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Case No: COP 11426732

**IN THE HIGH COURT OF JUSTICE**
**FAMILY DIVISION**

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 14/10/2010

**Before** :

**MRS JUSTICE MACUR DBE**

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**Between :**

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| **An NHS Foundation Trust** | **Applicant** |
| **- and -** | |
| **D** | **Respondent** |
| **(by her litigation friend the Official Solicitor)** | |

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**Mr Russell Stone** (instructed by **The Legal Department of a NHS Trust**) for the **Applicant**
**Ms Bridget Dolan** (instructed by **Official Solicitor to the Superior Court**) for the **Respondent**

Hearing dates: 29 September 2010

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# Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

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MRS JUSTICE MACUR DBE

This judgment is being handed down in private on 14 October 2010 It consists of 9 pages and has been signed and dated by the judge. The judge hereby gives leave for it to be reported.

The judgment is being distributed on the strict understanding that in any report no person other than the advocates or the solicitors instructing them (and other persons identified by name in the judgment itself) may be identified by name or location and that in particular the anonymity of the children and the adult members of their family must be strictly preserved.

## Mrs Justice Macur DBE :

1. D is a 69 year old woman with a long history of schizophrenia. She has had numerous admissions as a psychiatric inpatient in the past 39 years. She has a history of refusing medical care. Her last admission followed deterioration in her mental state considered to be due to her non-compliance with her medication regime. More significantly in this case, for the purpose of considering her best interests overall, she believes that there is a conspiracy on the part of medical personnel to subjugate and experiment upon her, if not kill her.

2. She was discharged subject to a Community Treatment Order under S17A Mental Health Act 1983 to a 'supported' hostel in the community in 2008. The terms of that Order do not conflict with the circumstances envisaged as necessary to facilitate and provide the medical care for relief of her particular physical symptoms.

3. D has a third degree prolapsed uterus (procidentia) which requires surgical intervention to relieve what must be significant discomfort, remove ulcerated tissue and prevent recurrence and possible malignancy, reduce/eliminate urinary tract infections and prevent associated kidney failure which could be fatal. If left untreated D's 'independence' and daily activity will be compromised. It is likely that D needs to undergo a hysterectomy and pelvic floor repair.

4. She disagrees that there is anything medically wrong with her condition, believing that her condition is a normal consequence of her aging process. To date it has been impossible to conduct a thorough medical examination to evaluate the exact extent of the treatment and likely measures necessary to determine a final surgical plan. Her mental condition is unlikely to be sufficiently relieved in the short or medium term to render her amenable to such assessment.

5. The Applicant is the NHS Foundation Trust for the hospital at which it is proposed that D will undergo her medical treatment if sanctioned by this Court in the absence of her consent. As Applicant in these proceedings it asks the Court to determine : (i) whether D lacks capacity to make decisions in relation to treatment for the prolapsed uterus; (ii) whether D lacks capacity to engage in these proceedings in relation to the same; (iii) whether it is in D's best interests to undergo surgery and other necessary treatment for the prolapsed uterus which is anticipated to involve long period sedation, hysterectomy and pelvic floor repair; and, (iv) whether in order to provide/facilitate such surgery and treatment it is lawful to deprive her of her liberty by either physical or chemical restraint.

6. In view of the issues at stake both Counsel representing the NHS Trust and D by her Litigation Friend, the Official Solicitor applied that this hearing be in public. I agreed. There is, unarguably and rightly, public interest in any application involving the restraint of a non consenting vulnerable person for the purpose of

unwelcome surgical intervention involving the administration of sedative drugs to remove that person from their normal place of abode to a hospital and thereafter.

7. Hedley J has previously directed the manner in which the parties are to be addressed in any order of the Court. However, in the circumstances of a public hearing, it is also necessary that a Reporting Restriction Order was made prohibiting the publishing of any information that may lead to the identification of D, the NHS Trust or any medical professional or institution in which D resides, including any picture of the same and also reference to the content D's delusion. The latter is a sad reflection of D's disordered mental state and instructive in formulating the decision of the Court but is capable of inappropriate titillation and low humour at the expense of D and those who provide her care. Any report of this judgement must be edited as to this particular and all names anonymised by initialisation.

8. It is important to record that all care staff, medical personnel, the NHS Trust and Official Solicitor have obviously given anxious consideration to promote the welfare of D, aware of the nature and extent of her suspicion and antipathy of doctors, nurses and hospitals and thereby to contemplate the integrity of the individual concerned in the proposals they make to the Court. There has been joint instruction of an independent Consultant Anaesthetist and Consultant Psychiatrist to report on best interests, issues of deprivation of liberty, capacity and best interests arising from the care plan of medical diagnosis and surgical intervention proposed. I am satisfied that the independent expert witnesses and treating clinicians have discussed the matter in full. There is now no dispute between them.

9. <u>Capacity:</u>
Professor Tom Sensky, Emeritus Professor of Psychological Medicine at Imperial College London and Consultant Psychiatrist to the Occupational Health department at West London Mental Health NHS Trust, instructed as an independent expert, concludes after his own assessment following personal interview with D and from available medical records that she has a recognised psychiatric disturbance which constitutes a disturbance of her mind and which substantially impairs her ability to weigh relevant information about her medical treatment in the balance, and also interferes with her ability to understand and retain information. He considers that the delusional beliefs which are a symptom of D's schizophrenia impair her capacity to make decisions about her medical treatment and to participate fully in legal proceedings in respect of the same. He cannot conceive of any strategies or methods which are likely to persuade D to co-operate with future medical treatment. He considers there is little prospect of any improvement in the symptoms of her schizophrenia which means her impaired decision making regarding medical treatments is likely to be permanent.

10. D's treating Consultant Psychiatrist reports her fixed persecutory delusions and experiences of auditory hallucinations. She believes her prolapsed uterus is a

consequence of a normal process so does not accept the warnings of adverse medical consequences should it remain untreated. In his view she lacks capacity to weigh up the information regarding her physical condition. He is aware that she dismisses all offers of medical care unless acutely unwell. She will sometimes be resistant to her regular intramuscular injection of antipsychotic medication. In these circumstances her treating psychiatrist does not consider that she will attend at a hospital voluntarily and will refuse to submit to medical treatment.

11. I accept the opinions of Professor Sensky and the treating psychiatrist. I bear in mind the Mental Capacity Act 2003, sections 1 to 3. I declare that D lacks capacity to make decisions concerning and relating to medical treatment required in respect of her prolapsed uterus, or to engage in this litigation concerning the same other than by her Litigation Friend, the Official Solicitor.

12. Medical Considerations.
Dr F, GP was asked to visit D on 6 July 2009. D refused to be examined but did "spontaneously take down her underclothes" in front of a window which allowed Dr F to observe a second or third degree prolapsed uterus. D accompanied by her daughter visited the doctor's surgery on 23 July 2009. On examination she had marked procidentia with associated thickening and inflammation suggestive of a chronic condition. Temporary reduction was attempted but extremely short lived. D refused insertion of pessary ring which was felt, in any event to be unlikely to remain in situ. Dr F notes, from D's records, suspected repeated urinary tract infections in October 2009 at which times D refused examination or treatment. She had been admitted to hospital with sepsis secondary to such an infection in August 2009 and required intravenous antibiotics.

13. A Senior Urogynaecology Nurse Specialist attended to examine D on 19 November 2009 but D refused to be examined. In January 2010, Dr F visited D to elicit and respond to concerns regarding treatment of the prolapse. D on that occasion voiced concerns about anaesthesia and her belief that her entire vagina would be removed with consequent inability to engage in sexual intercourse thereafter. She thought it a common condition, which should not be cut.

14. Ms H is a Registered Mental Health Nurse and care co-ordinator based at the sheltered living community in which D resides. She knows and cares for D and has a positive relationship with her. Ms H last caught sight of D's procidentia on 19 July 2010. She noticed that the skin was cracked and there were traces of blood and it was malodorous. It had been noted that D appeared to be making more rushed and frequent trips to the toilet and was spending longer in the bath than usual. It is reasonable to infer that there may be a urinary tract infection and the warm water provides some relief from discomfort.

15. Professor C is Professor of Urogynaecology employed by the NHS Trust Applicant. She attended a 'best interest case conference' convened to consider D in March 2010. She confirmed the possible adverse medical sequellae to leaving the described procidentia untreated as indicated above. She does not consider that conservative management by ring pessary would be appropriate or effective. In her view definitive repair is only possible by vaginal hysterectomy and pelvic floor repair.

16. Pre-surgery it would be necessary to treat ulcerated tissue by application of hormonal cream nightly for 3 weeks and then 3 times weekly pending surgery. D refused the cream on 19 November 2009 and will therefore need to be admitted to hospital 96 hours prior to surgery for insertion of oestrogen packing. A urethral catheter will need to be in place. These procedures would require active participation of the patient in that they should be maintained in situ. In this case it is acknowledged that D will likely need to be sedated to prevent her manual interference.

17. Professor C recognises the risks of surgery to include possible adverse reaction to general anaesthesia; bleeding, infection, deep vein thrombosis, damage to bladder, bowel or ureta, recurrence and dysparunia. Against that she notes the following. There is no record of previous adverse reaction to anaesthetic or family history to suggest the same. The risk of bleeding is minimal if the surgery is performed vaginally. It is proposed that intravenous antibiotics will be administered prior during and post operation, Attention will be paid to adverse effect of reduced mobility by way of support stocking and anticoagulant medicine. Damage to internal organs occurs in 1-2% of cases and there will be post operative monitoring will elicit the same. D does not have the risk factors most often associated with failure. D is not believed to have a current sexual partner.

18. Post surgery some vaginal bleeding may be experienced. Internal sutures will dissolve within 90 days. Discharge is normally 2 days post operation with advice to avoid strenuous activity and heavy lifting.

19. Dr C, Consultant Anaesthetist and Clinical Lead for Anaesthetics and Critical Care employed by the Applicant NHS trust has reviewed D's medical records in the absence of opportunity to meet or examine her and has discussed her case with colleagues. He advises that if D were to eat or drink normally it would be possible to add a short acting benzodiazepine to a drink. Unfortunately, this is unfeasible given Ms H's reports of D's reluctance to accept food from others in the belief that she will be poisoned. In these circumstances he considers sedation tantamount to general anaesthesia would be required. Intramuscular injection would be necessary.

20. The administration of the anaesthetic is potentially life threatening and will require expert assistance and airway protection. A paramedic crew will need to be

on hand to take over the care of D after receipt of the injection prior to her admission to the critical care unit of the NHS Trust hospital. The prospect of D tolerating cannulation is remote but will be necessary for the intravenous delivery of antibiotics. A nastrogastric tube will be required for enteral nutrition. It is likely that all such invasive procedures required pre and post operatively will not be tolerated by D and require continued sedation. Verbal contact with D will therefore be lost for a considerable period. Airway support will be necessary. Other potential complications include infection, ventilator associated pneumonia and thrombo-embolic complications; all of which may be minimised by careful nursing and prophylaxis.

21. Overview:
Dr Bell, Consultant in Intensive Care/Anaesthesia at the General Infirmary at Leeds prepared an interim report on 26 August 2010. Dr Bell, whilst accepting that the proposed treatment plan MAY be in D's best interests expressed concern about the absence of comprehensive gynaecological assessment precluded appropriate surgical planning , evaluation of surgical risks and secondary procedures; absence of assessment of cardio respiratory reserve had not been possible which precluded strategic planning for "surgical or systematic hurdles or complications"; absence of pre-determination of physiological tolerance of intubation and ventilation ; the risks of protracted deep sedation could not be defined in terms of severity and impact on future health status ; and, the decision making process either in the necessity to consider intervention which would impact upon her quality of life or resuscitation in extremis.

22. There has since been a full discussion between Dr Bell and the other Consultants who will be involved in D's treatment. The following 'best interest recommendations' made to the Court as agreed by all.

23. There is to be an informal end of bed assessment of D in her home to identify any obvious contra indications from an anaesthetic or critical care perspective to what is proposed to be initial sedation, potential physical restraint through to major surgery, prolonged sedation and ventilatory support. If no such contraindication Dr C will liaise with relevant others to devise a strategy to achieve D's compliance for transfer to the designated hospital, voluntarily or by means of chemical/physical restraint. Upon arrival at hospital, Professor C will make full assessment of the feasibility of operative intervention. If not feasible, D to be allowed to revive and be discharged home with arrangements for palliative care. If feasible, D to be transferred to critical care facility for pre operative procedures, invasive monitoring and other critical care routine. If satisfactory response is achieved, D to be prepared for vaginal hysterectomy and repair. In the event of unsatisfactory response or escalating requirement for support D will be awakened for discharge or palliative care. During surgery all necessary interventions to be at the discretion of the operating surgeon save that certain interventions with predictable outcome on D's future quality of life, for example colostomy be avoided. In the event of major surgical interventions with no simple treatable

reversible cause consideration to be given to palliation rather than further operative intervention. In the event of major systematic problems with significant implications for dependency on future health care intervention consideration to be given to palliation rather than introduction of new therapies. Provision of intensive care to be continued post operatively until confident that emergence agitation will not translate into serious complication of surgery.

25. Ms H and Ms E will provide support following discharge from hospital, particularly in encouraging D to maintain good levels of hygiene and by unobtrusive monitoring of her physical condition. D is known to purchase over the counter painkillers which will relieve any pain and discomfort.

26. I am left in no doubt as to the necessity to investigate the implications of surgical intervention to relieve D's current medical condition. I determine that such investigation is unlikely to be possible to conduct with D's consent or whilst she is fully conscious unless physically restrained. Unless there be contra indication in D's particular physiological circumstances the physical benefits likely to flow from successful surgical repair of the procidentia are overwhelming when compared with the general day to day risks associated with surgery under general anaesthetic. The 'usual' risks are thereby entirely proportionate to the outcome sought.

27. Mental Health Considerations:
Her treating psychiatrist considers that any initial distress post operatively and dependent upon 'value' she placed on her deluded belief would be counteracted by her overall improved health, comfort and general well being and increased mobility. He believes that she will need sedation beyond the expertise of a psychiatric team and unless fully sedated throughout the course of treatment would suffer considerable distress and advises against physical restraint as an alternative means to compel her attendance at hospital. Professor Sensky considers sedation, restraint and deprivation of liberty envisaged as necessary for surgical intervention to become possible are much more likely to preserve the quality of D's life than no intervention at all. Professor Sensky reminds the Court that people with chronic and enduring mental disorder have a considerably restricted life and only limited skills to adapt to changing life circumstances. In this regard it is important to try to preserve D's capacity to live day to day in a manner to which she has become accustomed and to give due weight to her preferences and priorities. D is known to be 'active' particularly in summer months, taking long walks. The surgical intervention offers the prospect to preserve her mobility and consequent independence.

28. D's Wishes and Feelings:
Professor Sensky expresses his opinion that D's current views and wishes are driven by her delusional beliefs about doctors and medical treatments. Her expressed wishes not to have treatment must be viewed in this context. D has expressed no wish to disregard her health or not to continue living. I accept

Professor Sensky's evidence that these views, literally observed, would be counter intuitive to best interests since they are completely bound up with her delusional beliefs.

29. Counsel instructed by the Official Solicitor recognises the delicate balance to be drawn but does not argue against the declarations sought nor seek to challenge the best interest decisions proposed.

30. The circumstances of D's case are unusual in that it is necessary to contemplate the chemical/physical restraint of a vulnerable person not merely to administer medical aid but to transport, investigate and prepare for such. Nevertheless in all the circumstances of this case as indicated above which present "significant clinical, ethical and legal challenge" I conclude that it is undoubtedly in D's best interests that I should sanction the deprivation of her liberty in so far as it is required to remove her to and retain her in hospital to conduct necessary medical investigations into and thereafter administer the appropriate treatment of her procidentia with all such necessary restraint, physical or chemical, to achieve the same -consistent so far as possible with maintaining D's dignity throughout.

31. I am satisfied that the Care Plan is the best that can be devised. Her clinicians must be given the greatest possible flexibility consistent with delivering the best care to D and must therefore be free to exercise their professional clinical judgement for optimal strategy throughout all procedures dependant upon D's response. To do otherwise would require the NHS Trust applicant to return to Court for sanction at each stage. I determine it is undesirable and without the best interests of D to require them to do so.

32. Continued Efforts:
Whilst I have no reason to believe that D will otherwise submit to necessary medical investigation and treatment I consider D should continue to be advised in appropriate terms about the benefits of surgery to attempt to elicit her co-operation and consent to necessary procedures without alerting her in advance to circumstances which in itself will cause unnecessary anxiety and distress. It is inappropriate and counter productive that she should be 'duped' into believing that an injected sedative is in fact her regular depot antipsychotic medication. To do so would fuel D's paranoid beliefs.

33. In advising D and in the course of administering any sedation or applying physical restraint I consider it is necessary and in D's best interests to avoid alienating those members of staff and medical personnel with whom she has formed a relationship of trust. In these circumstances unless it is considered better overall and less likely to cause distress that sedation and restraint be applied by Ms H or Ms E they should remain distant from those procedures which will be likely to damage future relationships with D. D's daughter may be instrumental in persuading her mother as to the benefits of hospital admission but in light of her

own mental health difficulties from time to time is an unreliable source. She is more likely to be capable of support post operation than before but due regard should be given to encourage her participation in the treatment plan for her mother.

34. The order containing such declarations and directions to be drawn accordingly.