IN THE COURT OF PROTECTION

Case No: 13143714

Neutral Citation No. [2017] EWCOP 25

Courtroom no.10

60 Canal Street
Nottingham
Nottinghamshire
NG1 7EJ

Thursday, 12th October 2017

Before:
THE HONOURABLE MR JUSTICE KEEHAN

B E T W E E N:

NOTTINGHAM CITY COUNCIL

&

JT
(by her litigation friend, the Official Solicitor)

MISS KHALIQUE QC appeared on behalf of the Applicant
MR HOCKTON appeared on behalf of the Respondent

JUDGMENT
(For Approval)

MR JUSTICE KEEHAN:

Introduction

1. This serious medical treatment case was issued by the Applicant, University Hospitals of North Midlands NHS Trust (hereafter referred to as 'The Trust'). On 29 September 2017 the Trust has applied for the following orders: 1) a declaration that the respondent JT lacks capacity to make decisions regarding her surgery to treat her breast cancer and 2) an order that it is lawful and in JT's best interest to undergo surgical removal by wide label excision of ductal adenocarcinoma of her left breast under general anaesthetic.

2. The respondent, whom I shall refer to as JT, is a 66-year-old woman who has a well established diagnosis of paranoid schizophrenia. She is treated with anti-psychotic medication but her condition has proved to be resistant to treatment. JT has been diagnosed with cancer of the left breast after repeated examination by consultant breast surgeons and clinical testing. She does not accept that she has breast cancer. She maintains she simply has a cyst in her left breast. Further, she believes that the consultants and clinicians, with whom she has come into contact, are actors or impostors.

3. For transparency this hearing has been conducted in public. At the outset I was, by consent, invited to make a transparency order. I readily do so, in accordance with the new procedure in the Court of Protection.

The Law

4. By s.1(2) of the Mental Capacity Act 2005, a person must be assumed to have capacity unless it is established that he lacks capacity. There is a two-stage test for determining whether a person is capacitous: first the diagnostic test set out in s.2 of the Act and then the functional test set out in s.3. Section 2(1) reads as follows: 'A person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain'.

5. Section 3(1) reads:

> 'For the purposes of section 2, a person is unable to make a decision for himself if

he is unable—
(a) to understand the information relevant to the decision,
(b) to retain that information,
(c) to use or weigh that information as part of the process of making the decision, or
(d) to communicate his decision (whether by talking, using sign language or any other means)'.

6. If a person is found to lack capacity the Court then proceeds to make a best interests decision pursuit to s.1(5), which provides, 'An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests'.

7. The determination of best interests is set out in s.4. Section 4(1) provides:

> 'In determining for the purposes of this Act what is in a person's best interests, the person making the determination must not make it merely on the basis of—
> (a) the person's age or appearance, or
> (b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about what might be in his best interests'.

8. Further s.4(2) provides, 'The person making the determination must consider all the relevant circumstances and, in particular, take the following steps' and s.4(3):

> 'He must consider—
> (a) whether it is likely that the person will at some time have capacity in relation to the matter in question, and
> (b) if it appears likely that he will, when that is likely to be'.

9. I do not need, for the purposes of this judgment, to set out the remaining provisions of s.4 of the 2005 Act, but I take account of the same, when considering (a) whether the proposed surgery is in JT's best interests and (b) whether and in what circumstances JT may be deprived of her liberty, if restraint has to be applied at any time, either in transporting her to the hospital for surgery or during surgery at PRU. I take account of the decision of the Court of Appeal in *R (Ferreira) v HM Senior Coroner for Inner South London* [2017] EWCA Civ 31, in particular the judgment of Arden LJ paragraph 89, where Arden LJ explained that where action or restraint is necessary in the context of emergency medical treatment, that that will not of itself give rise to a deprivation of liberty. Nevertheless, as there is a risk or a chance that JT may need to be restrained for the purposes of transporting her to hospital for any surgery that may be approved, I will authorise any such deprivation, following as I do my decision in the case of *NHS Trust v G* [2015] 1 WLR 1984.

Background

10. JT has suffered from paranoid schizophrenia for over 25 years. Dr Hussain, her treating consultant psychiatrist for the last 18 years, advised the Court that her condition has proved to be treatment resistant and that she will not be persuaded to accept a different anti-psychotic medication like Clozapine which is often used as a treatment in persistent cases.

11. JT has been seen by Dr Hussain every two months over the last 18 years or so, but since 27 July 2017 she has stopped seeing him because she believes that he is part of a conspiracy for her to undergo an operation, or treated for a condition, namely breast cancer, which she does not have. JT is supported in the community by a community psychiatric nurse. She was initially referred to the Trust breast care services by her General Practitioner in February 2017. She cancelled three consultant appointments offered to her. In June she was the subject of an urgent referral to the breast services by the GP. She was seen by a locum consultant breast surgeon on 8 June 2017, who diagnosed a malignant lump in her left breast, which was confirmed by an ultrasound scan and a biopsy of the breast lump.

12. Her treating consultant breast surgeon, Mr Marla discussed JT's case in a multidisciplinary meeting on 16 June 2017. It was agreed JT had a malignant tumour. On 21 June 2017 she attended an appointment with the locum consultant surgeon, accompanied by her brother, when she was prescribed a course of Anastrozole. This medication could result in a slight shrinkage of the size of the cancer over a period of time. Subsequently her brother notified the breast team that JT refused to take the medication. Mr Marla saw JT with her brother on 26 July 2017. By this time he had received a letter from Dr Hussain formally raising, for the first time with the breast care team, the issue of JT's capacity to consent to medical treatment. Mr Marla therefore undertook a detailed consultation and an in-depth review of her understanding of her medical condition.

13. Further, on 3 August he personally accompanied JT to the radiology department for a repeat ultrasound scan. He explained the findings to her and had a long discussion with her and her brother about the condition and proposed treatment.

14. He booked her in tentatively for surgery on 12 September, but she refused to have surgery or to attend a pre-operative assessment. After discussion with JT's psychiatric team, Dr

Marla decided to convene a best interests meeting on 18 September 2017. A plan was made to review JT at an outpatient clinic on 28 September 2017 to discuss the next steps with her, including making the application to this Court. JT declined to attend. However, a breast care nurse telephoned JT later that day. JT said she would have the operation, but only privately, because she had been messed around by the Trust, which was not a real hospital, and further she did not accept that she had cancer and asserted that (i) her brother had told her that the lump was in fact a control box that is inside her and (ii) that her brother was not her real brother.

15. In consequence of the foregoing, the Trust made this application. If it is granted, it is proposed that JT would undergo the proposed surgery, in the window of 17 October-2 November.

16. I should add that JT was spoken to yesterday in person at her home by a solicitor agent, Ms Yvonne Chapman, instructed by the Official Solicitor. Her brother was also in attendance. During the course of that conversation she indicated that she still did not accept that she had cancer. She wanted to undergo further tests and said if she was to have an operation she would want it undertaken privately. She indicated that if I made an order that she should undergo treatment, that she would comply with it, but she did not wish to see me and was content that her views were conveyed to me by the solicitor. In consequence of this conversation, Ms Chapman considered that JT lacked capacity to conduct these proceedings.

17. In a similar vein I have an addendum report from Dr Hussain, in which he confirmed that in his view, JT lacks capacity to conduct these proceedings.

Capacity to make a decision in relation to medical treatment

18. Dr Hussain has had professional responsibility for JT's medical health care for a very substantial period of time. In his statement of 26 September 2017 he said as follows:

> 'It is my view that JT meets the diagnostic test set out in section 2 of the NCA because there is a disturbance in the functioning of her mind and brain. She has active symptoms of paranoid schizophrenia - a mental disorder that she has fixed delusional beliefs, which are persecutory in nature and she has a complete lack of insight into her psychiatric and physical condition. When I reviewed JT in my clinic on 13 July 2017 my opinion is that she was not able to understand the relevant

information regarding her cancer diagnosis. Her understanding is that she does not suffer from breast cancer, and it is a conspiracy on the part of her enemies to pretend that she had the illness, so they can enforce some procedure or treatment on her of their own making. She believes she had been taken to a fake hospital by a fake impostor brother who was seen by fake doctors and this is all part of a conspiracy. She refused to accept any medication for surgical treatment. Her ability to weigh up information relating to her decision is impaired. She cannot perceive there to be any benefits from the proposed surgery and as a result of her delusional beliefs described above, she has underplayed the risks, as her belief is firmly that she does not have any cancer. On this basis I believe that she needs a functional test under Section 3 of the NCA. She cannot weigh or understand or weigh the risk of not having the cancer treated or removed. While she is able to communicate her thoughts back to the treated team, and is able to communicate that she does not want the operation, I understand she prefers not to turn up to appointments instead. She is not able to provide an explanation as to why she does not want the operation, although I understand from the treating team she said she would like to receive private treatment elsewhere and then does not'.

19. In relation to the issue of physical restraint, which I interpolate here, Dr Hussain says:

> 'I understand there may be a requirement to restrain JT in order to get her into hospital from home. In my dealings with her over the years she has never required restraint, and I believe once you make the legal requirement of co-operation, i.e. the Court makes a decision that is in her best interests to treat her, then she is likely to comply with the procedure, despite believing it to be part of a conspiracy. Restraint is required to sedate her in order to get her to hospital for subsequent surgical procedure. I believe the impact and distress is likely to be short lived. In the longer term I believe this course of events, restraint, is likely to be included in her existing delusional beliefs, but her distress would not be any more than it would be if she did not have paranoid schizophrenia'.

20. The clinical experience of Mr Marla entirely supported Dr Hussain's conclusion in respect of JT's lack of capacity to make a decision, in respect of her medical condition and treatment. In his statement on 29 September 2017 he gave the following account of his consultation with JT on 26 July.

> 'We discussed her initial presentation and investigations. She was convinced she had been seen by actors on her last two visits and wanted a test to prove that she had a cancerous lump in her breast to be repeated. She agreed to be examined by me. I could feel an approximately 3cm hard lump in her left breast involving skin. JT was convinced that the lump I was feeling was a cyst in her breast. I took her to a mirror and showed her the skin changes and got her to feel how hard the lump was. I then showed her the ultrasound images at the imaging port, her biopsy result stating that it was an invasive cancer. She agreed with me but wanted the tests repeated again. She was happy to come back for a repeat ultrasound scan to reassure her. At this point I formed the opinion that she lacked capacity due to her psychiatric condition. She openly explained to me that she had been seen by actors on her previous visit

and this was not a hospital. She also mentioned that people caring for her health and psychiatric problem, which she did not believe she had, was poisoning her with drugs'.

21. Mr Marla then describes how on 3 August he accompanied JT to the radiology department and explained the ultrasound scan then taken of her. He then further makes observations about her condition thus:

> 'If left it is likely that this - that is the growth - would progressively grow and reach through the skin and form an ulcer which will erode through the surrounding breast. This is usually compounded with secondary infections and gets very difficult to manage. At the same time it may also spread to other organs and metastases may eventually be fatal'.

22. In relation to the capacity to make a decision, Mr Marla concluded as follows:

> 'In respect of Section 2 of the NCA, following my consultations on 26 July, and 3 August, I believe JT met the diagnostic test is there was a disturbance in the functioning of her mind caused by the active symptoms of paranoid schizophrenia. JT accepted some of the information I gave her at an intellectual level i.e. that there is a lump in her breast. However, she misbelieves the diagnosis and subsequently does not think she requires any treatment. I do not believe JT can understand the information provided to her relevant to risks and benefits of not removing the cancer. I believe she is able to retain some of the information discussed but cannot weigh that information as part of a decision making process and therefore I am of the opinion that she lacks the capacity to make a decision regarding the treatment. She is unable to fulfil the functional tests under section 3 of the NCA. When I discussed the implications of not having treatment, JT does not appear to be able to communicate her reasons for refusing, although she is able to communicate her decisions back to me. Her response appears to be an initial agreement, then declining to come in to hospital'.

23. On the basis of the evidence of Dr Hussain and Mr Marla, and in the circumstances set out above, I am clearly satisfied that JT lacks the capacity to make a decision about her medical treatment in respect of her diagnosed breast cancer.

Best interests decision

24. As I have indicated above, if JT does not receive the proposed surgery, followed by a course of radiotherapy, Mr Mahla has advised that it is likely to be fatal to JT. In relation to the treatment options, Mr Mahla has advised that there were three; a) anti-hormonal therapy, b) breast conserving surgery, or c) a mastectomy. The benefit and risks of anti-hormonal

therapy are described by Mr Mahla in his statement:

> 'The benefits include halting the growth of the tumour and slow shrinkage of the tumour over a period of time. It is important to note that tumour cells can over a number of months or years, escape the effects of the anti- hormonal medication and the cancer can start to regrow. Risks include side effects of the tablets, depending on the type of anti-hormonal medication. This can include deep vein thrombosis, cancer in the womb, joint pains from vein filling, causing osteoporosis and fractures'.

25. The benefits and risks of breast conserving surgery are as follows:

> 'Benefits include preserving the rest of the breast tissue which is psychologically important for women. It helps them maintain their femininity and improves their quality of life. The operation can be done as a day case, which would also be beneficial for JT, as she could go back to familiar surroundings the same day. Risks include requiring further surgery, the margins of the first specimen are [inaudible] this happens in one out of six cases. Most of them require a small surgery where re-excision of the margin is performed. All women having WLE normally receive radiotherapy; the rest of the breast tissue is part of the treatment'.

26. The benefit and risks of the mastectomy are set out by Mr Marla thus:

> 'The benefit of the mastectomy would be the likelihood of requiring radiotherapy after surgery would be reduced but not completely ruled out. Risks from mastectomy include psychological distress at losing the breast, longer recovery time, and inpatient stay'.

27. During the best interests meeting that was held on 18 September, it was felt by all present, including JT's brother, and the community nurse practitioner, that a full mastectomy would be too distressing and detrimental to JT's mental health, especially if she continued to disbelieve her cancer diagnosis.

28. Accordingly, the consensus of JT's treating clinicians is the best solution for her was considered to be option b, for her to undergo breast conserving surgery, namely surgical removal of the ductal oedema carcinoma. Mr Marla advised as follows:

> 'In the case of JT, and following discussion with the brother and community nurse, who has also known JT for 30 years, it was decided that this would be the best solution for her. A decision was made to surgically remove the cancerous lump would offer the maximum benefit to JT, even in the absence of any further therapy anti-hormone or radiotherapy. It could leave a relatively small scar on the breast, but preserve the rest of the breast tissue. She would hopefully[?] recover in a few

days to a couple of weeks after surgery'.

29. He concluded that:

> 'My opinion is that the wide late excision of the central node[?] biopsy is the safest option for JT, which will allow us to remove the cancerous mass and halt the progression of this disease. I believe this is the best option with minimum physical and psychological morbidity'.

30. The treating consultant oncologist, Dr. El-Helw, and Mr Marla, are agreed that JT would be unlikely to attend voluntarily the conventional 15 sessions post operative of radiotherapy. Accordingly, it is recommended she undergoes a shorter course of 5 sessions together with anti-hormone tablets or injections.

31. I have had the benefit of reading a witness statement from Dr Bingham, the consultant anaesthetist, and from a senior nurse, Mr Broad, in relation to the provision of anaesthesia to JT for the purposes of surgery and also the extent to which it may be necessary to restrain her either en route to the hospital or during, in the course of preparing for the procedure. Both the anaesthetist and the nurse are immensely experienced in dealing with people who are vulnerable individuals who lack capacity and in particular, Mr Broad, who would support JT whilst undergoing surgery, and he would take the lead of physical restraint of JT.

32. I am satisfied, in particular, that Dr Bingham has assessed the risks in administering general anaesthesia to JT, and I am satisfied with his conclusion that it is in her best interests to undergo general anaesthesia for the purposes of this operation.

33. On the totality of the consensus of medical evidence before me, I am satisfied that first, JT does have breast cancer as diagnosed by clinicians, and that the best option in her best interests for her, is to undergo surgery to remove the carcinoma. I am satisfied that it is a measured and proportionate response to her medical condition and for her not to undergo surgery would not be in her best interests and could lead to fatal consequences for her. It would appear from the opinion of Dr Hussain, and from what JT has said to Ms Chapman yesterday that if this Court does indeed conclude that she needs to undergo surgery, she is likely to comply, although she would be unhappy.

34. In conclusion, in all of the circumstances, I give permission to the Trust to bring this application. I make the declaration that JT lacks the capacity to conduct these proceedings and lacks the capacity to make the decisions about her medical treatment. I will make an order that it is lawful for the Trust to undertake, and in the best interests of JT, to undertake the proposed surgery and the consequential orders, including authorising restraint where necessary and authorising any deprivation of her liberty.

End of Judgment

Transcript from a recording by Ubiqus
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