is in RH's best interests to undergo the proposed minimally invasive diagnostic process and removal of any blockage to the urinary tract, as this has the potential benefit of avoiding kidney failure and a reduced life expectancy. The Official Solicitor reviewed and agreed the final Care Plan dated 3 January 2024.
63. In respect of the restraint proposed, the Official Solicitor agrees with the Trust's analysis as to when restraint is permissible under the MHA and the need for authorisation for any deprivation of liberty related to medical (physical) treatment to facilitate the implementation of the Care Plan.
64. The Official Solicitor also invites me to direct that, should the proposed procedure not reveal any blockage to RH's urinary tract, the matter return to court for a further best interests decision to identify all the available treatment options, as currently the only likely treatment for RH would be the insertion of a long term catheter which Mr S did not consider would be in his best interests notwithstanding that, absent such catheterisation, RH will risk kidney failure and a premature death.

Discussion

Capacity

65. I am satisfied on the totality of the evidence, including the written and oral evidence of Dr L, Dr S, Dr A and Ms C that on the balance of probabilities, RH lacks capacity to conduct these proceedings and make decisions regarding the proposed treatment. In particular, Dr L gave clear and convincing evidence that demonstrates that RH is unable to make a decision about his urinary and kidney condition as he has no understanding of his diagnosis, the purpose of exploratory surgery, and the treatment he needs. He refuses to engage with discussions around this.
66. By reason of his diagnosis of hebephrenic schizophrenia, RH suffers with delusions including that there is nothing wrong with him and that the hospital wants to remove his kidneys and kill or harm him. In Dr L's view, these persistent delusions render him unable to weigh up the relevant information and he cannot see the various parts of the argument and how they relate to one another per Hedley J in *PCT v P, AH and The Local Authority* at [35] *supra*. There is no evidence before me that RH can weigh up and understand the risks, pros and cons of any aspects of the treatment or Care Plan and he is unable to consent to treatment for his urinary and kidney condition.
67. Despite some overall improvement in his presentation following a recent change in his anti-psychotic medication, this has not relieved RH of his persistent delusional thoughts and there are no practical steps to assist him to make a capacitous decision in the time available. I am therefore satisfied that he lacks capacity to make the relevant decisions for the purposes of sections 2 and 3 of the MCA and will make a section 15 declaration to that effect.

Best Interests

68. I am required to consider and apply section 4 of the MCA and have in mind the judgment of the Supreme Court in *Aintree (supra)* at [39] *per* Baroness Hale which requires me to look at RH's welfare in the widest sense, not just medical but social and psychological. I also remind myself that a lack of capacity is not an off-switch for RH's wishes and feelings: *Wye Valley NHS Trust v Mr B* [2015] EWCOP 60.
69. Although RH has repeatedly expressed a firm wish not to undergo any procedure, this wish can only be given limited weight in light of Dr L's evidence that it is underpinned by a delusional belief. The option of 'no treatment' which accords with RH's wishes, would mean losing an opportunity to undertake a simple procedure to relieve the blockage, or at the very least, provide diagnostic information. Worse still, on the evidence currently available, 'no treatment' would mean that RH's kidney function would deteriorate, and his life expectancy would be significantly reduced.
70. Whilst I must have regard to RH's individual autonomy, and I do afford this great respect, I do not give his wishes and feeling predominant weight in the context of his delusional belief and having regard to the complex matrix of other factors to be considered: *M v N (by her litigation friend, the OS), Bury Clinical Commissioning Group* [2015] EWCOP 9 per Hayden J at [28] - [30].

71. I have taken into account the risks, pros and cons of the treatment proposed, including pain, bleeding and discomfort, and the possibility of a catheter being required for a short time post-operatively, which may necessitate the use of additional sedative medication or restraint to prevent RH from removing it. The benefits are clear in that if there is an obvious blockage which can be relieved by a small incision, this will prevent urinary retention and kidney function will improve, avoiding kidney failure and premature death; this is overwhelmingly in RH's best interests. If the cause of the blockage is not readily apparent, the procedure will have nonetheless been diagnostically beneficial and will allow the clinical teams at both hospitals to reconsider the available options.
72. I accept that some degree of restraint is likely to be required in circumstances where RH is refusing the procedure and has paranoid delusions that his kidneys are going to be removed against his wishes. However, it is in RH's best interests to use restraint if necessary and as a last resort, to ensure that he arrives at the hospital, undergoes the procedure, and complies with the post-operative recovery requirements for the same reason that the procedure itself is in his best interests.
73. I take into account the necessity for staff from P Hospital to be on the ward with a ratio of 4:1 to manage RH's mental health as well as to facilitate the operation and recovery period at W Hospital. These are undoubtedly very significant interferences in RH's rights but are entirely necessary and proportionate because without the option of using restraint, RH is likely to be non-compliant and the treatment could not be safely delivered. The orders I shall make in this regard are permissive and it is clear that the Trust's approach, endorsed by the Official Solicitor, is to use the least restrictive measures in a stepped manner, as set out in the Care Plan.
74. I agree with the Trust's analysis that whilst restraint is permissible under s63 of the MHA for the treatment of RH's mental disorder, in all other circumstances where restraint is proposed to keep RH safe for the *purpose* of receiving physical treatment, this requires authorisation by this court and I grant the order sought.
75. Ms C and Dr L told me that RH is the best he has ever been on his current medication regime, after suffering from many years with treatment-resistant schizophrenia. He has been enjoying more frequent visits outside of the hospital including overnight stays with his mother, permissible under s17 of the MHA. It was clear from their oral evidence that the psychiatric team consider that RH has now achieved a better quality of life, is likely to cope better and that the outcome of the proposed treatment will allow RH to resume a quality of life which he would consider worthwhile: *Aintree* at [44].
76. I have also considered the views of RH's mother very carefully. She has provided valuable insight into RH as an individual and has also expressed her own views as to his best interests. She agrees with the Trust's Care Plan including the use of restraint and will be actively involved in supporting RH during his hospital admission and post operative recovery.

Conclusion

77. I grant the Trust's application and make the declarations and orders sought pursuant to sections 15 and 16 of the MCA. I shall also make the directions sought by the

Official Solicitor to re-list this matter before me in March 2024 in the event that no obstruction is found at the operative procedure due to take place on 9 January 2024.

78. Finally, I am grateful to both counsel for their assistance and focussed submissions. I recognise the considerable efforts made by the Official Solicitor in conducting her investigations and making arrangements to meet with RH at very short notice. I am grateful to Mr Sachdeva for his unreserved apology to the court for the failure of the Trust to comply with the directions and order of Theis J. However, as I observed above, the Trust brought this application in a frenzied and unhelpful manner. This impacted on the court's ability to determine the case and the Official Solicitor's ability to present her position as litigation friend to RH, which ultimately necessitated an adjournment. The parties have agreed an order for consequential directions which I have approved in the expectation that those will be complied with.